1989

Medicare

Part A Intermediary Manual

Part 3 - Claims Process

U.S. Department of
Health and Human Services
Health Care Financing Administration
HCFA-Pub. 13-3 Thru Rev. 1425
Reprint 5/89

HE 22 8/6

FOREWORD

A. Function of the Part A Intermediary Manual.--This manual makes available to the Part A intermediary, in a form suitable for ready reference, informational and procedural material needed for the prompt and accurate processing of claims for services furnished under the provisions of the Health Insurance for the Aged Act (Medicare). It also contains information needed to answer questions which may be asked about the program and should help to assure that the law is uniformly applied nationally without regard to where covered services are furnished.

Throughout this manual when reference is made to an intermediary function, it is to be construed that the term "intermediary" is to include "bill paying HMO." Although the HMO is not responsible for the Admission/Query process per se, proper correlation of utilization data with the ensuing bill requires knowledge by the HMO of the query and reply process, the spell of illness concept, entitlement and benefit data, and the general contents of this manual.

B. Contents and Organization.--

1. Contents.—The manual provides instructions for implementation of the provisions of Title XVIII of the Social Security Act and Medicare regulations. It amplifies the basic statutory provisions for coverage of services and the requirements which must be met for Medicare payment to be made. The procedures and documentation required have been devised to satisfy the administrative needs of the program and are slanted toward the usual case. However, an attempt has been made to cover some infrequent situations that may occur.

2. Organization.--The Part A Intermediary Manual is divided into three separate parts:

Part 1--Fiscal Administration contains instructions for reimbursement of administrative costs, budget preparation and execution, letter of credit method of advancing funds, and accountability.

Part 2--Audits-Reimbursement-Program Administration includes instructions for intermediaries on provider audits, instructions on provider reimbursement pertinent only for intermediaries, and instructions in other areas of program administration not directly related to the claims process.

Part 3--Claims Process contains informational and procedural material the intermediary needs for the efficient processing and payment of claims. This includes instructions dealing with coverage of services, bill review, payment and postpayment actions, reasonable charges, and other pertinent claims procedures.

READEX FICHE best copy available

C. Relation Between the Part A Intermediary Manual and Other Reference Material.--Title XVIII of the Social Security Act is the statutory basis for the broad objectives and operations of the Medicare program and is the foundation for the regulations and all manual material.

In addition to the Part A Intermediary Manual, the Medicare Bureau issues separate manuals for Part B carriers, participating providers of health services, and Social Security Administration components to provide guidance in specific areas in the administration or participation in the Medicare program. The Part A Intermediary Manual is self-contained and requires no cross-referral to any of the other manuals. However, users may refer to the Social Security Act and Department Health Regulations, to determine the legal basis underlying a particular policy or procedure embodied in the instructions.

Although the Part A Intermediary Manual does not have the effect of regulations, a careful effort has been made to insure that the provisions of the law and regulations are accurately reflected.

The health insurance regulations are interpretations, implementations, and policies flowing from the statute and are formally approved and published by the Secretary of the Department of Health, Education, and Welfare. Regulations have the force and effect of law and are binding on all parties.

The Health Care Financing Administration (HCFA) also publishes Health Care Financing Administration Rulings under the authority of the Administrator of HCFA, to make available official rulings which relate to the health care financing programs under his jurisdiction. HCFA jurisdiction includes responsibility for the Medicare and Medicaid programs, certification of health standards for health care facilities, the Professional Standards Review Organization program, maintenance of program integrity against fraud and abuse, and the Provider Reimbursement Review Board.

The rulings include materials that the Freedom of Information Act requires to be made public, such as final opinions, including concurring and dissenting opinions, and orders made in the adjudication of cases. The rulings also include statements of policy and interpretations adopted by HCFA or one of its components and not published in the Federal Register, indexes of administrative staff manuals, and instructions to staff that affect the public.

Examples of kinds of materials published in the Health Care Financing Administration Rulings are: significant Federal court decisions covering HCFA programs and significant decisions of Administrative Law Judges, the Appeals Council of the Social Security Administration, the Provider Reimbursement Review Board, and the Administrator of HCFA on behalf of the Secretary. Also published are opinions of the Office of General Counsel and other formal policy statements.

Rulings are intended to exemplify general manual instructions and do not alter existing policy guidelines. However, they may place more emphasis on a particular program area that has been identified as a problem. The rulings do not have the force and effect of a statute or regulation, but provide illustrative case material useful in interpreting and applying policies and procedures contained in instructional issuances.

In processing claims, contractors should be guided by the rulings in deciding those cases where the pivotal facts are substantially the same as in the ruling. A ruling would not be applicable to other cases where the facts in a particular case were not substantially the same as those stated in the ruling. Additionally, the effect of subsequent legislation, regulations, court decisions, and rulings must also be considered in determining the applicability of a particular ruling to a specific factual situation.

D. Part A Intermediary Manual Revisions.--The manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, supplements and revised sections, pages, or chapters are issued as the need presents itself. Changed material is indicated in the left margin of a page in the following manner:

┌ Line on which change begins

└ Line on which change ends

The revision transmittal sheet identifies new page numbers and the pages replaced, and summarizes the principal changes in the material being issued. When a major change in policy or procedures is involved, the background and effective date for the change is provided. If, at a later date, you wish to again refer to the background explanation given on a transmittal sheet, you can identify the transmittal by its number which appears on each manual page.

E. Use of the Revision Transmittal Check Sheet.--Immediately after the title page, a check sheet has been provided on which receipt of revisions can be recorded. Revised manual transmittals should be filed in transmittal number order to avoid discarding a more recent page in favor of an older one.

If it appears that you have been skipped in the distribution of a particular transmittal, keep in mind that the transmittals are not always distributed in strict numerical sequence. Allow 10 working days after receipt of a higher numbered transmittal before requesting a transmittal that you have not received.

F. Effective Dates for Medicare Issuances.--Medicare manual transmittals specify the effective dates for changes in policy or procedures and new policies or procedures, effective with material released for publication sometime after November 30, 1977. The effective date indicates at which point in the adjudicative process it applies; usually this will be for services furnished on and after a certain date. The transmittal specifies whether the material involves a change in policy or procedures, new policy or procedures, or simply a clarification of existing policy or procedures.

1. New Policy or Procedure or a Change in the Old.--If the material is a new policy or procedure or a change in the old, specific effective dates are shown. New policies or changes in policies almost invariably carry prospective dates. (The administrative finality rules in Part A, § 3799.13 still apply.) The effective date depends upon the situation that gave rise to the issuance. It may be mandated by legislation or regulations or it may be based on operational considerations, e.g., a systems change that requires time for reprogramming.

2. Clarification of a Policy or Procedures.--A clarification of policy or procedures does not revise a rule already in effect but rather is intended to clarify or improve its understanding. It includes situations where it is necessary to elaborate on a particular policy or rule. An effective date is not specified for a clarification of policy or procedure.

3. Correcting an Erroneous Policy Statement.--Where a proposed policy issuance corrects a prior statement or policy, recognizing that such prior policy was in error and yielded erroneous adjudicative results, it will be given retroactive effect specified in the transmittal.

8-66 CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

This Check Sheet should be placed at the front of the Manual immediately after the Foreword, to provide a record of Manual revisions received. Part A Intermediary Manual revisions will be issued under cover of numbered "Revision Transmittals."

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
1.	8/66	21.	2/67	41.	7/67	61.	1/68	81.	3/68
2.	9/66	22.	2/67	42.	7/67	62.	1/68	82.	4/68
3.	9/66	23.	2/67	43.	7/67	63.	2/68	83.	4/68
4.	9/66	24.	2/67	44.	8/67	64.	1/68	84.	4/68
5.	11/66	25.	2/67	45.	8/67	65.	2/68	85.	5/68
6.	11/66	26.	3/67	46.	8/67	66.	1/68	86.	5/68
7.	11/66	27.	3/67	47.	8/67	67.	2/68	87.	5/68
8.	12/66	28.	3/67	48.	8/67	68.	2/68	88.	5/68
9.	12/66	29.	3/67	49.	8/67	69.	2/68	89.	5/68
10.	12/66	30.	4/67	50.	8/67	70.	2/68	90.	6/68
11.	12/66	31.	4/67	51.	9/67	71.	2/68	91.	6/68
12.	12/66	32.	5/67	52.	9/67	72.	2/68	92.	6/68
13.	12/66	33.	5/67	53.	9/67	73.	2/68	93.	6/68
14.	12/66	34.	5/67	54.	10/67	74.	2/68	94.	6/68
15.	1/67	35.	5/67	55.	10/67	75.	3/68	95.	6/68
16.	1/67	36.	5/67	56.	10/67	76.	3/68	96.	6/68
17.	1/67	37.	Part I	57.	10/67	77.	3/68	97.	7/68
18.	2/67	38.	6/67	58.	11/67	78.	3/68	98.	7/68
19.	1/67	39.	7/67	59.	1/68	79.	3/68	99.	7/68
20.	1/67	40.	7/67	60.	1/68	80.	3/68	100.	7/68

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS 8-66

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
101.	7/68	126.	1/69	151.	9/69	176.	8/70	201.	2/71
102.	7/68	127.	1/69	152.	10/69	177.	8/70	202.	2/71
103.	7/68	128.	1/69	153.	10/69	178.	9/70	203.	2/71
104.	8/68	129.	2/69	154.	11/69	179.	9/70	204.	4/71
105.	8/68	130.	2/69	155.	11/69	180.	9/70	205.	5/71
106.	8/68	131.	3/69	156.	12/69	181.	10/70	206.	5/71
107.	8/68	132.	3/69	157.	11/69	182.	11/70	207.	5/71
108.	8/68	133.	3/69	158.	12/69	183.	11/70	208.	5/71
109.	8/68	134.	4/69	159.	1/70	184.	11/70	209.	5/71
110.	9/68	135.	4/69	160.	1/70	185.	11/70	210.	5/71
111.	9/68	136.	4/69	161.	3/70	186.	11/70	211.	5/71
112.	9/68	137.	4/69	162.	3/70	187.	11/70	212.	6/71
113.	9/68	138.	5/69	163.	4/70	188.	11/70	213.	6/71
114.	10/68	139.	6/69	164.	4/70	189.	11/70	214.	6/71
115.	10/68	140.	6/69	165.	4/70	190.	12/70	215.	6/71
116.	10/68	141.	6/69	166.	4/70	191.	12/70	216.	6/71
117.	11/68	142.	6/69	167.	5/70	192.	12/70	217.	7/71
118.	11/68	143.	8/69	168.	5/70	193.	12/70	218.	8/71
119.	11/68	144.	8/69	169.	6/70	194.	12/70	219.	8/71
120.	11/68	145.	8/69	170.	6/70	195.	1/71	220.	8/71
121	11/68	146.	8/69	171.	6/70	196.	2/71	221.	8/71
122.	11/68	147.	8/69	172.	6/70	197.	2/71	222.	8/71
123.	12/68	148.	9/69	173.	7/70	198.	2/71	223.	9/71
124.	12/68	149.	9/69	174.	7/70	199.	2/71	224.	9/71
125	12/68	150.	9/69	175.	7/70	200.	2/71	225.	9/71

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
226.	10/71	251.	3/72	276.	8/72	301.	1/73	326.	5/73
227.	10/71	252.	3/72	277.	8/72	302.	1/73	327.	5/73
228.	10/71	253.	4/72	278.	8/72	303.	1/73	328.	5/73
229.	10/71	254.	4/72	279.	9/72	304.	2/73	329.	5/73
230.	10/71	255.	4/72	280.	9/72	305.	2/73	330.	5/73
231.	11/71	256.	4/72	281.	9/72	306.	2/73	331.	5/73
232.	11/71	257.	4/72	282.	9/72	307.	3/73	332.	6/73
233.	11/71	258.	4/72	283.	9/72	308.	2/73	333.	6/73
234.	12/71	259.	4/72	284.	9/72	309.	2/73	334.	6/73
235.	12/71	260.	5/72	285.	9/72	310.	3/73	335.	6/73
236.	1/72	261.	5/72	286.	10/72	311.	3/73	336.	6/73
237.	1/72	262.	5/72	287.	11/72	312.	4/73	337.	6/73
238.	1/72	263.	6/72	288.	11/72	313.	4/73	338.	7/73
239.	1/72	264.	6/72	289.	11/72	314.	4/73	339.	7/73
240.	1/72	265.	6/72	290.	11/72	315.	4/73	340.	7/73
241.	2/72	266.	6/72	291.	11/72	316.	4/73	341.	7/73
242.	2/72	267.	6/72	292.	11/72	317.	4/73	342.	8/73
243.	2/72	268.	6/72	293.	12/72	318.	4/73	343.	8/73
244.	2/72	269.	6/72	294.	12/72	319.	4/73	344.	8/73
245.	3/72	270.	6/72	295.	12/72	320.	4/73	345.	8/73
246.	3/72	271.	7/72	296.	12/72	321.	4/73	346.	8/73
247.	3/72	272.	7/72	297.	12/72	322.	4/73	347.	8/73
248.	3/72	273.	7/72	298.	12/72	323.	4/73	348.	8/73
249.	3/72	274.	8/72	299.	1/73	324.	5/73	349.	8/73
250.	3/72	275.	8/72	300.	1/73	325.	5/73	350.	8/73

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS 6-71

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
351.	8/73	376.	1/74	401.	7/74	426.	11/74	451.	4/75
352.	9/73	377.	2/74	402.	7/74	427.	11/74	452.	4/75
353.	9/73	378.	2/74	403.	7/74	428.	11/74	453.	4/75
354.	9/73	379.	3/74	404.	7/74	429.	11/74	454.	4/75
355.	9/73	380.	3/74	405.	7/74	430.	11/74	455.	4/75
356.	10/73	381.	3/74	406.	9/74	431.	12/74	456.	4/75
357.	10/73	382.	3/74	407.	7/74	432.	12/74	457.	4/75
358.	10/73	383.	3/74	408.	8/74	433.	12/74	458.	4/75
359.	10/73	384.	4/74	409.	8/74	434.	12/74	459.	5/75
360.	10/73	385.	3/74	410.	8/74	435.	12/74	460.	5/75
361.	10/73	386.	4/74	411.	8/74	436.	12/74	461.	5/75
362.	11/73	387.	4/74	412.	9/74	437.	1/75	462.	6/75
363.	11/73	388.	4/74	413.	9/74	438.	1/75	463.	6/75
364.	11/73	389.	4/74	414.	9/74	439.	1/75	464.	6/75
365.	11/73	390.	4/74	415.	9/74	440.	1/75	465.	6/75
366.	11/73	391.	5/74	416.	9/74	441.	1/75	466.	6/75
367.	11/73	392.	5/74	417.	9/74	442.	2/75	467.	6/75
368.	11/73	393.	5/74	418.	10/74	443.	1/75	468.	6/75
369.	12/73	394.	5/74	419.	10/74	444.	2/75	469.	6/75
370.	12/73	395.	5/74	420.	10/74	445.	2/75	470.	6/75
371.	12/73	396.	5/74	421.	11/74	446.	3/75	471.	6/75
372.	1/74	397.	6/74	422.	11/74	447.	3/75	472.	7/75
373.	1/74	398.	6/74	423.	11/74	448.	3/75	473.	7/75
374.	1/74	399.	6/74	424.	11/74	449.	3/75	474.	7/75
375.	1/74	400.	6/74	425.	11/74	450.	3/75	475.	7/75

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
476.	8/75	501.	12/75	526.	3/76	551.	6/76	576.	10/76
477.	8/75	502.	12/75	527.	3/76	552.	7/76	577.	10/76
478.	8/75	503.	12/75	528.	3/76	553.	7/76	578.	10/76
479.	8/75	504.	12/75	529.	3/76	554.	7/76	579.	
480.	8/75	505.	12/75	530.	3/76	555.	7/76	580.	10/76
481.	8/75	506.	3/76	531.	4/76	556.	7/76	581.	11/76
482.	9/75	507.	12/75	532.	4/76	557.	7/76	582.	11/76
483.	4/75	508.	12/75	533.	4/76	558.	7/76	583.	11/76
484.	10/75	509.	12/75	534.	4/76	559.	7/76	584.	11/76
485.	10/75	510.	1/76	535.	4/76	560.	8/76	585.	12/76
486.	10/75	511.	1/76	536.	4/76	561.	8/76	586.	12/76
487.	10/75	512.	1/76	537.	4/76	562.	8/76	587.	12/76
488.	10/75	513.	1/76	538.	5/76	563.	8/76	588.	12/76
489.	10/75	514.	1/76	539.	5/76	564.	8/76	589.	12/76
490.	10/75	515.	1/76	540.	5/76	565.	9/76	590.	1/77
491.	10/75	516.	2/76	541.	5/76	566.	9/76	591.	1/77
492.	10/75	517.	2/76	542.	5/76	567.	9/76	592.	1/76
493.	10/75	518.	2/76	543.	5/76	568.	9/76	593.	1/77
494.	10/75	519.	2/76	544.	5/76	569.	10/76	594.	1/77
495.	11/75	520.	3/76	545.	5/76	570.	9/76	595.	1/77
496.	11/75	521.	3/76	546.	5/76	571.	9/76	596.	1/77
497.	11/75	522.	3/76	547.	6/76	572.	9/76	597.	1/77
498.	11/75	523.	3/76	548.	6/76	573.	10/76	598.	1/77
499.	11/75	524.		549.	6/76	574.	10/76	599.	2/77
500.	11/75	525.	3/76	550.	6/76	575.	10/76	600.	2/77

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
601.	2/77	626.	9/77	651.	3/78	676.	4/78	701.	7/78
602.	2/77	627.	9/77	652.	2/78	677.	4/78	702.	7/78
603.	3/77	628.	9/77	653.	3/78	678.	4/78	703.	7/78
604.	3/77	629.	9/77	654.	3/78	679.	5/78	704.	8/78
605.	3/77	630.	9/77	655.	2/78	680.	5/78	705.	8/78
606.	3/77	631.	10/77	656.	3/78	681.	5/78	706.	8/78
607.	4/77	632.	10/77	657.	3/78	682.	5/78	707.	8/78
608.	4/77	633.	10/77	658.	3/78	683.	5/78	708.	8/78
609.	4/77	634.	10/77	659.	3/78	684.	5/78	709.	8/78
610.	5/77	635.	10/77	660.	3/78	685.	5/78	710.	8/78
611.	5/77	636.	11/77	661.	3/78	686.	6/78	711.	8/78
612.	5/77	637.	11/77	662.	3/78	687.	6/78	712.	9/78
613.	5/77	638.	11/77	663.	3/78	688.	6/78	713.	9/78
614.	6/77	639.	11/77	664.	3/78	689.	6/78	714.	9/78
615.	6/77	640.	11/77	665.	4/78	690.	6/78	715.	9/78
616.	6/77	641.	11/77	666.	4/78	691.	6/78	716.	9/78
617.	6/77	642.	12/77	667.	4/78	692.	6/78	717.	10/78
618.	7/77	643.	12/77	668.	4/78	693.	6/78	718.	9/78
619.	7/77	644.	1/78	669.	4/78	694.	6/78	719.	10/78
620.	7/77	645.	2/78	670.	4/78	695.	7/78	720.	10/78
621.	8/77	646.	2/78	671.	4/78	696.	7/78	721.	10/78
622.	8/77	647.	2/78	672.	4/78	697.	7/78	722.	10/78
623.	8/77	648.	2/78	673.	4/78	698.	7/78	723.	11/78
624.	8/77	649.	2/78	674.	4/78	699.	7/78	724.	11/78
625.	9/77	650.	2/78	675.	4/78	700.	7/78	725.	12/78

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
726.	12/78	751.	4/79	776.	8/79	801.	11/79	826.	2/80
727.	12/78	752.	4/79	777.	8/79	802.		827.	2/80
728.	12/78	753.	4/79	778.	8/79	803.		828.	2/80
729.	12/78	754.	4/79	779.	8/79	804.		829.	2/80
730.	1/79	755.	4/79	780.	8/79	805.	11/79	830.	2/80
731.	1/79	756.	4/79	781.	8/79	806.		831.	2/80
732.	1/79	757.	4/79	782.	9/79	807.	11/79	832.	3/80
733.	1/79	758.	5/79	783.	9/79	808.		833.	3/80
734.	1/79	759.	5/79	784.	9/79	809.		834.	3/80
735.	1/79	760.	5/79	785.	9/79	810.	12/79	835.	4/80
736.	1/79	761.	5/79	786.	9/79	811.		836.	4/80
737.	1/79	762.	5/79	787.	9/79	812.		837.	4/80
738.	2/79	763.	5/79	788.	9/79	813.		838.	4/80
739.	2/79	764.	5/79	789.	9/79	814.	12/79	839.	4/80
740.	2/79	765.	5/79	790.	10/79	815.	1/80	840.	4/80
741.	2/79	766.	6/79	791.	10/79	816.	1/80	841.	4/80
742.	2/79	767.	6/79	792.	10/79	817.	1/80	842.	4/80
743.	2/79	768.	6/79	793.	10/79	818.		843.	4/80
744.	2/79	769.	6/79.	794.	10/79	819.	1/80	844.	4/80
745.	2/79	770.	6/79	795.	10/79	820.	1/80	845.	5/80
746.	3/79	771.	7/79	796.	10/79	821.	1/80	846.	5/80
747.	3/79	772.	7/79	797.	10/79	822.	1/80	847.	5/80
748.	3/79	773.	7/79	798.	10/79	823.	2/80	848.	5/80
749.	3/79	774.	8/79	799.	10/79	824.	2/80	849.	5/80
750.	3/79	775.	8/79	800.		825.	2/80	850.	5/80

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
851.	5/80	876.		901.	2/81	926.		951.	
852.	5/80	877.		902.	2/81	927.		952.	
853.	6/80	878.		903.	4/81	928.		953.	
854.	6/80	879.		904.	4/81	929.		954.	
855.	6/80	880.		905.	4/81	930.		955.	
856.	6/80	881.		906.	4/81	931.	✓	956.	
857.	6/80	882.		907.	5/81	932.		957.	
858.	7/80	883.		908.	5/81	933.		958.	
859.	7/80	884.		909.	5/81	934.		959.	✓
860.	7/81	885.		910.	5/81	935.		960.	
861.		886.		911.	5/81	936.		961.	
862.		887.	1/81	912.	6/81	937.	✓	962.	
863.		888.	1/81	913.	6/81	938.		963.	
864.		889.	1/81	914.	6/81	939.		964.	✓
865.		890.	1/81	915.	6/81	940.		965.	✓
866.		891.	1/81	916.	6/81	941.		966.	
867.		892.	2/81	917.	6/81	942.	mtrr	967.	✓
868.		893.	3/81	918.	6/81	943.		968.	✓
869.		894.	3/81	919.		944.		969.	✓
870.		895.	3/81	920.		945.		970.	
871.		896.	3/81	921.		946.	✓	971.	
872.		897.	3/81	922.		947.		972.	
873.		898.	3/81	923.		948.	✓	973.	
874.		899.	3/81	924.		949.		974.	
875.		900.	3/81	925.		950.		975.	✓

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

Trans. No.	Date
976.	5/18
977.	"
978.	6/1
979.	6/1
980.	6/7
981.	6/11
982.	6/11
983.	[illegible]
984.	[illegible]
985.	6/17
986.	6/11
987.	6/23
988.	7/9
989.	7/26
990.	8/3
991.	7/29
992.	8/3
993.	8/10
994.	8/10
995.	9/2
996.	9/2
997.	FWD
998.	✓
999.	9/25
1000.	9/25
1001.	11/3
1002.	11/9
1003.	11/3
1004.	11/22
1005.	"
1006.	"
1007.	"
1008.	"
1009.	"
1010.	"
1011.	"
1012.	"
1013.	1/11/83
1014.	1/3
1015.	1/17
1016.	1/27
1017.	1/17
1018.	1/11
1019.	1/11
1020.	1/12
1021.	1/27
1022.	1/27
1023.	2/2
1024.	3/9
1025.	3/24
1026.	3/9
1027.	3/28
1028.	3/24
1029	3/2
1030.	3/2
1031.	3/2
1032.	3/11
1033.	3/11
1034.	3/28
1035.	3/28
1036.	3/28
1037.	4/15
1038.	4/27
1039.	5/10
1040.	5/13
1041.	5/12
1042.	5/12
1043.	6/8
1044.	6/14
1045.	6/23
1046.	6/24
1047.	6/24
1048.	7/13
1049.	7/22
1050.	8/4
1051.	8/16
1052.	↑
1053.	↓
1054.	8/16
1055.	8/19
1056.	8/18
1057.	9/1
1058.	9/1
1059.	9/2
1060.	9/9
1061.	9/19
1062.	10/4
1063.	10/14
1064.	10/14
1065.	10/20
1066.	10/20
1067.	10/20
1068.	10/25
1069.	10/25
1070.	11/2
1071.	11/4
1072.	12/30
1073.	"
1074.	"
1075.	"
1076.	"
1077.	1/3/84
1078.	1/12
1079.	1/16
1080.	1/24
1081.	1/24
1082.	1/23
1083.	1/31
1084	2/1
1085.	2/7
1086.	2/16
1087.	2/10
1088.	2/16
1089.	2/28
1090.	2/28
1091.	2/28
1092.	3/6
1093.	3/14
1094.	3/24
1095.	3/14
1096.	3/21
1097.	3/14
1098.	
1099.	3/21
1100.	3/27
1101.	4/1
1102.	4/4
1103.	4/9
1104.	4/16
1105.	4/17
1106.	4/18
1107.	4/18
1108.	4/20
1109.	4/23
1110.	5/9

CHECK SHEET OF PART A INTERMEDIARY MANUAL REVISION TRANSMITTALS

Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date	Trans. No.	Date
1111.	5/9	1138.	8/8	1165.	11/30	1192.	3/11	1219.	6/10
1112.	5/9	1139.	8/27	1166.	11/30	1193.	3/4	1220.	6/10
1113.	CIA	1140.	9/7	1167.	12/4	1194.	3/14	1221.	CIA
1114.	5/16	1141.	9/7	1168.	12/4 CIA	1195.	3/26	1222.	6/11
1115.	5/16	1142.	CIA	1169.	1/7/8 CIA	1196.	3/14	1223.	CIA
1116.	5/18	1143.	9/7	1170.	"	1197.	3/14	1224.	6/21
1117.	5/21	1144.	9/17	1171.	"	1198.	3/20	1225.	7/5
1118.	5/21 CIA	1145.	9/24	1172.	"	1199.	3/26	1226.	7/23
1119.	5/21	1146.	9/27	1173.	CIA	1200.	5/3	1227.	7/18
1120.	5/22	1147.	9/19	1174.	"	1201.	4/17	1228.	7/18
1121.	5/22	1148.	CIA	1175.	"	1202.	4/16	1229.	7/23
1122.	5/21	1149.	9/27	1176.	"	1203.	4/17	1230.	7/31
1123.	[illegible]	1150.	"	1177.	CIA	1204.	4/16	1231.	8/2
1124.	6/5	1151.	"	1178.	CIA	1205.	4/15	1232.	8/1
1125.	6/13	1152.	CIA	1179.	CIA	1206.	4/16	1233.	7/31
1126.	6/21	1153.	CIA	1180.	1/7	1207.	CIA	1234.	8/8
1127.	6/28	1154.	11/13	1181.	1/7	1208.	4/22	1235.	8/15
1128.	7/5	1155.	10/9	1182.	1/16	1209.	4/26	1236.	8/20
1129.	7/5	1156.	CIA	1183.		1210.	5/6	1237.	9/4
1130.	7/12	1157.	11/13	1184.	1/24	1211.	5/7	1238.	8/26
1131.	7/12 CIA	1158.	11/13	1185.	1/28	1212.	5/10 CIA	1239.	9/18
1132.	CIA	1159.	11/13	1186.	CIA	1213.	CIA	1240.	CIA
1133.	CIA	1160.	11/13	1187.	2/21	1214.	5/23 CI MANUAL	1241.	
1134.	7/30	1161.	CIA	1188.	3/5	1215.	5/21	1242.	9/27
1135.	8/1	1162.	11/13	1189.	2/27	1216.	5/24	1243.	10/6
1136.	8/8	1163.	11/16	1190.	3/11	1217.	5/30	1244.	10/11
1137.	8/8	1164.	1/7/83	1191.	2/7	1218.	CIA	1245.	11/1

CHECK SHEET FOR INTERMEDIARY MANUAL PART 3

This check sheet should be placed at the front of the manual to provide a record of manual revisions.

1246	11/20	1267	3/10	1288	8/1	1309	2/4
1247	11/28	1268	[illegible]	1289	8/14	1310	2/10
1248	11/26	1269	3/26	1290	8/15	1311	2/18
1249	11/26	1270	4/2	1291	8/26	1312	2/24
1250	1/6/86	1271	4/14	1292	8/25	1313	2/26
1251	11	1272	5/6	1293	8/26	1314	2/26
1252	11	1273	5/13	1294	9/17	1315	3/6
1253	11	1274	5/12	1295	9/30	1316	3/6
1254	11	1275	5/21	1296	10/7	1317	3/6
1255	11	1276	6/5	1297	10/9	1318	3/10
1256	1/[illegible]	1277	6/13	1298	10/9	1319	3/10
1257	1/31	1278	6/11	1299	10/23	1320	3/31
1258	2/15	1279	6/13	1300	11/1	1321	4/15
1259	2/10	1280	6/23	1301	11/7	1322	4/15
1260	2/[illegible]	1281	6/25	1302	11/14	1323	4/22
1261	2/21	1282	7/20	1303	1/5/87	1324	4/25
1262	3/7	1283	7/10	1304	1/6	1325	4/28
1263	3/20	1284	7/18	1305	1/6	1326	5/1
1264	3/7	1285	7/21	1306	1/15	1327	[illegible]
1265	3/20	1286	7/30	1307	2/4	1328	5/6
1266	3/14	1287	6/1	1308	2/4	1329	5/12

Rev. 1236

1330 5/20
1331 6/4
1332 6/12
1333 6/12
1334 6/17
1335 6/17
1336 6/29
1337 6/29
1338 7/09
1339 7/22
1340 7/87
1341 7/87
1342 7/87
1343 8/87
1344 8/87
1345 8/87
1346 8/87
1347 9/87
1348 9/87
1349 9/87
1350 9/87

1351 9/87
1352 9/87
1353 9/87
1354 10/87
1355 10/87
1356 10/87
1357 10/87
1358 11/87
1359 11/87
1360 11/87
1361 11/30
1362 12.87
1363 12.87
1364 12.87
1365 1/6/88
1366 1/21
1367 1/28
1368 1/21
1369 1/20
1370 1/25
1371 1/25

1372 2/9
1373 3/1
1374 3/1
1375 3/1
1376 3/21
1377 3/21
1378 4/15
1379 4/20
1380 4/25
1381 4/27
1382 4/25
1383 4/27
1384 5/11
1385 5/11
1386 5/11
1387 6/7
1388 6/15
1389 6/24
1390 7/11
1391 7/14
1392 7/20

1393 7/21
1394 8/2
1395 8/2
1396 8/2
1397 8/3
1398 8/15
1399 8/19
1400 8/19
1401 8/19
1402 8/31
1403 9/13
1404 [illegible]
1405 9/22
1406 9/28
1407 9/23
1408 10/26
1409 11/27
1410 INDEX
1411 11/28
1412 11/29
1413 11/22

Rev. 1236

1414 12/72
1415 12/77
1416 2/16/89
1417 2/13/89
1418 4/3
1419 4/3
1420 4/13
1421 4/17
1422 4/25
1423 5/89
1424 5/89
1425 5/89
1426
1427
1428
1429
1430
1431
1432
1433
1434
1435
1436
1437
1438
1439
1440
1441
1442
1443
1444
1445
1446
1447
1448
1449
1450
1451
1452
1453
1454
1455
1456
1457
1458
1459
1460
1461
1462
1463
1464
1465
1466
1467
1468
1469
1470
1471
1472
1473
1474
1475
1476
1477
1478
1479
1480
1481
1482
1483
1484
1485
1486
1487
1488
1489
1490
1491
1492
1493
1494
1495
1496
1497
1498

1499 ________
1500 ________
1501 ________
1502 ________
1503 ________
1504 ________
1505 ________
1506 ________
1507 ________
1508 ________
1509 ________
1510 ________
1511 ________
1512 ________
1513 ________
1514 ________
1515 ________
1516 ________
1517 ________
1518 ________
1519 ________
1520 ________
1521 ________
1522 ________
1523 ________
1524 ________
1525 ________
1526 ________
1527 ________
1528 ________
1529 ________
1530 ________
1531 ________
1532 ________
1533 ________
1534 ________
1535 ________
1536 ________
1537 ________
1538 ________
1539 ________
1540 ________
1541 ________
1542 ________
1543 ________
1544 ________
1545 ________
1546 ________
1547 ________
1548 ________
1549 ________
1550 ________
1551 ________
1552 ________
1553 ________
1554 ________
1555 ________
1556 ________
1557 ________
1558 ________
1559 ________
1560 ________
1561 ________
1562 ________
1563 ________
1564 ________
1565 ________
1566 ________
1567 ________
1568 ________
1569 ________
1570 ________
1571 ________
1572 ________
1573 ________
1574 ________
1575 ________
1576 ________
1577 ________
1578 ________
1579 ________
1580 ________
1581 ________
1582 ________

PART A - INTERMEDIARY MANUAL

PART 3 - CLAIMS PROCESS

TABLE OF CONTENTS FOR INTERIM MANUAL INSTRUCTIONS

Chapter | Section

I DEFINITIONS

Doctors of Podiatric Medicine (IM 84-3).............. IM 3030.3

V SPECIAL PROVISIONS RELATED TO PAYMENT

Government Subrogation Rights in Liability Insuarance Claims (IM 84-6)......................... IM 3419.11

Determining the Amount of Indemnification (IM-88-1)...... IM 3446.6

Conditional Payments for Services to Individuals Entitled to Benefits Solely on the Basis of End Stage Renal Disease and Who are Covered by Employer Group Health Plans (IM 88-2)........... IM 3490

Medicare As Secondary Payer for Disabled Individuals (IM 87-2)................................ IM 3492

VII BILL REVIEW

Implementation of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (IM-88-3)..................... IM 3600

Billing for DME Furnished as a Home Health Benefit (IM 84-4).................................... IM 3650.6

Change in Payment Rate (IM 87-1)........................ IM 3656.3

VIII PAYMENT PROCEDURES

Elements of Review (IM 87-3)............................ IM 3792.2

Hearing (IM 87-3)....................................... IM 3794

PART A INTERMEDIARY MANUAL

PART 3 - CLAIMS PROCESS

TABLE OF CONTENTS

Chapter		Section	Page
I	Definitions	3000	
	Hospital Insurance Entitlement		3
	SMI--Enrollment and Premiums		7
	Provider and Related Definitions		8.2
	Physician Defined		20.1
	Spell of Illness		21
II	Coverage of Services	3100	
	Inpatient Hospital Services		27
	Inpatient Psychiatric Hospital Services		33.10
	Duration of Covered Inpatient Hospital Services		33.14
	Hospital Services Covered Under Part B		37.1
	Covered and Noncovered Home Health Services		44
	Coverage of Extended Care Services Under Hospital Insurance		56.5
	Duration of Covered Extended Care Services		58.5
	Services Furnished by Skilled Nursing Facilities Covered Under Medical Insurance		58.7
	Hospice Services		58.8
	Provider-Based Physicians		58.9
	Outpatient Physical Therapy		58.15
	General Exclusions From Coverage		59
	End Stage Renal Disease		64.13
	Comprehensive Outpatient Rehabilitation Facility Services		64.25
III	Deductibles and Coinsurance Amounts	3200	
	Hospital Insurance (Part A) Deductibles and Coinsurance		67
	Supplementary Medical Insurance Incurred Expenses Deductible and Coinsurance		72.1
	Home Health Services Deductible and Coinsurance		72.3

Chapter		Section	Page
IV	Requirement for Payment	3300	
	Request for Payment		75
	Certification and Recertification by Physicians for Hospital Services		76.6
	Certification and Recertification by Physicians for Home Health Services		81
	Certification and Recertification by Physicians for Skilled Nursing Facilities Services		84
	Tuberculosis and Psychiatric Hospital Records		84.3
V	Special Provisions Related to Payment	3400	
	Refunds		87
	Workmen's Compensation		89
	Utilization Review		95
	Program Integrity		96.5
VI	Admission and Query Procedures	3500	
	Identifying the Patient's Health Insurance Record		99.1
	Notice of Admission Procedures		101.2
	Open Items		114.2
	Part B Queries and Replies		119
	Critical Cases		128.3
	Start of Care Procedures		129

Addendum

Chapter		Section	Page
	Addendum A - Advanced Record System		A-1
	Part A Query		A-1
	Part A Replies from SSA		A-3
	Part B Query		A-8
	Part B Replies		A-12
VII	Bill Review	3600	
	General Sections on Billing Procedures		175
	Billing Medicare for Physician Services		176.4
	Bill Processing		177.4
	Part B Services		185.2
	Hospital and SNF Billing		187
	Assurance of Payment Procedures for SNF's		208.2
	Provider Billing for Medical and Other Health Services (Form SSA-1483)		209

Chapter		Section	Page
	Ambulance Services Claims		232.37
	Billing by Home Health Agencies		232.45
	Processing Claims for Services Furnished by a Domestic Nonparticipating Provider		240.1
	Processing Claims for Services Furnished by a Foreign Provider		240.8E
	Periodic Interim Payment (PIP) Cases		240.9
	1972 Amendments Supplement Billing Medicare for Physician Services	A3604	
VIII	Payment and Postpayment Procedures	3700	
	Automatic Data Processing Systems Controls		242.3
	Benefit Checks and Provider Notices		243
	Social Security Office - Intermediary Contacts		243.2
	Overpayments		243.6
	Guarantee of Payment		244.5
	Underpayments		244.9
	Alien Payments		244.18
	Notices to Beneficiary		244.21
	SSA Notices		244.21
	Intermediary Notices		244.35
	Denial and Partial Denial Paragraphs		244.39
	Intermediary Notices About Emergency Claims		250
	Part B Notices		254.2
	Congressional Inquiries		254.17
	Disclosure of Information		255
	Appeals		260.1
	1972 Amendments Supplement Stock Denial Paragraphs	A3722	
IX	Bill Processing, Statistical Reports, and Claims Records	3800	
	Transmittals to Social Security Administration		271
	SSA Bill Processing		283
	Statistics and Reports		289
	Monthly Statistical Report on Status of Intermediary Workloads		293
X	Reimbursement for Services by Provider-Based Physicians	3900	

PART A INTERMEDIARY MANUAL ABBREVIATIONS

Following is a listing of standard abbreviations used throughout the Part A Intermediary Manual. These abbreviations should not be used in correspondence with the general public.

AC	Appeals Council
ALJ	Administrative Law Judge
ARS	Advanced Record System
BHA	Bureau of Hearings and Appeals
BHI	Bureau of Health Insurance
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CRD	Chronic Renal Disease
CSS	Christian Science Sanatorium
DHEW	Department of Health, Education and Welfare
DME	Durable Medical Equipment
ECF	Extended Care Facility (Now known as Skilled Nursing Facility)
EDP	Electronic Data Processing
EKG	Electrocardiogram
EOMB	Explanation of Medicare Benefits
ESRD	End Stage Renal Disease
FARC	Federal Archives and Records Center
GAO	General Accounting Office
GEP	General Enrollment Period
GPPP	Group Practice Prepayment Plan
HE	Hearings Examiner (Part A) (Now known as Administrative Law Judge)
HHA	Home Health Agency
HI	Health Insurance
HIB	Hospital Insurance Benefits (Part A)
HIRR	Health Insurance Regional Representative
HMO	Health Maintenance Organization
HO	Hearing Officer (Part B)
IEP	Initial Enrollment Period
IGEP	Initial General Enrollment Period
IL	Intermediary Letter
PIP	Periodic Interim Payment
QRRB	Qualified Railroad Retirement Beneficiary
R-HI	HI Enrollment Based on Renal Disease
RO	Health Insurance Regional Office
RRA	Railroad Retirement Act
RRB	Railroad Retirement Board
SA	State Agency
SMIB	Supplementary Medical Insurance Benefits (Part B)
SNF	Skilled Nursing Facility
SSA	Social Security Administration

SS Act	Social Security Act
SSO	Social Security Office
SSR	Social Security Rulings
UR	Utilization Review
VA	Veterans Administration
WC	Workmen's Compensation

CHAPTER I

DEFINITIONS

Section Page

Hospital Insurance Benefits--Entitlement

Hospital Insurance Entitlement.............................. 3001 3-3
    Transitional Provision.............................. 3001.1 3-3
    Hospital Insurance for Disability Beneficiaries....... 3001.2 3-4
    Hospital Insurance for Persons Needing Kidney Transplant or Dialysis.............................. 3001.3 3-4
    Hospital Insurance Obtained by Premium Payment........ 3001.4 3-5

Supplementary Medical Insurance--Enrollment and Premiums

Supplementary Medical Insurance.............................. 3003 3-6
    Eligibility for Enrollment.............................. 3003.1 3-6
    Automatic Enrollment to SMI for Individuals Entitled to Hospital Insurance after June 1973.............. 3003.2 3-7
    Enrollment Periods.............................. 3003.3 3-7
    Beginning of Coverage.............................. 3003.4 3-7.1
    Coverage Ends.............................. 3003.5 3-7.2
    Termination and Reenrollment.............................. 3003.6 3-7.2
    Premiums.............................. 3003.7 3-7.2
Waiver of Enrollment Period Requirements Because of Administrative Error.............................. 3004 3-8

Provider and Related Definitions

Provider Agreements.............................. 3005 3-8.2
    Responsibilities of Participating Provider............ 3005.1 3-8.2
    Term of Agreement With Providers Other Than SNF's..... 3005.2 3-9
    Term of Agreement With SNF's.............................. 3005.3 3-9
Admission of Medicare Patients for Care and Treatment 3006 3-9.1
Under Arrangements.............................. 3007 3-9.1
Termination of Provider Participation...................... 3008 3-9.2
    Voluntary Termination.............................. 3008.1 3-9.2
    Involuntary Termination, Including SNF Agreement Cancellations.............................. 3008.2 3-9.2
    Expiration and Renewal-Nonrenewal of SNF Term Agreements.............................. 3008.3 3-9.3
    Determining Payment for Services Furnished After Termination, Expiration, or Cancellation........... 3008.4 3-9.4
Change of Provider Ownership.............................. 3009.9 3-9.6
Hospital Defined.............................. 3010 3-9.6
Definition of Emergency Inpatient and Outpatient Services.... 3012 3-11
    Definition of an Emergency Services Hospital........... 3012.1 3-11

DEFINITIONS

	Section	Page
Psychiatric Hospital	3016	3-12
Certification of Parts of Institutions as Hospitals	3017	3-12
Part of a Tuberculosis or a Psychiatric Institution as a Tuberculosis or Psychiatric Hospital	3017.1	3-12
General Hospital Facility of Tuberculosis or Psychiatric Hospital	3017.2	3-12
Part of a General Hospital as a Tuberculosis or Psychiatric Hospital	3017.3	3-12
Skilled Nursing Facility Defined	3020	3-13
A Distinct Part of an Institution as a Skilled Nursing Facility	3020.1	3-14
Transfer Agreements	3020.2	3-14
Christian Science Sanatorium	3023	3-14
Definition of Home Health Agency	3025	3-17
Subdivisions of Agencies	3025.1	3-18
Arrangements by Home Health Agencies	3025.2	3-18
Rehabilitation Centers	3025.3	3-19.1
Definition of Hospice	3027	3-19.1
Subdivisions of Organizations	3027.1	3-19.1
Arrangements by Hospices	3027.2	3-19.1

Physician Defined

	Section	Page
Physician	3030	3-20.1
Doctors of Medicine and Osteopathy	3030.1	3-20.1
Dentists	3030.2	3-20.1
Podiatrists	3030.3	3-20.2
Physicians in Federal Hospital	3030.4	3-20.3
Optometrists	3030.5	3-20.3

Spell of Illness

	Section	Page
Spell of Illness (Benefit Period)	3035	3-21

3001. HOSPITAL INSURANCE ENTITLEMENT.

Hospital insurance (HI) (as well as supplementary medical insurance (SMI)) is available to three basic groups of "insured" individuals - the aged (although certain aged individuals can qualify for hospital insurance without being "insured"), the disabled, and those with end-stage renal disease. Following is an explanation of how an individual becomes "insured" as well as an explanation of the eligibility requirements for each group.

A. Insured Status.—To be eligible for premium-free hospital insurance (HI), an individual must be "insured" based on his or her own earnings or those of a spouse, parent or child. To be insured, the worker must have a specified number of quarters of coverage (QC's); the exact number required is dependent on whether the person is filing for HI on the basis of age, disability, or end-stage renal disease. QC's are earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA) during the person's working years. QC's earned by an individual who pays the full FICA tax are usable to insure the person for both monthly social security benefits and HI. Federal employees were exempt from payment of FICA taxes prior to January 1983. However, beginning in January 1983, Federal employees became subject to the HI portion of the FICA tax (those actually employed in January 1983 were also deemed to have earned HI quarters of coverage for their Federal service prior to January 1983). Also, Government employees who pay only the HI portion of the FICA tax are only insured for HI; they are not insured for monthly social security benefits. State and local government employees hired after 3/31/86, who do not pay the full FICA tax, must pay the HI portion of the FICA tax. Employees hired prior to 4/1/86 may be voluntarily covered for the HI tax by the State or local government entity.

B. The Aged.—To be eligible for HI on the basis of age, a person must be age 65 or older and either eligible for monthly social security or railroad retirement cash benefits, or would be eligible for such benefits if the worker's government QC's were regular social security QC's. An individual who is insured for monthly benefits need not actually file an application to receive the benefits. If such a person continues to work beyond age 65, he or she may instead elect to file an application for HI only.

Premium-free HI for the aged begins with the month in which the individual attains age 65, provided he or she files an application for HI or for cash benefits and HI within 6 months of the month in which he or she attains age 65. If the application is filed later than that, HI entitlement can be retroactive for only 6 months. An individual attains age 65 on the day before his or her 65th birthday. For example, if an individual is born on August 1, the attainment date is July 31, and HI begins with July 1. Entitlement generally does not end until death.

3001.1 Transitional Provision.—In 1966, when the Medicare law took effect, a person needed in excess of 3 years of work under social security to be eligible for premium-free HI. To "blanket-in" many elderly people who had not had the opportunity to be working in jobs subject to FICA taxes, or who had not worked long in such jobs, the law provided a special transitional insured requirement allowing entitlement to HI without the individual being fully insured if certain residence and citizenship or alien status requirements are met. The work requirements for this transitional provision were designed to increase in such a way that, for persons becoming age 65 in 1974 or later, the provision has essentially been phased out. The only applicability the provision has today occurs where the very old person, for some reason, has not yet filed for HI.

3001.2 Hospital Insurance for Disability Beneficiaries.-- A disabled person who is entitled to social security or railroad retirement benefits on the basis of disability is automatically entitled to HI after 24 months of entitlement to such benefits. Since there is a 5-month disability benefits waiting period, the person actually becomes entitled to HI after being disabled for 29 months. In addition, disabled persons who are not insured for monthly social security disability benefits but would be insured for such benefits if Government QC's were social security QC's are deemed to be entitled to disability benefits and automatically entitled to HI after being disabled for 29 months. The months in the Medicare qualifying period need not be consecutive so that months from a previous period of (deemed) disability benefit entitlement generally may be counted in determining when the qualifying period requirement is met. HI entitlement on the basis of disability is available not only to the worker, but to the widow, widower or child of a deceased, disabled or retired worker if any of them become disabled within the meaning of the Social Security or Railroad Retirement Acts.

If an individual recovers from a disability, HI entitlement ends with the month after the month he or she is notified of the disability termination. However, if the individual's (deemed) disability benefit entitlement ends only because he or she was working, HI entitlement may continue for up to 24 additional months.

3001.3 Hospital Insurance for Persons Needing Kidney Transplant or Dialysis.--Individuals of any age who receive dialysis or renal transplantation for end-stage renal disease (ESRD) are eligible for HI (and are deemed enrolled for SMI unless such coverage is refused) if they file an application and they (1) meet certain work requirements for insured status under the social security or railroad retirement programs or as Government employees, or (2) are entitled to monthly social security benefits or an annuity under the Railroad Retirement Act, or (3) are the spouses or dependent children of such insured or entitled persons.

HI entitlement usually begins after a 3-month waiting period has been served, i.e., with the first day of the third month after the month in which a course of renal dialysis begins. Entitlement begins before the waiting period has expired if the individual (1) receives a transplant or (2) participates in a self-dialysis training program during the waiting period. For those falling into category (1), entitlement begins with the month the individual is admitted as an inpatient to a hospital for procedures in preparation for or anticipation of a kidney transplant provided the transplant surgery takes place within the following 2 months. If the transplant is delayed more than 2 months after the preparatory hospitalization, entitlement begins with the 2nd month prior to the monthof transplant. Entitlement for those falling into category (2) begins with the first month of the course of dialysis if the individual is expected to complete the self-dialysis training program and self-dialyze thereafter. Eligibility is based on the earliest entitlement date when someone could possibly qualify under several different provisions.

HI coverage based on ESRD ends with the earliest of the following dates: (1) the day an individual dies, or (2) the last day of the 12th month after the month the course of dialysis is discontinued, unless the individual receives a kidney transplant during that period or begins another course of dialysis, or (3) the last day of the 36th month after a person receives a kidney transplant. If the transplant fails and a regular course of dialysis is initiated or another transplant is performed within the 36 months, entitlement continues. If a person whose entitlement based on ESRD has ended, begins a new course of dialysis or has a kidney transplant, reentitlement begins without a waiting period.

3001.4 Hospital Insurance Obtained by Premium Payment.--

A. Eligibility Requirements.-- Individuals who want hospital insurance coverage but who are not otherwise eligible (i.e., do not qualify under either the regular, transitional or ESRD provisions, §§ 3001, 3001.1, 3001.3) may obtain such coverage on or after July 1, 1973, by enrolling timely, paying a monthly premium, and upon meeting the following three requirements:

- attaining age 65
- enrolling in the supplementary medical insurance program
- being a resident of the U.S.; and either
  - a citizen, or
  - an alien lawfully admitted for permanent residence, who has resided continuously in the U.S. for the 5 years prior to the month of enrollment.

B. Premiums.-- Each year, the Secretary of HHS announces the amount of the standard hospital insurance premium payable for each month in the following calendar year. The applicable premium amount is 33/76 (about 43.4 percent) of the hospital insurance deductible for that calendar year. The premium is rounded to the nearest $1.

States and public organizations, through agreements with the Secretary, may pay premiums for groups of enrollees under the rules governing group payment of SMI premiums. However, the individual must enroll for himself during an appropriate enrollment period; there is no buy-in for premium hospital insurance.

C. Beginning of Coverage.--

1. Initial Enrollment Period (IEP).-- Persons may enroll for Premium hospital insurance by filing a request during the IEP which begins the third month before the month of first eligibility and lasts for 7 months. The individual's IEP for Premium hospital insurance is in most cases the same 7-month period as the IEP for SMI.

The individual may enroll for hospital insurance when he or she enrolls for SMI, or later during his IEP. The beginning date of an individual's Premium hospital insurance coverage period is determined by the rules applicable to SMI coverage based on an SMI enrollment during an IEP. (See §3003.3.)

2. General Enrollment Period (GEP).-- Eligible persons who have not enrolled for Premium hospital insurance during their IEP, or whose Premium hospital insurance has been terminated, may enroll during a GEP (January 1 - March 31 of each year) if they are enrolling or have enrolled for SMI. As under SMI, an eligible person who enrolls for hospital insurance during a GEP after the end of the IEP will have hospital insurance coverage beginning the following July.

The same restrictions on enrollment and reenrollment apply as in the supplementary medical insurance program. Individuals who enroll late pay a 10 percent per year premium penalty.

D. End of Coverage.-- A beneficiary's entitlement under tthe provision terminates:

- with the month of the individual's death;
- (for nonpayment of premiums) with the last day of the third month following the premium billing month;
- with the end of the month following the month in which he or she files a voluntary request for termination;
- with the month SMI coverage is terminated; or
- with the month before the month in which he or she becomes entitled to hospital insurance under the regular, transitional, or ESRD provisions. (See §§3001, 3001.1, 3001.3.)

Supplementary Medical Insurance--Enrollment and Premiums

3003. SUPPLEMENTARY MEDICAL INSURANCE.

3003.1 Eligibility for Enrollment.-- To obtain supplementary medical insurance coverage, eligible individuals must enroll in the plan during an enrollment period open to them and pay the required premiums. They are eligible to enroll if they are eligible for premium-free HI (as shown in §§3001-3001.3), or are resident citizens or resident aliens. To qualify as a resident alien, an individual must have been lawfully admitted for permanent residence and have resided continuously in the United States during the 5 years immediately preceding the month of enrollment.

By agreement with the Secretary of Health and Human Services, States may enroll in the supplementary medical insurance plan eligible individuals who are receiving money payments under certain public assistance programs as specified in the agreement. Persons entitled to monthly social security benefits or railroad retirement benefits may be included in such "buy-in" agreement at the option of the State.

The State may also choose to enroll all individuals eligible for medical assistance under title XIX or those receiving cash assistance under specified titles of the Act.

3003.2 Automatic Enrollment in SMI.-- Beneficiaries (except those residing in foreign countries or Puerto Rico) are deemed to have enrolled in SMI in the month before the month for which they are entitled to hospital insurance, so that hospital insurance and SMI coverage start in the same month. Thus, monthly beneficiaries other than disability beneficiaries are deemed to enroll in the month before attainment of age 65. Disability beneficiaries are deemed to enroll in the 24th consecutive month of entitlement to disability benefits.

Every potential "deemed" enrollee is given a reasonable opportunity (at least 2 months) to decline SMI enrollment by filing notice to this effect. He or she is deemed not to have enrolled and does not incur any premium liability. A refusal of SMI not timely filed is treated as a request for voluntary termination under existing disenrollment rules once it has been established that the individual does not wish to have SMI.

3003.3 Enrollment Periods.-- Enrollment is possible only during specified enrollment periods:

An individual's initial enrollment period is of 7 months duration. It begins 3 full calendar months before and ends 3 full calendar months after the month in which the individual first meets all the requirements for enrollment.

A general enrollment period occurs each year from January 1 through March 31. Coverage is effective the following July 1. These periods afford enrollment opportunities to those who failed to enroll during their initial enrollment periods and to those whose enrollment has terminated.

A special enrollment period (SEP) is available, effective with November 1984, for individuals age 65 or over who did not enroll for SMI when first eligible (or who terminated SMI enrollment) because of coverage under an employer group health plan (EGHP). The SEP lasts for 7 months. It begins with the month in which the individual is no longer enrolled in an EGHP based on current employment.

A SEP also became available, effective January 1987 for disabled beneficiaries under age 65 who do not have ESRD, who did not enroll for SMI when first eligible (or who terminated SMI enrollment) because of coverage under an EGHP which is the primary payer of benefits. The disabled beneficiary may have the EGHP coverage based on his or her own current work (under the trial work period provisions) or as the family member of a current employee. The SEP lasts for 7 months and begins with the month in which Medicare becomes the primary payer of benefits.

3003.4 Beginning of Coverage.--

A. Enrollment during the individual's initial enrollment period-- coverage begins on the first day of:

- The month in which he or she attains age 65, if he or she enrolls before that month,
- The month after he or she attains age 65, if he or she enrolls in the month of attainment of age 65,
- The second month after enrollment, if he or she enrolls in the month after attainment of age 65, or
- The third month after enrollment, if he or she enrolls more than one month after the month of attainment of age 65.

B. Enrollment during a general enrollment period--coverage begins the following July 1.

C. Enrollment by a State of its welfare recipients--coverage begins on the latest of the following:

- First day of the third month after the month of the agreement with the State,
- First day of the first month in which the individual is both an eligible individual and a member of the coverage group, except that for a State which buys in for medically indigent persons under title XIX, if the individual is not receiving money payments under titles I, IV, (Part A), X, XIV, or XVI, the coverage begins on the first day of the second month after the month in which the individual is found or is reported by the State to SSA to be eligible for medical assistance, or
- The date specified in the agreement.

D. Enrollment during the individual's special enrollment period—coverage begins on the first day of:

- The month of enrollment, if he or she enrolls in the first month; or
- The month after the month of enrollment; if he or she enrolls during the following 6 months.

3003.5 Coverage Ends.--

A. An individual may notify SSA in writing, at any time, that he or she no longer wishes to participate in the supplementary medical insurance plan. Termination of coverage takes effect at the close of the calendar month following the calendar month in which the request for termination was filed.

B. Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums. (See § 3003.7).

C. If an individual is enrolled under a Federal-State agreement, coverage under the agreement ends on the last day of whichever of the following occurs first:

1. The month in which the State makes the determination that the individual is ineligible for welfare money payments and/or medical assistance, depending on the coverage specified in the agreement, provided that SSA receives notice by the 25th day of the second month after the calendar month in which the State's determination is made. (If SSA does not receive notification by that date, coverage ends on the last day of the second month before the month in which SSA receives such notice. Notice received in a calendar month but after the 25th day of that month is deemed to have been received in the following month); or

2. The month in which the State agreement is terminated.

When the individual's State enrollment ends, the coverage period continues as though he or she had individually enrolled in the initial enrollment period. The individual is responsible for the premiums but there is no increase for late enrollment regardless of the number of prior enrollment periods. The individual may terminate this deemed individual enrollment by requesting SMI termination during the last month of buy-in coverage or during the 6 succeeding months and have the individual SMI coverage end at the end of the month is which the request for termination is filed.

D. If not terminated sooner, coverage ends with the beneficiary's death.

3003.6 Termination and Reenrollment.-- An individual whose enrollment has terminated may reenroll only in a general enrollment period or a special enrollment period if the requirements are met.

Payment may be made for covered services if the individual was covered at the time the services were furnished, even though at the time the request for payment is filed with the intermediary the enrollment has been terminated.

3003.7 Premiums.--A premium is due for each month of entitlement under SMI. The SMI premium covers about one-fourth of the cost of the Part B program. In the third quarter of each calendar year, the Secretary of Health and Human Services announces the base premiums for SMI coverage that is payable as of the following January 1st. The SMI premium is the same for all enrollees even though the cost to the program is greater for ESRD enrollees and the disabled than it is for the aged. The SMI premium is refigured each year and is based on the lower of one-half of SMI program costs per aged enrollee or the general percentage by which social security benefits were increased during the calendar year in which the announcement occurs. (During the 5-year period January 1984 through December 1988, the formula for computing the SMI premium has been modified to provide that the Part B premium reflects exactly one-fourth of the cost of the Part B program. Beginning with the premium announced for the period beginning January 1989, however, the method of computing the SMI premium reverts back to the pre-January 1984 rules).

The base premium that is announced by the Secretary is paid by most enrollees. However, it is increased for those who enroll late or reenroll after a prior termination of entitlement. The amount of the increase is 10 percent of the base rate for each full 12-month period during which the individual could have been but was not enrolled in the program. No months in which an individual age 65 or over has EGHP coverage, or is disabled and has Medicare as secondary payer of benefits, is countable as a month in which the individual "could have been, but was not enrolled." The exception does not apply to individuals who are entitled, or could be entitled, to Medicare on the basis of ESRD.

SMI premiums are collected from benefits payable (in order of priority) by the Railroad Retirement Board, Social Security Administration, or Office of Personnel Management (Civil Service) unless the individual is covered under a State buy-in agreement. If the individual is entitled to such benefits but the payments are in suspense, e.g., due to work deductions, he or she is billed for the amounts due. Non-beneficiaries are also billed directly for the premiums due.

A grace period has been provided for payment of premiums by those who are billed directly. The period extends for 90 days after the month in which the bill is mailed. This 90-day grace period for paying overdue SMI premiums and continuing SMI coverage may be extended by SSA for good cause for up to an additional 90 days. Good cause, for example, is found if the enrollee was mentally or physically incapable of paying his or her premiums timely, or had some reasonable basis to believe that payment had been made, or the failure to pay was due to administrative error.

3004. WAIVER OF ENROLLMENT PERIOD REQUIREMENTS BECAUSE OF ADMINISTRATIVE ERROR.

SSA is authorized to take necessary action to correct an erroneous SMI or premium hospital insurance enrollment or nonenrollment which was based upon the action, inaction, or error of a government officer, employee, or agent. The action may include designating special individual enrollment periods and premium adjustments.

For purpose of this provision, an individual's enrollment or nonenrollment in SMI is considered to have been prejudiced and due to the "action, inaction, or error" of an officer, employee, or agent of the government, if there is an official record or other evidence showing that (a) the individual took reasonable appropriate and timely measures to assert his or her rights, and (b) due to administrative fault or other action-- which may or may not have been erroneous at the time taken--his or her rights have been or are likely to be impaired unless relief is given.

This authority applies to all Part B cases which have arisen since the Medicare program began on July 1, 1966. It is applied to cases which come to SSA's attention; however, do not search your files.

Provider and Related Definitions

3005. PROVIDER AGREEMENTS.

For purposes of section 1866 of the Social Security Act, the term "provider of services" (or "provider") means a hospital, skilled nursing facility, home health agency and, for the limited purpose of furnishing outpatient physical therapy or speech pathology services, a clinic, rehabilitation agency or public health agency which meets the applicable eligibility provisions of title XVIII of the Act and regulations issued thereunder (i.e., the conditions of participation).

To be a participating provider under Medicare, a provider must be in compliance with the applicable provisions of title VI of the Civil Rights Act of 1964 and must enter into an agreement under section 1866 of the Act which provides that it (1) will not charge any individual or other person for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts; and (2) will return any money incorrectly collected from the individual or other person on his behalf or make such other disposition as described in §§ 3401ff.

3005.1 Responsibilities of Participating Provider.-- Upon acceptance for participation, a provider becomes responsible for remaining in compliance with the terms of the agreement and the provisions of title XVIII and regulations issued thereunder. Where the agreement is made retroactive, the provider must comply with its responsibilities as of the retroactive date. Payment to the provider for covered items and services it furnishes on or after the effective date of the agreement will require that the provider have a recordkeeping capability sufficient for determining the cost of services furnished Medicare beneficiaries.

The termination of participation (§ 3008) does not immediately abrogate all of the provider's responsibilities and in specific matters a responsibility may extend beyond the effective date of termination. For example, the provider continues to be responsible (as applicable) for those provisions of the law and regulations which provide for program coverage to remain in effect for specified periods of time beyond the effective termination date, for those beneficiaries who were accepted for care and treatment by the provider before such date. The provider also continues to be responsible for filing a final cost report and/or the repayment of any overpayment, as these actions relate to final program cost settlement after termination.

3005.2 Term of Agreement With Providers Other than SNFs.-- With the exception of agreements with skilled nursing facilities, an agreement with a provider of services (§ 3005) is not time-limited and has no fixed expiration date. These agreements remain in effect until such time as there is a voluntary termination (§ 3008.1), an involuntary termination (§ 3008.2), or an invalidation of the agreement by reason of change of ownership (§ 3009).

3005.3 Term of Agreement With SNFs.-- All agreements with skilled nursing facilities are required to be for a specified term of up to 12 full calendar months with fixed expiration dates. In appropriate situations, the agreement may also contain a cancellation clause. Therefore, when it is determined that a skilled nursing facility is eligible and that its agreement for participation in the Medicare program will be accepted for filing, the term of the agreement will be determined in the following manner:

A. No Deficiencies.--Where the facility is certified as being in full compliance with all standards contained in the conditions of participation for skilled nursing facilities, the term of the agreement will, as appropriate to the period of certification for which the facility has been approved, be for a term of up to 12 full calendar months.

B. Deficiencies.--Where the facility is certified as not being in full compliance with all standards contained in the conditions of participation for skilled nursing facilities, the term of the agreement will, as appropriate to the period of certification or conditional period of certification for which the facility has been approved:

1. Be for a term which expires no later than the close of the 60th day following the last day of the time period specified in the facility's

written plan providing for the correction of deficiencies in meeting the conditions of participation, provided that such term will not exceed 12 full calendar months; or,

2. Provide a conditional term of up to 12 full calendar months, subject to a cancellation clause that the agreement may be cancelled on a predetermined date which shall be no later than the close of the 60th day following the last day of the time period specified in the facility's written plan providing for the correction of deficiencies in meeting the conditions of participation, provided that such date will occur within such 12-month term.

If the health and safety of Medicare patients will not be jeopardized thereby, the term of an agreement may be extended for 2 full calendar months where it is found necessary to prevent irreparable harm to the facility; or to prevent hardship to Medicare beneficiaries being furnished care by the facility; or if it is found to be impracticable within the term of the agreement to determine whether the facility is complying with the provisions of the Act and regulations issued thereunder.

Intermediaries are advised of the term of each SNF agreement by the HCFA regional office.

3006. ADMISSION OF MEDICARE PATIENTS FOR CARE AND TREATMENT.

The participation of a provider of services which voluntarily files an agreement to participate in the health insurance program contemplates that such provider will admit Medicare beneficiaries for care and treatment, and upon admission, will provide them with such services as are ordinarily furnished by the provider to its patients generally. A provider may have restrictions on the types of services it makes available and/or the types of health conditions it accepts, or may establish other criteria relating to the admission of persons for care and treatment. However, the law does not contemplate that such restrictions or criteria will apply only to Medicare beneficiaries as a class. It does contemplate, however, that if such restrictions or criteria apply to Medicare beneficiaries, they will be applied in the same manner in which they are applied to all other persons seeking care and treatment by the provider. Thus, a provider admission or patient policy or practice which is not consistent with the objective contemplated in the law may be used by HCFA as a basis for termination of the agreement for cause.

3007. UNDER ARRANGEMENTS.

A provider may have others furnish certain covered items and services to their patients through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. In permitting providers to furnish services under arrangements, it was not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered the provider must exercise professional responsibility over the arranged-for services.

The provider's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The provider must accept the patient for treatment in accordance with its admission policies, maintain a complete and timely clinical record on the patient which includes diagnosis, medical history, physician's orders, and progress notes relating to all services received, maintain liaison with the attending physician with regard to the progress of the patient and the need for revised orders or, in the case of home health services and outpatient physical therapy or speech pathology services, to assure that the required plan of treatment is periodically reviewed by the physician, secure from the physician the required certifications and recertifications, and see to it that the medical necessity of such services is reviewed on a sample basis by its utilization review committee in the case of a hopsital or skilled nursing facility or, in the case of home health agencies, clinics, rehabilitation agencies, and public health agencies, by the agency's staff or an outside review group.

3008. TERMINATION OF PROVIDER PARTICIPATION (See S 3482).

A provider may voluntarily terminate its participation in the program or have it terminated by the Secretary for cause.

3008.1 Voluntary Termination.—A provider may terminate its agreement (and in the case of a skilled nursing facility, it may terminate its agreement prior to the close of the specified term of its agreement) by filing with the Secretary a written notice of its intention to terminate the agreement. The Secretary may accept the termination date stated in the notice (the date must be the first day of a month and, in the case of a skilled nursing facility, must occur within the specified term of such facility's agreement) or set a different date. However, the termination date set by the Secretary shall not be more than 6 months from the date the provider's notice is filed.

See Part A Part 2 S2800.1 for additional information on voluntary termination and the intermediary's role.

3008.2 Involuntary Termination, Including SNF Agreement Cancellations.—The Secretary may terminate an agreement (and in the case of a skilled nursing facility, he may terminate its agreement prior to the close of the specified term of the agreement) with a provider if it is determined that the provider:

A. Is not complying substantially with the provisions of the agreement or with the applicable provisions of title XVIII of the Act and regulations; or

B. No longer meets the appropriate conditions of participation; or

C. Has failed to supply information which is necessary to determine whether payments are due or were due and the amounts of such payments; or

D. Refuses to permit examinations of fiscal and other records, including medical records.

The cancellation of an SNF agreement at the close of the predetermined date stated in the cancellation clause contained in such agreement (S 3005.3B) is viewed as an involuntary termination of the agreement by the Secretary for cause. Such actions involve a finding that the SNF has not satisfactorily completed its written plan providing for the correction of deficiencies with respect to one or more of the standards in the applicable conditions of participation, or that the facility has not made substantial effort and progress in correcting such deficiencies.

A provider which is dissatisfied with the Secretary's determination terminating its agreement is entitled to request a hearing thereon in accordance with the appeals procedures contained in Subpart O of Regulations No. 5. There is no reconsideration step before the opportunity for a hearing.

For the intermediary's role in procesing involuntary terminations see Part A Part 2 SS 2800.3 and 2801-2805.

NOTE: The involuntary termination of a hospital's approval authorizing it to provide extended care services (i.e., to be a swing bed facility—see sec. 3130.1) would not automatically result in the involuntary termination of the hospital's agreement relating to the provision of hospital services.

3008.3 Expiration and Renewal-Nonrenewal of SNF Term Agreements.—All agreements with skilled nursing facilities are required to be for a specified term of up to 12 full calendar months with fixed expiration dates. The agreement expires at the close of the last day of its specified term and is not automatically renewable from term to term. Where the term of an agreement is extended (see S 3005.3) the "close of the last day of its specified term" is the close of the day to which the agreement has been extended. Thus, where the term of an agreement is extended, the provider's participation in the program continues and the agreement will not expire until the close of the last day to which it has been extended.

Since an agreement with an SNF is not automatically renewable from term to term, each term agreement with an SNF will require that the SNF qualify for participation and that its agreement be accepted for filing. A participating SNF may, however, continue its participation under the agreement form previously accepted for filing provided the SNF continues to qualify for participation and the agreement form is again accepted for filing and renewed for a term which begins on the date immediately following the close of the last day of the prior term of the agreement. When the requirements for participation continue to be met there is no limit to the number of times that the SNF's agreement form may again be accepted and renewed for a specified term.

When the time-limited agreement (including an agreement which has had its term extended) is renewed on the day immediately following the close of the last day of its term, the expiration of the agreement is not considered a termination of participation in the program.

However, once an agreement with an SNF is (1) not renewed, or (2) voluntarily terminated by the SNF, or (3) involuntarily terminated (including cancellations) by the Secretary, the previously accepted agreement cannot again be accepted and renewed. In such cases, the SNF is required to execute and file a new agreement if it is again found eligible to participate in the Medicare program. The effective date of the new agreement must be determined in accordance with regulatory provisions (42 CFR 489.13).

The Secretary's determination not to accept and renew a SNF agreement is a determination relating to the qualifications of the SNF in the period immediately following the close of the SNF's existing agreement and the SNF is entitled to request a reconsideration of the determination in accordance with the appeals procedure contained in 42 CFR part 405 Subpart 0. Such determinations involve a finding that:

1. Based on a State agency resurvey and recertification, the SNF will not be approved for a period of certification because it is out of compliance with one or more conditions of participation

2. Based on a State agency resurvey and recertification, the SNF continues to be out of compliance with the same standard(s) in the conditions of participation as were found out of compliance during the term of the agreement and the facility will not be approved for a new period of certification or

3. The SNF has violated the terms of its agreement or the provisions of title XVIII or regulations promulgated thereunder.

In cases of nonrenewal by the Secretary, the intermediary's role is the same as for involuntary terminations. (See Part A, Part 2, SS 2800.3 and 2801-2805).

3008.4 Determining Payment for Services Furnished After Termination, Expiration, or Cancellation.— Effective with the date a provider agreement (or swing bed approval) terminates, expires, or is cancelled, no payment is made to the provider under such agreement for:

A. Hospital.—

1. Termination—Hospital Agreement.— Inpatient hospital services (including inpatient psychiatric hospital services) and swing bed extended care services furnished on or after the effective date of the hospital's termination, except that payment can ıtinue to be made for up to 30 days of

inpatient hospital services and/or swing bed extended care services (total of no more than 30 days) furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

2. Termination--Swing Bed Approval.--Swing bed extended care services furnished on or after the effective date of the termination of the hospital's swing bed approval, except that payment can continue for up to 30 days of extended care services furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

B. Skilled Nursing Facility.--

1. Termination--SNF.--Posthospital extended care services furnished on or after the effective date of termination of the agreement, where such agreement has been voluntarily terminated by the provider (§ 3008.1) or involuntarily terminated (see 3 below for cancellations) by the Secretary for cause (§ 3008.2), except that payment can continue to be made for up to 30 days of posthospital extended care services furnished on and after the termination date to beneficiaries who were admitted prior to the termination date.

2. Expiration--SNF.--Posthospital extended care services furnished on or after the date which follows the last day of the specified term of the agreement, where such agreement has expired at the close of the last day of its specified term (§ 3008.3), except that where the agreement has not been renewed, payment can be made for up to 30 days of posthospital extended care services furnished on and after the date which follows the last day of the specified term of such agreement to beneficiaries who were admitted on or before such last day.

3. Cancellation--SNF.--Posthospital extended care services furnished on or after the date which follows the predetermined date specified in a cancellation clause, where such agreement is cancelled by the Secretary pursuant to such cancellation clause (§ 3008.2), except that payment can be made for up to 30 days of posthospital extended care services furnished on and after the date which follows the predetermined date specified in such clause, to beneficiaries who were admitted on or before such predetermined date.

C. HHA and Hospice.--Home health and hospice services furnished under a plan which is established on or after the termination date, except that if the plan was established before the termination date, payment is made for services for up to 30 days following the effective date of termination.

D. Termination, Expiration, and Cancellation--Providers.--Other items and services, including outpatient physical therapy or speech pathology and diagnostic services, furnished on or after the effective date of termination or, in the case of an expiration or cancellation of an SNF agreement, on or after the day following the close of such agreement.

(See § 3600.4 for billing instructions concerning providers who are no longer participating).

3009. CHANGE OF PROVIDER OWNERSHIP

When an organization having a provider agreement undergoes a change of ownership, the agreement is automatically assigned to the new owner. A participating provider which plans to change ownership should give advance notice of its intention so that necessary action can be taken in the event the newly-owned institution does not wish to participate in the Medicare program. A participating provider which plans to enter into a lease arrangement (in whole, or in part) should also give advance notice of its intention. A change of ownership would occur for example:

A. Where a sole proprietor transfers title to an enterprise to another party;

B. Where, in the case of a partnership, the addition, removal, or substitution of a partner effects a termination of such partnership and creates a successor partnership or other entity;

C. Where an incorporated provider merges with an incorporated institution which is not participating in the program and the nonparticipating institution is the surviving corporation or where two or more corporate providers consolidate and such consolidation results in the creation of a new corporate entity;

D. Where an unincorporated provider (a sole proprietorship or partnership) becomes incorporated.

Whenever you learn of an impending change of ownership, or possible change of ownership, inform the regional office immediately. Refer any questions you may have concerning change of ownership situations to the regional office.

3010. HOSPITAL DEFINED

A hospital (other than psychiatric) means an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

To be eligible to participate in Medicare, a hospital must also be an institution which:

A. Maintains clinical records on all patients;

B. Has bylaws in effect with respect to its staff of physicians;

C. Has a requirement that every patient must be under the care of a physician;

D. Provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

E. Has in effect a hospital utilization review plan;

F. Is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing;

G. Meets other health and safety requirements found necessary by the Secretary of Health, and Human Services. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with exceptions specified in the law);

H. Is not primarily for the care and treatment of mental diseases;

Such an institution, if approved to participate as a hospital, may also be approved as a swing bed facility pursuant to demonstration authority or if the hospital is a rural hospital with less than 50 beds (see § 3101.1).

3012. DEFINITION OF EMERGENCY INPATIENT AND OUTPATIENT SERVICES

Payment may be made for certain Part A inpatient hospital services and Part B outpatient hospital services provided in a nonparticipating U.S. hospital where they are necessary to prevent the death or serious impairment of the health of the individual. Because of the threat to the life or health of the individual, the use of the most accessible hospital equipped to furnish such services is necessary. The determination of emergency services depends upon three separate findings:

- o The hospital meets the definition of an emergency hospital. (See §3012.1.)
- o The services meet the definition of emergency services. (See §3698.1.)
- o The hospital is substantially more accessible from the site of the emergency than is the nearest participating hospital. (See §3698.13.)

3012.1 Definition of an Emergency Services Hospital.—An emergency services hospital is a nonparticipating hospital which meets the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. (See §3010.) (A Federal hospital need not be licensed under State or local licensing laws to meet the definition of emergency hospital.) In addition, the hospital must be primarily engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type that §3010 describes in defining the term hospital, and must not be primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care (see requirement "a" of the definition of a SNF in §3020). Psychiatric hospitals that meet these requirements can qualify as emergency hospitals.

(Instructions and information concerning the coverage of domestic emergency hospital services are in §3698.)

Inpatient hospital services and related physician and ambulance services furnished outside the U.S. are covered under the limited conditions in §3154.

3016. PSYCHIATRIC HOSPITAL.

A psychiatric hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. To be eligible for participation in the program as a psychiatric hospital, it must meet the Medicare conditions of participation for hospitals or be deemed to meet those conditions based on accreditation by the Joint Commission on Accreditation of Hospitals (JCAH), have a utilization review plan, and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care.

3017. CERTIFICATION OF PARTS OF INSTITUTIONS AS HOSPITALS.

Under certain conditions a distinct part of a psychiatric institution may be certified as a psychiatric or general hospital.

3017.1 Part of a Psychiatric Institution as a Psychiatric Hospital.-- A distinct part of a psychiatric institution can be certified as a psychiatric hospital if it meets the conditions of participation even though the institution of which it is a part does not. If the distinct part meets requirements equivalent to the accreditation requirements of the JCAH, it can qualify under the program even though the institution itself is not accredited.

3017.2 General Hospital Facility of Psychiatric Hospital.-- A general hospital facility within a psychiatric hospital may be certified as a general hospital independent of the institution as a whole provided the general facility is a self-contained operational entity distinct from the rest of the institution. The general hospital facility would be regarded as a separate institution for this purpose since the law does not provide for certifying a "distinct part' of an institution as a general hospital. Services furnished in a separately certified general hospital facility are not subject to any of the benefit limitations applicable to the other parts of the institution, i.e., the reduction in benefit days in the first spell of illness (§ 3104) and the 190-day lifetime maximum on inpatient services in psychiatric hospitals (§ 3105).

3017.3 Part of a General Hospital as a Psychiatric Hospital.—There is no provision for a psychiatric wing of a general hospital to be certified as a psychiatric hospital. The distinct part provisions apply only to psychiatric institutions and not to general hospitals. However, this does not prevent the certification of a psychiatric hospital which is a part of a medical center or other large complex, provided the hospital operates as a separate functioning entity, i.e., it is located in a separate building, wing, or part of a building, has its own administration and maintains separate fiscal records.

3020. SKILLED NURSING FACILITY (FORMERLY EXTENDED CARE FACILITY) DEFINED.

A skilled nursing facility is an institution (or a distinct part of an institution, see § 3020l.), such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals (see § 3020.2 for transfer agreements and § 3005 for definition of participating hospital), and which:

a. Is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

b. Has policies (developed with the advice of and periodically reviewed by a professional group including one or more physicians and one or more registered professional nurses) to govern the skilled nursing care and related medical or other services it provides,

c. Has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies,

d. Has a requirement that the health care of every patient must be under the supervision of a physician,

e. Provides for having a physician available to furnish necessary medical care in cases of an emergency,

f. Maintains clinical records on all patients,

g. Provides 24-hour nursing service sufficient to meet nursing needs in accordance with the policies developed pursuant to (b) above, and has at least one registered professional nurse employed full time,

h. Provides appropriate methods and procedures for dispensing and administering drugs and biologicals,

i. Has in effect a utilization review plan,

j. Is licensed in accordance with State or local law, or is approved by the State or local licensing agency as meeting the licensing standards where State or applicable law provides for the licensing of institutions of this nature, and

k. Is in substantial compliance with health and safety requirements established by regulation. (These health and safety requirements are contained in the "Conditions of Participation for Skilled Nursing Facilities.")

A qualified skilled nursing facility is one which meets all the requirements in the above definition.

Note: The term skilled nursing facility does not include any institution which is primarily for the care and treatment of mental diseases. Also, the term skilled nursing facility (SNF) does not include swing bed hospitals authorized to provide and be reimbursed for extended care services, except that such swing bed hospitals must, in general, meet requirements the same as or comparable to many of those listed above (see §3130.1).

3020.1 A Distinct Part of an Institution as a Skilled Nursing Facility.-- In order to qualify for participation in the program as a skilled nursing facility, a distinct part of an institution must be physically separated from the rest of the institution, i.e., it must represent an entire physically identifiable unit consisting of all the beds within that unit, such as a separate building, floor, wing, or ward. Although it is required that the distinct part be identifiable as a separate unit within the institution, it need not necessarily be confined to a single location within the institution's physical plant. The distinct part may, for example, consist of several floors or wards which are scattered throughout several different buildings within the institutional complex. In each case, however, the patients of the distinct part would have to be located in units which are physically separate from those units housing all other patients of the institution. Various beds scattered throughout the institution would not comprise a distinct part for purposes of being certified as a skilled nursing facility.

3020.2 Transfer Agreements.-- To participate in the program a skilled nursing facility must have a written transfer agreement with one or more participating hospitals (see § 3005) providing for the transfer of patients between the hospital and the facility, and for the interchange of medical and other information. If an otherwise qualified skilled nursing facility has attempted in good faith, but without success, to enter into a transfer agreement, this requirement may be waived by the State agency. (See Conditions of Participation for Extended Care Facilities for the detailed requirements for transfer agreements).

3023. CHRISTIAN SCIENCE SANATORIUM.

A Christian Science Sanatorium operated or listed and certified by the First Church of Christ, Scientist, Boston, Mass., qualifies as both a hospital and skilled nursing facility. Sanatorium services are considered to be furnished by a sanatorium in its capacity as a hospital unless the individual elects to have them treated as sanatorium extended care services. Inpatient care in such an institution whether as hospital services or extended care services can begin or prolong a "spell of illness" (§ 3035).

Payment may be made to a participating sanatorium for as many as 120 days of covered Christian Science care in the same spell of illness--up to 90 days under the hospital provision and up to 30 days under the extended care provision. Payment for sanatorium extended care services may not be made for more than 30 days in each spell of illness, instead of the 100 days applicable to extended care services generally.

Payment can be made in the same spell of illness for both inpatient hospital services furnished in a hospital and those furnished by a sanatorium in its capacity as a hospital, but the total days of covered care cannot exceed the maximum of 90 days in a spell of illness (§ 3103).

Payment may not be made for sanatorium extended care services after an individual has been furnished posthospital inpatient extended care services during the same spell of illness in a qualified extended care facility other than a Christian Science sanatorium. Similarly, payment may not be made for posthospital extended care services furnished to an inpatient of an extended care facility other than a Christian Science sanatorium after he has been furnished, during the same spell of illness, covered sanatorium extended care services.

3025. DEFINITION OF HOME HEALTH AGENCY

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical, speech, or occupational therapy, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by:

1. furnishing both skilled nursing and at least one other therapeutic service directly to patients, or

2. furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

B. It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse.

C. It maintains clinical records on all patients.

D. It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations).

E. It meets other conditions found by the Secretary of Health, Education, and Welfare to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.

3025.1 Subdivisions of Agencies.--When the subdivision of an agency, such as the home care department of a hospital or the nursing division of a health department, wishes to participate as a home health agency, the subdivision must meet the conditions of participation and must maintain records in such a way that subdivision activities and expenditures attributable to services provided under the health insurance program are identifiable.

3025.2 Arrangements by Home Health Agencies.--

A. Arrangements made by a home health agency with others to furnish items or services must be such that receipt of payment by the home health agency for the services (whether in its own right or as agent) discharges the liability of the beneficiary or any other person to pay for the services.

Whether the services and items are furnished by the home health agency itself or by another agency under arrangements made by the home health agency, both must agree not to charge the patient for covered services and items and must also agree to return money incorrectly collected.

There are various situations in which a home health agency may have arrangements with another health organization or person to provide health services to its home health agency patients. Medicare always reimburses (and holds responsible) the primary provider. Thus, if a hospice or hospital provides some of its services through a contracting home health agency, it is the hospice or hospital which Medicare will reimburse; and it is the hospice or hospital which is responsible for the quality of care given by the home health agency under arrangements. There are 3 situations in which it is the home health agency which is the primary provider:

1. Where an agency or organization, in order to be approved to participate in the program makes arrangements with another agency or organization to provide the nursing or other therapeutic services which it cannot provide directly.

2. Where an agency or organization, which is already approved for participation, makes arrangements with others to provide services it does not provide.

3. Where an agency or organization, which is already approved for participation, makes arrangements with a hospital, skilled nursing facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment which cannot be made available to the patient in his place of residence.

B. If an agency's subdivision (acting in its capacity as a home health agency) makes an arrangement with its parent agency for the provision of these items and/or services, there need not be a contract or formal agreement. If, however, the arrangement is made between the home health agency and another provider participating in the health insurance program (hospital, skilled nursing facility, or home health agency, and, in the case of physical therapy services, clinics, rehabilitation agencies, and public health agencies), there must be a written statement regarding the services to be provided and the financial arrangements.

C. If the arrangements are with an agency or organization which is not a qualified provider of services, there must be a written contract which includes all of the following:

1. A description of the services to be provided.

2. The duration of the agreement and how frequently it is to be reviewed.

3. A description of how personnel will be supervised.

4. A statement that the contracting organization will provide its services in accordance with the plan of treatment established by the patient's physician in conjunction with the home health agency's staff.

5. A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.

6. A description of the method of determining reasonable costs and reimbursement by the home health agency for the specific services to be provided by the contracting organization.

7. An assurance that the contracting organization will comply with title VI of the Civil Rights Act.

D. If a home health agency notifies a beneficiary of noncoverage of services which another party has been furnishing under arrangements entered into by the agency, the initial notice, in and of itself, does not negate the contract between the agency and the other party. Unless the evidence shows that the contract has been formally terminated, the beneficiary is considered to still be the agency's patient and the other party to be the representative of the agency. Consequently, if upon initial notice that a service is no longer covered the other party continues to provide services to the patient, the other party is considered to be furnishing the services under arrangements with the home health agency, absent evidence to the contrary. Thus, if a beneficiary appeals the noncoverage of any or all of the arranged for services furnished after the notice, and a ruling is made in favor of the beneficiary, those services ruled on favorably would be reimbursable since they would constitute services furnished under arrangements by a certified home health agency. If the denial is sustained, however, the other party cannot bill the beneficiary for the denied services since the home health agency, not the other party, is responsible for the care rendered.

3025.3 Rehabilitation Centers.--When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not participating in the program as a hospital, skilled nursing facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes, and ordinances.

3027. DEFINITION OF HOSPICE

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals and meets the conditions of participation for hospices, and has a valid provider agreement.

3027.1 Subdivisions of Organizations.—When a subdivision of an organization, such as the home care department of a hospital, wishes to participate as a hospice, the subdivision must meet the hospice conditions of participation and must maintain records in such a way that activities and expenditures attributable to services provided under the hospice program are identifiable.

3027.2 Arrangements by Hospices.—Hospices are required to provide core services directly, that is, nursing services, physician services, medical social services and counseling. Other covered services may be provided under arrangement.

A. Arrangements made by a hospice to furnish items or services must be such that receipt of payment by the hospice for the services discharges the liability of the beneficiary or any other persons to pay for the services. Whether the services and items are furnished by the hospice itself or by another organization under arrangments made by the hospice, both must agree not to charge the patient for covered services and items and must agree to return money incorrectly collected.

B. The agreement includes at least the following:

1. Identification of the services to be provided.

2. A stipulation that services may be provided only with the express authorization of the hospice.

3. The manner in which the contracted services are coordinated, supervised and evaluated by the hospice.

4. The delineation of the role(s) of the hospice and the contractors in the admission process, patient/family assessment and the interdisciplinary group care conferences.

5. Requirements for documenting that services are furnished in accordance with the agreement.

6. The qualifications of the personnel providing the services.

Physician Defined

3030. PHYSICIAN.

Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in §3030.2) doctor of podiatric medicine (within the limitations in §3030.3), or doctor of optometry (within the limitations of §3030.5) and with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

In all States, the issuance by the State of a license to practice medicine constitutes legal authorization. Temporary State licenses also constitute legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, such local standards will be used in determining whether a particular physician has legal authorization. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations will be covered.

NOTE: The term "physician" does not include such practitioners as a Christian Science practitioner or naturopath.

3030.1 Doctors of Medicine and Osteopathy.--The requirement that a doctor of medicine must be legally authorized to practice medicine and surgery by the State in which he performs his services is met where a physician is licensed by the State to practice medicine and surgery.

A doctor of osteopathy who is legally authorized to practice medicine and surgery by the State in which he performs his services qualifies as a physician. In addition, a licensed osteopath or osteopathic practitioner qualifies as a "physician" to the extent that he performs services within the scope of his practice as defined by State law. For example, in some States osteopaths and osteopathic practitioners are limited in their practice to the manipulation of bones and muscles; such legally authorized services are covered.

3030.2 Dentists.--A dentist qualifies as a "physician" if he is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic X-ray examinations in connection with covered services. Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth. (See §3162 and Coverage Issues Manual §50-26.) The coverage of any given dental service is not affected by the professional designation of the "physician" rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

3030.3 Doctors of Podiatric Medicine.--A doctor of podiatric medicine is included within the definition of "physician" but only with respect to those functions which he is legally authorized to perform in the State in which he performs them. This means that the professional services provided by a doctor of podiatric medicine within the scope of his applicable State license (except those services which are specifically excluded) are "physician's services" reimbursable on a reasonable charge basis under Part B.

A doctor of podiatric medicine may hold any of the following professional degrees of which the first three are the most common: Pod.D. or D. P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiropodist, Graduate Chiropodist, or in a very few instances another podiatry degree. Within a particular State, all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from State to State as to the authorized scope of podiatric practice.

A doctor of podiatric medicine is considered a "physician," subject to the limitations cited, for any of the following purposes:

o making the required physician certification and recertification of the medical necessity for Part A and Part B services;

o establishing and periodically reviewing a home health plan of treatment; and

o serving as a member of a Utilization Review (UR) committee, but only if at least two of the physicians on the UR committee are doctors of medicine or osteopathy. The performance of these functions must also be:

— consistent with the policy of the hospital, skilled nursing facility or home health agency at which the functions are performed; and

— consistent with the scope of the professional service provided by a doctor of podiatric medicine as authorized by applicable State law.

A doctor of podiatric medicine is also considered a "physician," subject to the limitations cited, for purposes of the outpatient physical therapy (OPT) benefit. The OPT benefit requires, among other things, that an individual be under the care of a physician and that a plan of treatment for outpatient physical therapy services be established by such physician or by a qualified physical therapist. Since the OPT benefit also provides coverage of physical therapy services furnished by a physical therapist in independent practice, a podiatrist (when acting within the scope of his practice under State law) is considered a physician for purposes of meeting the OPT requirements when services are provided by an independently practicing physical therapist.

A doctor of podiatric medicine is not considered a "physician" for the purpose of performing any of the physician activities required to qualify an institution or organization as a skilled nursing facility or home health agency.

3030.4 Physicians in Federal Hospitals.--There are many physicians performing services in hospitals operated by the Federal Government--military hospitals, Veterans Administration hospitals, and Public Health Service hospitals. Normally the services provided by a physician in a Federal hospital are not reimbursable except when the hospital provides services to the public generally as a community institution. Such a physician working in the scope of his Federal employment may be considered as coming within the statutory definition of "physician" even though he may not have a license to practice in the State in which he is employed.

3030.5 Optometrists.--A doctor of optometry, legally authorized to practice optometry by the State in which he performs such function, is a "physician" as defined in the law with respect to the provision of any item or service the optometrist is authorized to perform by State law or regulation.

Prior to April 1, 1987, an optometrist was considered a physician only with respect to services related to the condition of aphakia (absence of the natural crystalline lens of the eye). The following are examples of examination services which were covered when furnished by optometrists if related to the condition of aphakia: case history, external examination, ophthalmoscopy, biomicroscopy, tonometry, visual fields, ocular motility, binocular function, and evaluation for contact lenses, if the optometrist furnishing these services was legally authorized to perform them.

NOTE: The exclusions from coverage concerning vision care services (see §3157) continue to apply, whether performed by doctors of medicine, osteopathy, or optometry.

Spell of Illness

3035. BENEFIT PERIOD (SPELL OF ILLNESS)

A benefit period is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient, up to certain specified maximum amounts, can be paid for by the hospital insurance plan. For example, a patient is eligible for 90 days of hospital care in a benefit period and 100 days of extended care services during the same benefit period. A patient may be eligible for as many as 150 days of hospital care in a benefit period if he draws on his lifetime reserve. (See §3106.) As long as a person continues to be entitled to hospital insurance, there is no limit on the number of benefit periods he may have. The term "benefit period" is synonymous with "spell of illness." Since the term "spell of illness" could connote a single illness or a particular "spell" of sickness, the term "benefit period" is used in communications with the public.

A. Starting a Benefit Period.--A benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits.

A provider qualified to start a benefit period is a hospital (including a psychiatric hospital) or SNF that meets all the requirements of the definition of such an institution. A hospital which meets all requirements in §3012.1 is also a qualified hospital for purposes of beginning a benefit period when it furnishes the patient covered inpatient emergency services. Thus, generally, the benefit period begins when covered inpatient services are initially furnished to an entitled individual. However, see discussion in §3622 on beginning a spell of illness with the noncovered care furnished by a nonparticipating provider. Also, see §3121.1A for beginning a benefit period for purposes of qualifying for posthospital home health benefits.

A "qualified hospital" in Canada or Mexico (see §3121.1C) is also a qualified provider for purposes of beginning a benefit period when it furnishes the patient covered inpatient hospital services. See §3121.1A for beginning a benefit period for the purpose of qualifying for posthospital home health benefits when the prior hospitalization was in a foreign hospital.

If a person is in a nonqualified institution and is subsequently transferred to a qualified hospital (general or psychiatric), his benefit period begins on admission to the qualified hospital.

Admission to a qualified SNF or to the SNF level of care in a swing bed hospital begins a benefit period even though payment for the services cannot be made because the prior hospitalization or transfer requirement has not been met. (See §3131.) Inpatient care in a Christian Science Sanatorium (whether as hospital or extended care services) can begin or prolong a benefit period.

B. Ending a Benefit Period.--The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor of a SNF. To determine the 60-consecutive-day period, begin counting with the day the individual was discharged.

1. Definition of "Hospital" or "SNF" for Ending a Benefit Period.—It is important to note that a benefit period cannot end while a beneficiary is an inpatient in a SNF or hospital, even if the SNF or hospital does not meet all of the requirements that are necessary for starting a benefit period.

a. "Hospital."—In order to end a benefit period, for at least 60 consecutive days, a beneficiary cannot have been in a hospital which meets the initial requirement in the definitions in SS3010, 3012.1, or 3016. That is, the beneficiary cannot have been in a facility that is primarily engaged in providing, by or under the supervision of physician(s), to inpatients:

- Diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for injured, disabled, or sick persons; or
- Psychiatric services for the diagnosis and treatment of mentally ill persons; or
- Medical services for the diagnosis and treatment of tuberculosis.

A stay in a hospital outside the United States will prolong a benefit period. It may be assumed, in the absence of evidence to the contrary, that:

- A foreign hospital in which a beneficiary spent one or more days meets the requirement of the definition in S3010; and
- The beneficiary's statement about length and place of stay are correct.

b. "SNF."—Similarly, to end a benefit period, a beneficiary cannot have been an inpatient in a SNF for at least 60 consecutive days; where "SNF" (including one primarily for the care and treatment of mental diseases or tuberculosis) is defined as a facility which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled, or sick persons.

For purposes of benefit period determinations, a facility or part of a facility that is licensed or certified solely as an intermediate care facility (ICF) is not a facility that meets the above requirement. Therefore, a facility or part of a facility licensed or certified solely as an ICF is not a "SNF" for benefit period determinations and a stay in such a facility or part of a facility will not prolong a benefit period. This is the case even if a Medicare SNF waiver payment has been made under SS3431.3 and 3431.4 for care provided in an ICF distinct part. A SNF waiver payment made consistent with those provisions will not convert an ICF distinct part into a "SNF" for purposes of benefit period determinations.

c. Examples.—An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

EXAMPLE 1: X was born 8/9/18. On 7/28/83, X entered a participating general hospital. After he had been in the hospital for 2 weeks, X was discharged on 8/11/83. On his doctor's orders, X entered a participating SNF on 8/15/83, and remained there until his discharge on 10/27/83. He had no further inpatient stays in 1983.

X's benefit period began on 8/1/83, the first day of the month he attained age 65 and was entitled to hospital insurance. The benefit period ended 12/25/83, the end of the 60-day period beginning with the date of his last discharge.

EXAMPLE 2: Y, over age 65, entered a participating general hospital on 7/28/83, for treatment of a heart condition. He was discharged on 8/11/83. On 8/20/83, Y entered a nonparticipating nursing home, which provided primarily skilled nursing care and related services. Y remained in this facility until his discharge on 10/27/83. On 12/25/83, Y was again admitted to a participating hospital because of injuries suffered in an accident. He was discharged on 1/13/84, and had no further inpatient stays in 1984.

Y's benefit period began on 7/28/83. His stay in the nursing home began less than 60 days after his hospital stay and the benefit period was continued even though the stay was not covered. The subsequent hospital stay began less than 60 days after the nursing home stay and continued the benefit period although the condition treated was unrelated to his prior stays. The benefit period ended on 3/13/84, the end of the 60-day period beginning with the day of last discharge.

EXAMPLE 3: Z, over age 65 and entitled to hospital insurance benefits, was admitted to General Hospital on 8/1/83, and discharged on 8/10/83 having received nonemergency hospital services. General Hospital met all the requirements in the definition of a hospital except those concerning utilization review and health and safety. While General Hospital met the minimum requirements for a prior-stay hospital, Z's benefit period did not begin with his admission to this hospital because (1) the hospital did not meet all of the requirements in the definition of a hospital; and (2) although the hospital satisfied the requirements for coverage of emergency services, Z did not receive emergency inpatient care. Z was admitted to Haven Convalescent Home on 8/20/83, and remained an inpatient of the home until his discharge on 3/1/84. He had no further inpatient stays in 1984. Haven Convalescent Home became a participating SNF on 1/1/84.

Z's benefit period began 1/1/84, the day Haven Convalescent Home was determined to be a qualified SNF and the services Z received from that date through discharge were extended care services even though they were not covered and, therefore, not charged against Z's Medicare SNF utilization. (The services were not covered posthospital extended care services because Z was not admitted to a participating SNF within 14 days after discharge from the hospital.). Z's benefit period ended 4/29/84, the end of the 60-day period beginning with the date of his discharge from the convalescent home.

2. Definition of "Inpatient" for Ending a Benefit Period.—Generally, a beneficiary is an "inpatient" of a SNF or hospital if the beneficiary is in the SNF or hospital (i.e., not on an outpatient basis). The type of care actually received is not relevant.

However, as a result of recent court orders, a different definition of "inpatient" applies in determining the end of a benefit period in some jurisdictions. That rule or definition is that a beneficiary was an inpatient in a SNF only if the beneficiary's care in the SNF met certain skilled level of care standards. The beneficiary must have needed and received a skilled level of care while in the SNF. This means that in order to have been an "inpatient," the beneficiary must have required skilled services on a daily basis and received daily skilled services which could, as a practical matter, only have been provided in a SNF on an inpatient basis. See standards (1) and (3) in the first paragraph of §3132. If these provisions were not met during the prior SNF stay, the beneficiary was not an inpatient of the SNF and, therefore, the prior SNF stay did not prolong a benefit period. This rule applies when adjudicating claims from hospitals and SNFs located in: Maine Massachusetts, New Hampshire, Rhode Island, Connecticut, New York, Vermont, Delaware, New Jersey, Pennsylvania, The Virgin Island, Kentucky, Michigan, Ohio, Puerto Rico, and Tennessee. The rule applies to all determinations made on or after January 1, 1985, whether they are initial decisions or determinations on reconsideration. The rule is also effective for determinations received by the beneficiary (or the beneficiary's representative) on or after August 7, 1982, for claims from hospitals and SNFs in Maine, New Hampshire, Vermont, Massachusetts, Connecticut and Rhode Island.

In each of the 16 jurisdictions where the special rule applies, use the following presumptions for determining whether the skilled level of care standards described above were met during a prior SNF stay:

Presumption 1: A beneficiary's care in a SNF met the skilled level of care standards described above if a Medicare or Medicaid SNF claim was paid for the care, unless such payment was made under waiver of liability rules.

Presumption 2: A beneficiary's care in a SNF did not meet the skilled level of care standards described above if a claim was paid for the services provided in the SNF under Medicare waiver of liability rules pursuant to §3431A (i.e., not pursuant to §§3431.3 and 3431.4).

Presumption 3: A beneficiary's care in a SNF met the skilled level of care standards described above if a SNF claim was paid for the services provided in the SNF under Medicare waiver of liability rules pursuant to §§3431.3 and 3431.4.

Presumption 4: A beneficiary's care in a SNF did not meet the skilled level of care standards described above if a Medicaid claim for the services provided in the SNF was denied on the grounds that the services received were not at the skilled level of care (even if paid under applicable waiver of liability provisions).

Presumption 5: A beneficiary's care in a SNF shall be presumed to have met the skilled level of care standards described above if a Medicaid or Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at the skilled level of care.

Presumption 6: A beneficiary's care in a SNF shall be presumed not to have met the skilled level of care standards described above if a Medicare claim for the services provided in the SNF was denied on the grounds that the services were not at the skilled level of care and no waiver of liability payment was made under §3431A.

Presumption 7: A beneficiary's care in a SNF shall be presumed not to have met the skilled level of care standards described above if no Medicare or Medicaid claim was submitted by the SNF.

Presumptions (1) through (4) cannot be rebutted. Thus, prior Medicare and Medicaid claim determinations that necessarily required a level of care determination for the time period under consideration are binding for purposes of a later benefit period calculation. Presumptions (5) through (7) can be rebutted by beneficiary showings that the level of care needed or received is other than that which the presumption would dictate.

Presumption 6 can be rebutted because the Medicare skilled level of care definition for coverage purposes is broader than the skilled level of care definition used here for benefit period determinations. Specifically, requirement (2) in the first paragraph of §3132 (regarding the requirement for prior hospital care related to the SNF care) is included for meeting Medicare SNF coverage requirements but is not included in the standard for benefit period determinations. Therefore, Medicare payment could have been denied for a SNF stay on level of care grounds (i.e., not even waiver payment was made), because of noncompliance with that requirement, even though skilled level of care requirements for benefit period determinations were in fact met by the SNF stay. Consequently, when there has been a Medicare SNF payment denial on level of care grounds the beneficiary must be given the opportunity to demonstrate that he still needed and received a skilled level of care for purposes of benefit period determinations.

This issue does not arise when there has been a Medicaid SNF claim denied on level of care grounds. That is because the Medicaid skilled level of care standard for SNF coverage is the same as Medicare's skilled level of care standard for benefit period determinations. Therefore, when a Medicaid SNF claim is denied on level of care grounds, that level of care determination is binding for purposes of a benefit period determination. (See presumption 4.)

Medicare "no payment" bills submitted by a SNF result in Medicare program payment determinations (i.e., denials). Therefore, such "no payment" bills will trigger the appropriate presumptions. This will also be the case in any State where the Medicaid program utilizies "no payment" bills which lead to Medicaid program payment determinations. If a SNF erroneously fails to submit a Medicare claim (albeit a no-pay claim) when Medicare rules require such submission, request compliance with Medicare's rules. Once the no-pay bill is submitted and Medicare has made a denial, the applicable presumption (other than presumption 7) will be triggered.

Where the presumptions are rebuttable (i.e., (5) through (7)), rebuttal showings are to be permitted at both intermediary determination levels under 42 CFR, Part 405, Subpart G (i.e., a rebuttal showing regarding the status of a prior SNF stay could be made at the time that an inpatient claim is submitted and/or at the reconsideration level). Evaluate rebuttal documentation even if the presumption being rebutted was triggered by a Medicaid denial.

Notes:

1. Except as noted below, this special rule for the 16 jurisdictions listed above is applicable in all cases where a prior SNF stay could affect benefit period status; not just in those instances where a beneficiary is in "exhausted" or "copay" status and is therefore seeking to renew a benefit period. The rule has equal application where it results in the beneficiary having to start a new benefit period and pay a new deductible, without receiving an increase in the amount of Medicare benefits paid. However, for claims from hospitals and SNFs in Maine, New Hampshire, Vermont, Massachusetts, Connecticut, and Rhode Island, the pertinent court decision (i.e., Mayburg v. Heckler, 574 F. Supp. 922 (D. Mass. 1983), on appeal, No. 84-1022 (1st Cir., August 2, 1984)) required that the rule be applicable to some determinations which had already been made. In those instances, i.e., where a reopening is required to implement the rule, the special provision is applicable only in cases where the beneficiary is in an "exhausted" or "co-pay" benefits status such that application of the rule would benefit him or her. Reopenings would not be done to apply the rule in instances where the beneficiary would not be benefited (i.e. there would be no reopenings unless the beneficiary would experience a net gain in Medicare beneficiary payments).

2. Application of the special rule and presumptions regarding SNF "inpatient" status is based strictly on the location of the SNF or hospital whose Medicare inpatient claim is being adjudicated (i.e., it applies to claims from SNFs and hospitals in the 16 jurisdictions described above). Application of the rule is not determined by the location of the SNF where any prior stay occurred.

A3030 and A3030.3 Podiatrists.--The phrase "doctor of podiatry or surgical chiropody" in Section 1861(r)(3) of the Social Security Act has been changed in the 1980 Amendments to read "doctor of podiatric medicine." Effective January 1, 1981, a podiatrist is considered a "physician" for purposes of constituting a member of a UR committee if at least two of the other committee physician members are doctors of medicine or osteopathy. In addition, the podiatrists's performance of these utilization review functions must be: (1) consistent with the policy of the hospital or skilled nursing facility in which he performs them; (2) functions which the podiatrist is legally authorized by the State to perform.

Effective January 1, 1981, a podiatrist is considered a "physician" for the purpose of making required physician certification and recertification of medical necessity for Part A and Part B services if the podiatrist's performance of these functions is: (1) consistent with the policy of the institution or agency with respect to which he performs them; and (2) legally authorized by the State.

Effective January 1, 1981, a podiatrist is considered a "physician" for the purpose of establishing and periodically reviewing a home health plan of treatment if the podiatrist's performance of these functions is: (1) consistent with the policy of the institution or agency with respect to which he performs them; and (2) is legally authorized by the State. (See Section 3120.3.)

Cross refer: Sections 3030, 3030.3

A3040.—MEDICARE SECONDARY TO EMPLOYER GROUP HEALTH PLANS FOR INDIVIDUALS ENTITLED ON THE BASIS OF END STAGE RENAL DISEASE

A3040.1. General—Section 2146 of P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, effective October 1, 1981, provides for the coordination of benefits between Medicare and employer group health insurance plans during a 12-month period in the case of individuals entitled to Medicare solely on the basis of end-stage renal disease (ESRD). Under this provision Medicare is secondary payor if an employer group health plan covers the same services. This provision does not apply to beneficiaries entitled to Medicare benefits on the basis of being 65 years of age or because of disability.

For purposes of this instruction, an employer group health plan means a health plan that is of, or contributed to by, an employer, and that provides medical care directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families.

The amendment applies to services furnished on or after October 1, 1981 to entitled individuals whose 12-month periods began in October 1981 or later. Thus it can apply to services furnished as early as October 1981 where there is no waiting period for ESRD entitlement (transplant or self-dialysis training cases), but will not affect services rendered earlier than January 1982 in cases in which Medicare entitlement follows a 3-month waiting period.

Providers have been instructed to annotate the remarks item of all claims for services furnished on and after October 1, 1981 to ESRD beneficiaries whose entitlement began in October 1981 or later, to indicate whether or not the individual is covered under an employer group health plan. The name and address of the plan and the beneficiary's plan identification number should also be entered.

A3040.2 Period in Which Medicare is Secondary to Employer Group Health Plans.—Medicare benefits are not payable or are subject to recovery to the extent that benefits have been paid, or will be paid promptly by an employer group health plan for services furnished during the 12-month period which begins with the earlier of (1) the month in which the individual starts a regular course of renal dialysis or (2) in the case of an individual who receives a kidney transplant, the first month in which the individual is eligible for Medicare benefits. Medicare is the secondary payor under these circumstances during the portion of this 12-month period in which the individual is entitled to Medicare. Since Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis, Medicare will usually be the secondary payor for the first 9 months of an indivdual's entitlement. However, for those individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payor for up to the first 12 months of the individual's Medicare entitlement. Medicare as secondary payor may make supplementary payments if payment by the employer plan is less than the amount charged. Payments made by Medicare initially as a primary payor e.g., where the intermediary is not aware that the beneficiary has coverage under an employer group health plan or where prompt payment by the employer plan cannot be assumed, will be subject to recovery.

A3040.3 Actions by Intermediary Until Permanent Instructions are Issued.—Intermediaries should prepare for implementation of this provision by taking the following actions:

1. Intermediaries should keep a record of all claims by providers and renal dialysis facilities for services furnished on or after October 1, 1981 through the 12th month of entitlement to persons who became entitled to Medicare on the basis of ESRD in October 1981 or later. Intermediaries should utilize the annotations which providers are required to make on their claims in accordance with Section A3040.1 to help them maintain these records. When instructions are issued, these claims will be reexamined for possible recoupment of the Medicare reimbursement if it is determined that the services are subject to this provision. It is not necessary to search your records or to initiate development concerning claims already paid.

2. Benefits should ordinarily be paid as usual for services rendered individuals entitled to Medicare on the basis of ESRD. If it should come to the intermediary's attention that an employer group health plan has already paid for services furnished on or after October 1, 1981 that could be subject to this provision, no Medicare payment should be made. Such claims should not be processed to completion. They should be held until instructions are issued on how to calculate the amount of Medicare secondary reimbursement. The beneficiary and the provider should be informed of the status of the claim.

CHAPTER II
COVERAGE OF SERVICES

	Section	Page
Inpatient Hospital Services		
Covered Inpatient Hospital Services	3101	26.5
Bed and Board	3101.1	27.1
Nursing and Other Services	3101.2	28.2
Drugs and Biologicals	3101.3	28.3
Supplies, Appliances, and Equipment	3101.4	31
Other Diagnostic or Therapeutic Items or Services	3101.5	31
Services of Interns or Residents-in-Training	3101.6	33
Inpatient Services in Connection With Dental Services	3101.7	33
Physical Therapy Furnished by the Hospital or by Others Under Arrangements with and Under the Supervision of the Hospital	3101.8	33.2
Occupational Therapy Furnished by the Hospital or by Others Under Arrangements With the Hospital and Under its Supervision	3101.9	33.5A
Respiratory Therapy Furnished by the Hospital or by Others Under Arrangements with the Hospital and Under its Supervision	3101.10	33.5E
Speech Pathology Services Furnished by the Hospital Under Arrangements with the Hospital and Under Its Supervision	3101.10A	33.5I
Inpatient Hospital Stays for Rehabilitation Care	3101.11	33.6
Pregnancy		
Health Care Associated With Pregnancy	3101.12	33.9A
Infertility		
Treatment for Infertility	3101.13	33.9A
Services Related to and Required as a Result of Services Which are Not Covered Under Medicare	3101.14	33.9B
Inpatient Psychiatric Hospital Services		
Covered Inpatient Psychiatric Hospital Services	3102	33.10
Active Treatment in Psychiatric Hospitals	3102.1	33.10
Nonpsychiatric Care in a Psychiatric Hospital	3102.2	33.14
Duration of Covered Inpatient Hospital Services		
Inpatient Hospital Benefit Days	3103	33.14
Counting Inpatient Days	3103.1	33.14
Late Discharge	3103.2	34
Leaves of Absence	3103.3	34
Discharge or Death on First Day of Entitlement or Participation	3103.4	35

COVERAGE OF SERVICES

	Section	Page
Inpatient Psychiatric Benefit Days Reduction	3104	35
Patient Status on Day of Entitlement	3104.1	36
Institution's Status in Determining Days Deducted	3104.2	36
Days of Admission, Discharge, and Leave	3104.3	36
Reduction for Psychiatric Services in Hospitals	3104.4	36
Determining Days Available-Date of Entitlement After 1967	3104.5	36.1
Determining Days Available-Date of Entitlement Before 1968-Patient Still In First Spell of Illness	3104.6	36.2
Inpatient Psychiatric Hospital Services--Lifetime Limitation	3105	36.4
Lifetime Reserve Days	3106	36.5
When Payment Will Be Made for Reserve Days	3106.1	36.6
Election Not to Use Lifetime Reserve Days	3106.2	36.6
Content of Election	3106.3	36.10
Election Format	3106.4	36.11
Revocation of Election	3106.5	36.11
Revocation Format	3106.6	36.12
Inpatient Service Days Counting Toward Benefit Maximums	3107	37

Hospital Services Covered Under Part B

	Section	Page
Medical and Other Health Services Furnished to Inpatients of Participating Hospitals	3110	37
Surgical Dressings, and Splints, Casts, and Other Devices Used for Reduction of Fractures and Dislocations	3110.3	37.2
Prosthetic Devices	3110.4	37.3
Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes	3110.5	37.5
Total Parenteral Nutrition and Enteral Nutrition Furnished to Individuals Who Are Not Inpatients	3111	37.6
Outpatient Hospital Services	3112	37.6
Outpatient Defined	3112.1	37.6
Distinguishing Outpatient Hospital Services Provided Outside the Hospital	3112.2	38
Outpatient Diagnostic Services	3112.3	38
Outpatient Therapeutic Services	3112.4	38.2
Sleep Disorder Clinics	3112.5	38.4
Intermittent Peritoneal Dialysis Services	3112.6	38.5
Outpatient Hospital Psychiatric Services	3112.7	38.7
Outpatient Observation Services	3112.8	38.10
Rental and Purchase of Durable Medical Equipment	3113	39
Definition of Durable Medical Equipment	3113.1	39
Necessary and Reasonable	3113.2	39.2
Repairs, Maintenance, Replacement, and Delivery	3113.3	40.1
Coverage of Supplies and Accessories	3113.4	40.2
Miscellaneous Issues Included in the Coverage of Equipment	3113.5	40.2

CHAPTER 2

COVERAGE OF SERVICES

Section Page

Definition of Beneficiary's Home........................ 3113.6 40.3
Payment for Durable Medical Equipment................... 3113.7 40.4
Ambulance Service... 3114 41.2
Services of Interns and Residents.......................... 3115 43

Covered and Noncovered Home Health Agency Services

Conditions to be Met for Coverage of Home Health Services.... 3116 43.2
Reasonable and Necessary Services...................... 3116.1 43.2
Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services.................................... 3116.2 44.1
Use of Utilization Screens and "Rules of Thumb"........ 3116.3 44.2
Conditions Beneficiary Must Meet to Qualify for Coverage of Home Health Services............................... 3117 44.2
Confined to the Home................................... 3117.1 44.3
Services Are Provided Under a Plan of Care Established and Approved by a Physician............................. 3117.2 44.5
Under the Care of a Physician.......................... 3117.3 44.7
Needs Skilled Nursing Care on an Intermittent Basis or Physical Therapy or Speech Therapy or has a Continued Need for Occupational Therapy.............................. 3117.4 44.7
Physician Certification................................ 3117.5 44.8
Coverage of Services Which Establish Home Health Eligibility. 3118 44.8
Skilled Nursing Care................................... 3118.1 44.9
Skilled Therapy Services............................... 3118.2 46.3
Coverage of Other Home Health Services...................... 3119 46.10
Skilled Nursing Care, Physical Therapy, Speech Therapy and Occupational Therapy.............................. 3119.1 46.10
Home Health Aide Services.............................. 3119.2 46.10
Medical Social Services................................ 3119.3 47.2
Medical Supplies and the Use of Durable Medical Equipment.. 3119.4 47.4
Services of Interns and Residents...................... 3119.5 47.5
Outpatient Services.................................... 3119.6 47.6
Part-Time or Intermittent Home Health Aide and Skilled Nursing Services................................... 3119.7 47.6

Special Conditions for Coverage for Home Health Services

Special Conditions for Coverage of Home Health Services Under Supplementary Medical Insurance............. 3122 54.1
Non-Eligibility Under Hospital Insurance................ 3122.1 54.1
Change to Medical Insurance Home Health Services on Change of Residence...................... 3122.2 54.1

COVERAGE OF SERVICES

Section Page

Duration of Home Health Services

Duration of Home Health Services.......... 3123 54.1
- Duration of Home Health Services Under Hospital Insurance.......... 3123.1 54.1
- Duration of Home Health Services Under Supplementary Medical Insurance.......... 3123.2 54.3
- Examples of Duration of Services Under Hospital and Medical Insurance.......... 3123.3 54.3

Counting Visits Under the Hospital and Medical Plans.......... 3124 55
- Visit Defined.......... 3124.1 55
- Counting Visits.......... 3124.2 55
- Evaluation Visits.......... 3124.3 55.1

Other Home Health Coverage Issues

Specific Exclusions from Coverage as Home Health Services.... 3125 55.2
Medical and Other Health Services Furnished by Home Health Agencies.......... 3127 55.2
Physician Certification for Medical and Other Health Services Furnished by Home Health Agency.......... 3128 55.3

Coverage of Extended Care Services Under Hospital Insurance

Requirements--General.......... 3130 55.5
Hospital Providers of Extended Care Services.......... 3130.1 55.5
Prior Hospitalization and Transfer Requirements.......... 3131 55.6
- Three-Day Prior Hospitalization.......... 3131.1 56
- Three-Day Prior Hospitalization--Foreign Hospital.......... 3131.2 56
- Thirty-Day Transfer.......... 3131.3 56.1

CHAPTER 2

COVERAGE OF SERVICES

Covered Level of Care in Skilled Nursing Facilities

	Section	Page
Skilled Nursing Facility Level of Care--General	3132	56.13
Skilled Nursing and Skilled Rehabilitation Services	3132.1	56.13
Direct Skilled Nursing Services to Patients	3132.2	56.18
Direct Skilled Rehabilitation Services to Patients	3132.3	56.19
Nonskilled Supportive or Personal Care Services	3132.4	57.1
Daily Skilled Services--Defined	3132.5	57.2
Services Provided on an Inpatient Basis as a "Practical Matter"	3132.6	57.2

Covered Extended Care Services

	Section	Page
Covered Extended Care Services	3133	57.5
Nursing Care provided by or Under the Supervision of a Registered Professional Nurse	3133.1	57.6
Bed and Board in Semi-Private Accommodations Furnished in Connection With Nursing Care	3133.2	57.6
Physical, Speech and Occupational Therapy Furnished by Skilled Nursing Facility (Formerly Extended Care Facility) or by Others Under Arrangements With the Facility and Under Its Supervision	3133.3	57.7
Medical Social Services to meet the Patient's Medically Related Social Needs	3133.4	58.1
Drugs and Biologicals	3133.5	58.1
Supplies, Appliances and Equipment	3133.6	58.2A
Medical Services of an Intern or Resident--In-Training	3133.7	58.3
Other Diagnostic or Therapeutic Services Provided by a Hospital	3133.8	58.5
Other Services	3133.9	58.5

COVERAGE OF SERVICES

Section Page

Duration of Covered Extended Care Services

Extended Care Benefit Days.................................. 3135 58.6
- Inpatient Day Defined.................................. 3135.1 58.6
- Late Discharge.................................. 3135.2 58.6
- Leaves of Absence.................................. 3135.3 58.7
- Discharge or Death on First Day of a Skilled Nursing Facility's Participation........................... 3135.4 58.7

Inpatient Extended Care Services Counting Toward Maximums.... 3136 58.7

Services Furnished by Skilled Nursing Facilities
Covered Under Medical Insurance

Medical and Other Health Services Furnished to SNF Patients.. 3137 58.7
- Diagnostic Services and Radiological Therapy............ 3137.1 58.8

Ambulance Service.................................. 3138 58.8

Covered Hospice Services

Requirements-General.................................. 3140 58.8

Election Procedures.................................. 3141 58.8A
- Election, Revocation and Change of Hospice.............. 3141.1 58.8A

Coinsurance.................................. 3142 58.8B

Requirements for Coverage.................................. 3143 58.8C
- Covered Services.................................. 3143.1 58.8C
- Special Coverage Requirements.......................... 3143.2 58.8D

Provider-Based Physicians

Provider-Based Physicians' Services.......................... 3145 58.9
- Direct Dealing Group Practice Prepayment
- Health Care Prepayment Plans (HCPPs), Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs)--Reimbursement of Professional Component.................................. 3145.1 58.10
- Preadmission Diagnostic Services Furnished At Hospital to Which Patient is Admitted...................... 3145.2 58.10
- Agreement to Accept Assignment...................... 3145.3 58.10A

Radiological and Pathological Services Furnished to Hospital Inpatients.......................... 3146 58.11
- Who Must Execute The Agreement.......................... 3146.1 58.14
- Scope of the Agreement.................................. 3146.2 58.15
- Language of the Agreement.............................. 3146.3 58.16
- Where the Agreement Should be Filed..................... 3146.4 58.18
- Effective Date of Agreement and Contractor Action on Receiving It.................................. 3146.5 58.18
- Termination of Agreement.............................. 3146.6 58.19
- Physician or Entity Moves.............................. 3146.7 58.20
- Submission of Claims Under Agreement.................. 3146.8 58.20
- Carrier and Intermediary Action........................ 3146.9 58.20

CHAPTER 2

COVERAGE OF SERVICES

Outpatient Physical Therapy and Speech Pathology Services

	Section	Page
Coverage of Outpatient Physical Therapy and Speech Pathology Services	3147	58.21
Services Furnished Under Arrangement With Providers	3147.1	58.21
Conditions for Coverage of Outpatient Physical Therapy or Speech Pathology Services	3148	58.21
Physician's Certification and Recertification	3148.1	58.21
Outpatient Must be Under the Care of a Physician	3148.2	58.21
Outpatient Physical Therapy or Speech Pathology Services Furnished Under a Plan	3148.3	58.22
Requirement that Services be Furnished on an Outpatient Basis	3148.4	58.23
Outpatient Physical Therapy Services Furnished in the Office of an Independently Practicing Physical Therapist Under Arrangements Made by a Public Health Agency or Hospital in Rural Communities	3149	58.24

General Exclusions From Coverage

General Exclusions	3150	59
Services Not Reasonable and Necessary	3151	59
Devices Not Approved by FDA	3151.1	59
No Obligation to Pay for or Provide Services	3152	60
Items and Services Furnished, Paid for or Authorized by Government Entities--Federal, State or Local Governments.	3153	62
Items and Services Which a Non-Federal Provider Furnishes Pursuant to an Authorization Issued by a Federal Agency	3153.1	62
Items and Services Furnished by Federal Provider of Services or Federal Agency	3153.2	62.2
Items or Services Paid For by Governmental Entity	3153.3	62.3
Services Not Provided Within the United States	3154	63.2
Services Resulting From War	3155	63.3
Personal Comfort Items	3156	63.3
Routine Services and Appliances	3157	63.3A

Exclusion of Foot Care and Supportive Devices for the Foot

Excluded Foot Care Services	3158	63.4
Application of Foot Care Exclusions to Provider Services	3158.1	64
Supportive Devices for Feet	3158.2	64.1

COVERAGE OF SERVICES

Section Page

Custodial Care

Custodial Care.. 3159 64.1
  Custodial Care Under a Hospice Program................ 3159.1 64.1

Other Exclusions

Cosmetic Surgery...................................... 3160 64.9
Charges Imposed by Immediate Relatives of the Patient or Members of His Household............................. 3161 64.9
Dental Services Exclusion............................. 3162 64.11
Items and Services Under a Worker's Compensation Law....... 3163 64.12
Inpatient Hospital Services Not Delivered Directly or Under Arrangement by the Hospital..................... 3164 64.12

End Stage Renal Disease

Introduction.. 3165 64.13
Composite Rate Reimbursement for Outpatient Maintenance Dialysis.................................. 3166 64.13
Definitions... 3166.1 64.13
Frequency of Dialysis Sessions........................ 3166.2 64.16
Outpatient Maintenance Dialysis--Coverage................. 3167 64.16
  Laboratory Services Included Under the Composite Rate... 3167.1 64.17
  Laboratory Tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD) and Hemofiltration.................. 3167.3 64.17
Drugs and Biologicals................................. 3168 64.18a
Composite Rate Reimbursement for Patients Dialyzing at Home....................................... 3169 64.19
  Items and Services Included Under the Composite Rate for Home Dialysis.................................... 3169.1 64.19
  Beneficiary Selection Form (HCFA-382) for Home Dialysis Patients.. 3169.2 64.20

COVERAGE OF SERVICES

End-Stage Renal Disease

	Section	Page
Coverage of Infacility Dialysis Sessions Furnished to Home Patients Who Are Traveling	3169.3	64.20
Home Dialysis Equipment--General	3170	64.20
Installation and Delivery of Home Dialysis Equipment	3170.1	64.20a
Current Use of Equipment	3170.2	64.20b
Other Requirements for Coverage of Home Dialysis Equipment	3170.3	64.20b
Home Dialysis Equipment Provided to Home Hemodialysis and Peritoneal Dialysis Patients	3170.4	64.21
Coverage of Home Dialysis Supplies	3170.5	64.21
Coverage of Home Dialysis Support Services	3170.6	64.21
Continuous Ambulatory Peritoneal Dialysis	3171	64.21a
Certification of Facilities Furnishing CAPD Services	3171.1	64.21a
Institutional Dialysis Services Furnished to CAPD Patients	3171.2	64.21a
Support Services and Supplies Furnished to Home CAPD Patients	3171.3	64.21c
Training	3172	64.21c
Hemodialysis Training	3172.1	64.21c
Intermittent Peritoneal Dialysis (IPD) Training	3172.2	64.21d
Continuous Ambulatory Peritoneal Dialysis (CAPD) Training	3172.3	64.21d
Continuous Cycling Peritoneal Dialysis (CCPD) Training	3172.4	64.21e
Physicians' Services During Self-Dialysis Training	3172.5	64.21e
Inpatient Hospital Dialysis	3173	64.21f
Inpatient Dialysis in Hospitals Certified to Provide ESRD Services	3173.1	64.21f
Inpatient Dialysis in Hospitals Certified to Provide Medicare Services	3173.2	64.21f
Inpatient Dialysis in Nonparticipating Hospitals	3173.3	64.21f
Extended Intermittent Peritoneal Dialysis	3173.4	64.22
Services Provided Under An Agreement	3173.5	64.22
Services Provided Under An Arrangement	3173.6	64.22
Dialysis Services Provided Under Arrangements to Hospital Inpatients	3173.7	64.22
Hemofiltration	3174	64.22
Hemoperfusion	3175	64.22a
Transplantation	3178	64.23
Identifying Candidates for Transplantation	3178.1	64.23
Identifying Suitable Live Donors	3178.2	64.23
Pretransplant Outpatient Services	3178.3	64.23a
Pretransplant Inpatient Services	3178.4	64.23a
Living Donor Evaluation, Patient Has Entitlement or Is In Pre-Entitlement Period	3178.5	64.23a

COVERAGE OF SERVICES

	Section	Page
Kidney Recipient Admitted for Transplant Evaluation	3178.6	64.23a
Kidney Recipient Evaluated for Transplant During Inpatient Stay	3178.7	64.23b
Kidney Recipient Admitted for Transplantation and Evaluation	3178.8	64.23b
Post-Transplant Services Provided to Live Donor	3178.9	64.23b
Physicians' Services	3178.10	64.23b
Coverage After Recipient Has Exhausted Part A	3178.11	64.23b
Cadaver Kidneys	3178.12	64.23c
Services Involved	3178.13	64.23c
Tissue Typing Services for Cadaver Kidney	3178.14	64.23c
Cadaver Excision Yielding Two Kidneys	3178.15	64.23c
Provider Costs Related to Cadaver Kidney Excisions	3178.16	64.23c
Noncovered Transplant Related Items	3178.17	64.23d
Other Covered Services	3178.18	64.23d
Hospitals that Excise But Do Not Transplant Kidneys	3178.19	64.23e

Comprehensive Outpatient Rehabilitation Facility Services

Comprehensive Outpatient Rehabilitation Facility Services	3180	64.25
Covered CORF Services and Noncovered Services	3181	64.25
Provision of Services	3182	64.26
Specific CORF Services	3183	64.27
Physicians' Services	3183.1	64.27
Physical Therapy Services	3183.2	64.27
Occupational Therapy Services	3183.3	64.28
Speech Pathology Services	3183.4	64.28
Respiratory Therapy Services	3183.5	64.28
Prosthetic and Orthotic Devices	3183.6	64.28
Social Services	3183.7	64.28
Psychological Services	3183.8	64.29
Nursing Services	3183.9	64.29
Drugs and Biologicals	3183.10	64.29
Supplies, Appliances and Equipment	3183.11	64.30
Home Environment Evaluation	3183.12	64.30
Psychiatric Services Limitation	3185	64.30

Inpatient Hospital Services

3101. COVERED INPATIENT HOSPITAL SERVICES.

Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services. (Inpatient hospital services do not include extended care services provided by hospitals pursuant to swing bed approvals (see § 3130.1).)

In any case where Part A payment can be made, all nonphysician services delivered to an inpatient of a hospital (except pneumococcal vaccine and its administration and hepatitis B vaccine and its administration) must be treated as "inpatient hospital services," to be paid for only by Part A.

Beginning with hospital cost reporting periods occurring on or after October 1, 1983, while some hospitals continue to be paid on a reasonable cost basis for inpatient hospital services, most come under a Medicare prospective payment system (PPS). Under PPS, Medicare will pay a fixed amount for a case. That amount is determined by the Diagnosis Related Group (DRG) into which the case falls. This means that a given all or nothing Medicare payment will be made for a case, based on the DRG assigned, so long as the admission is medically necessary and appropriate. Futhermore, under PPS, if an appropriately admitted case results in an extraordinarily long stay (i.e., becomes a day outlier) or results in the expenditure of extraordinary resources (i.e., becomes a cost outlier) additional money, known as outlier payment, is added to the regular Medicare prospective payment amount for the particular DRG.

Therefore, in PPS hospitals, coverage restrictions continue but noncovered care can have only three effects: (1) lead to denial of an admission; (2) in appropriately admitted cases where a noncovered procedure was performed, result in payment of a different DRG (i.e., one which excludes payment for the noncovered procedure); or (3) in appropriately admitted cases that become day or cost outlier cases, lead to denial of some or all of an outlier payment. The following examples illustrate this principle. If care is noncovered because a patient does not need to be hospitalized, deny the admission and make no Part A (i.e., PPS) payment unless paid under waiver of liability. If a patient is appropriately hospitalized but receives (beyond routine services) only noncovered care (e.g., acupuncture), deny the admission. (Note: Do not deny an admission so long as inpatient hospital care was medically necessary and covered services required for the adequate treatment and/or diagnosis of the patient's illness were provided, even if noncovered care was also rendered. Under PPS, Medicare assumes that it is paying for only the covered care rendered whenever covered services needed to treat and/or diagnose the illness were in fact provided.) If a noncovered procedure is provided along with covered nonroutine care, a DRG change rather than an admission denial might occur. If, noncovered procedures such as acupuncture are elevating costs into the cost outlier category or prolonging the patient's stay into day outlier status, outlier payments is denied in whole or in part.

For purposes of prospective payments, most of the subsequent discussion regarding coverage of inpatient hospital services is relevant only in the context of determining the appropriateness of admissions, which DRG, if any, to pay, and the appropriateness of payment for any outlier cases. (See § 3690ff for related operational instructions).

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. The physician should use a 24-hour period as a benchmark, i.e., he or she should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's bylaws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital.

In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

- Minor Surgery or Other Treatment.--When a patient with a known diagnosis enters a hospital for a specific minor surgical procedure or other treatment that is expected to keep him in the hospital for only a few hours (less than 24), he is considered an outpatient for coverage purposes regardless of: the hour he came to the hospital; whether he used a bed; and whether he remained in the hospital past midnight.

- Renal Dialysis.--Renal dialysis treatments are usually covered only as outpatient services but may under certain circumstances be covered as inpatient services depending on the patient's condition. A patient who is staying at his home, who is ambulatory, whose condition is stable and who comes to the hospital for routine chronic dialysis treatments, and not for a diagnostic workup or a change in therapy, is considered an outpatient. On the other hand, a patient undergoing short-term dialysis until his kidneys recover from an acute illness (acute dialysis), or a person with borderline renal failure who develops acute renal failure every time he has an illness and requires dialysis (episodic dialysis) is usually an inpatient. A patient may begin dialysis as an inpatient and then progress to an outpatient status.

Under Medicare, the peer review organization (PRO) for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. The PRO is authorized by the Medicare law to make these judgments, and the judgments are binding for purposes of Medicare coverage. In making these judgments, however, PROs consider only the medical evidence which was available to the physician at the time an admission decision had to be made, and do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary.

NOTE: When patients requiring extended care services occupy beds in a hospital, they are considered inpatients of the hospital. In such cases, the services furnished in the hospital will not be considered extended care services, and payment may not be made under the program for such services. (See §§ 3421.2 and 3130.1 for exceptions to this rule). Such a situation may arise where the hospital is part of an institution having a distinct part SNF, and either there is no bed available in the distinct part SNF or for any other reason the institution fails to place the patient in the appropriate bed. The same rule applies where the hospital is a separate institution. For the same reason, where patients who require inpatient hospital services occupy beds in a skilled nursing facility, payment cannot be made on their behalf for the services furnished to them in the SNF. (See § 3133).

(If a patient received items or services in excess of, or more expensive than, those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services or for only the appropriate prospective payment amount. This provision applies not only to inpatient services but to all hospital services under Parts A and B of the program).

(If a patient received items or services in excess of, or more expensive than, those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. This provision applies not only to inpatient services but to all hospital services under Parts A and B of the program).

3101.1 Bed and Board.--

A. Accommodations--General.-- Effective for accounting periods beginning after December 31, 1977, Health Care Financing Administration regulations provide for apportionment of routine service costs on the basis of average per diem cost under both the Departmental and the Combination methods of cost apportionment. Thus, the program will pay the same amount for routine services whether the patient has a private room not medically necessary, a private room medically necessary (Medicare does not pay for deluxe accommodations in any case), a semiprivate room (two, three, or four-bed accommodations), or ward accommodations, if its ward accommodations are consistent with program purposes (see F below).

A provider having both private and semiprivate accommodations may nevertheless charge the patient a differential for a private room if:

1. The private room is not medically necessary; and

2. The patient (or relative or other person acting on his behalf) has requested the private room, and the provider informs him at the time of the request of the amount of the charge.

The private room differential may not exceed the difference between the customary charge for the acommodations furnished and the most prevalent semiprivate accommodation rate at the time of the patients admission.

Where the provider bills for a private room as a covered service, i.e., shows the charge for the room as a covered charge on the HCFA-1453, the intermediary will deem the private room to be medically necessary. Where the provider, on the other hand, shows a private differential as a noncovered charge, the intermediary will assume that the private room is not medically necessary.

If the beneficiary (or his representative) protests a charge for the private room on the grounds that the privacy was medically necessary, such protest will, if not in written form, be reduced to writing and forwarded to the intermediary. The intermediary will then develop the facts and make a specific determination regarding the medical necessity of the private room. (If an intermediary receives many protests of this kind, the provider may need guidance on what constitutes medical necessity for privacy). If the protest is received after the claim is processed, it will be treated as a request for reconsideration.

If at any time in the course of development (or thereafter within the period when the determination is not administratively final under § 3799FF the provider acknowledges that the private room was medically necessary, the intermediary will make an immediate finding to this effect.

Where it is necessary to develop the medical necessity of a private room, the guidelines in subsections B and C will apply.

B. Medical Necessity: Need for Isolation.--A private room is medically necessary where isolation of a beneficiary is required to avoid jeopardizing his health or recovery, or that of other patients who are likely to be alarmed or disturbed by the beneficiary's symptoms or treatment or subjected to infection by the beneficiary's communicable disease. For example, communicable diseases, heart attacks, cerebrovascular accidents, and psychotic episodes may require isolation of the patient for certain periods. (See C below concerning medical necessity not based on need for isolation.)

In establishing the medical necessity for isolation, the date of the physician's written statement is not controlling, nor is the presence of a written statement. The crucial question is whether a private room was ordered by the physician because it is necessary for the health of the patient himself or of other patients. In the absence of such an order, a patient who requested the room with knowledge of the amount of the charge may be charged appropriately, even though a physician subsequently submits a statement that the room was medically necessary. There may be cases in which the physician's written statement of medical necessity, though dated after admission or even after discharge, merely confirms an order made informally at or before the time the beneficiary was admitted to the private room (e.g., the physician made arrangements by phone for the patient's admission, gave the diagnosis, and stated the beneficiary would need a private room). In such cases, assuming that the private room was medically necessary, the lack of a written statement by the physician, or the fact that the written statement was prepared after discharge, would not be controlling. The patient may not be charged.

C. Medical Necessity: Admission Required and Only Private Rooms Available.--A private room is considered to be medically necessary even though the beneficiary's condition does not require isolation if he needs immediate hospitalization (i.e., his medical condition is such that hospitalization cannot be deferred) and the hospital has no semiprivate or ward accommodations available at the time of admission.

Effective August 1, 1972, medical necessity will be considered to exist in an SNF where semiprivate and ward accommodations are unavailable and admission cannot be deferred until such accommodations become available because it would endanger the beneficiary's health or recovery, require that the beneficiary's hospitalization be prolonged after he is ready for discharge to an SNF (§ 3421.2), or require that he forfeit program coverage by delaying admission beyond the applicable transfer period. (See §§ 3131.3 and A3131B).

It need not be considered whether semiprivate or ward accommodations were available in some other accessible hospital or SNF. Where medical necessity exists, the provider may not charge the beneficiary a private room differential until semiprivate or ward accommodations become available. Thereafter the provider may transfer the patient to the nonprivate accommodations, or allow him to continue occupancy of the private room, subject to an appropriate differential charge (described in A above) if he requests the private room with knowledge of the amount of the charge.

If the admission could be deferred until semiprivate or ward accommodations become available, the beneficiary should be informed of the amount of the differential he must pay for a private room if he wishes to be admitted immediately; the beneficiary may be charged the specified differential if he has been admitted to the private room at his request (or at the request of his representative) with knowledge of the amount of the charge.

D. Charges for Deluxe Private Room.--A beneficiary found to need a private room (either because he needs isolation for medical reasons or because he needs immediate admission when no other accommodations are available) may be assigned to any of the provider's private rooms. He does not have the right to insist on the private room of his choice, but his preferences should be given the same consideration as if he were paying all provider charges himself. The program does not, under any circumstances, pay for personal comfort items. Thus, the program does not pay for deluxe accommodations and/or services; these would include a suite, or a room substantially more spacious than is required for treatment, or specially equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities. If he (or his representative) requests such deluxe accommodations, the provider should advise that there will be a charge, not covered by Medicare, of a specified amount per day (not exceeding the differential defined in the next sentence) and may charge him that amount for each day he occupies the deluxe accommodations. The maximum amount he may be charged for such accommodations is the differential between the most prevalent private room rate (see § 3635.1 for determination of most prevalent private room rate) at the time of admission and the customary charge for the room occupied. The beneficiary may not be charged this differential if he (or his representative) does not request the deluxe accommodations.

The beneficiary may not be charged such a differential in private room rates if that differential is based on factors other than personal comfort items. Such factors might include differences between older and newer wings, proximity to lounge, elevators or nursing stations, desirable view, etc. Such rooms are standard one-bed units and not deluxe rooms for purposes of this instructions, even though the provider may call the- deluxe and have a higher customary charge for them. No additional charge may be imposed upon the beneficiary who is assigned to a room which may be somewhat more desirable because of these factors.

E. All-Private Room Providers.--If the patient is admitted to a provider which has only private accommodations, and no semiprivate or ward accommodations, medical necessity will be deemed to exist for the accommodations furnished. Beneficiaries may not be subjected to an extra charge for a private room in an all-private room provider.

F. Wards.--The law contemplates that Medicare patients should not be assigned to ward accommodations except at the patient's request or for a reason consistent with the purposes of the health insurance program.

When ward accommodations are furnished at the patient's request or for a reason determined to be consistent with the program's purposes, payment will be based on the average per diem cost of routine services (see paragraph A above). Where ward accommodations are assigned for other reasons, the law provides what may be a substantial penalty. (See 2 below.)

Any request by the patient (or relative or other person responsible for his affairs) for ward accommodations must be obtained by the provider in writing and kept in its files.

1. Assignment Consistent with Program Purposes.--It is considered to be consistent with the program's purposes to assign the patient to ward accommodations if all semiprivate accommodations are occupied, or the facility has no semiprivate accommodations. However, the patient must be moved to semiprivate accommodations if they become available during his stay.

Some hospitals, and possibly some skilled nursing facilities, have a policy of placing in wards all patients who do not have private physicians. Such a practice may be consistent with the purposes of the program if the intermediary determines that the ward assignment inures to the benefit of the patient. In making this determination, the principal consideration is whether the assignment is likely to result in better medical treatment of the patient (e.g., it facilitates necessary medical and nursing supervision and treatment). The intermediary should ask a provider having this policy to submit a statement describing how the assignments are made, their purpose, and the effect on the care of patients so assigned.

If the intermediary makes a favorable determination on a practice affecting all ward assignments of Medicare patients in the institution, a reference should be made on the appropriate billing form for patients whom the hospital assigned a ward pursuant to such practice.

2. Assignment Not Consistent with Program Purposes.--It not consistent with the purposes of the law to assign a patient ward ccommodations on the basis of his social or economic status, his national origin, race, or religion, or his entitlement to benefits as a Medicare patient, or any other such discriminatory reason. It is also inconsistent with the purposes of the law to assign patients to ward accommodations merely for the convenience or financial advantage of the institution.

If a ward assignment is made neither at the patient's request nor for a reason consistent with the purpose of the program, the reimbursement to the provider for routine services is decreased by the difference between the institution's customary charges for semiprivate accommodations at the most prevalent rate (see G below) at the time of the patient's admission and the charge customarily made for the ward accommodations furnished the patient. The reduction in payment, when applicable, will be made at the end-of-year settlement.

When the intermediary cannot ascertain from the billing form the reason for a ward assignment, it need not develop further where application of the formula would not result in a reduction in payment to the provider; i.e., there is no difference in the provider's customary charges for semiprivate and ward accommodations.

EXAMPLE: The reasonable cost for routine services in Hospital X is $72 per day. The most prevalent customary charge for a semiprivate room is $77 per day, while $70 per day is the customary charge for ward accommodations. In such a case, development of the reason for the ward assignment will be necessary. If it is determined that the patient was assigned to a ward neither at his request nor for a reason consistent with the purposes of the program, the hospital will be paid only $65 per day for the ward accommodations, computed as follows: $72 (the reasonable cost for routine services) minus a differential of $7 (obtained by subtracting $70 from $77). However, if it is determined that the patient was assigned to the ward at his own request or for a reason consistent with the purposes of the program, the hospital will be paid $72, i.e., the reasonable cost of routine services.

G. Charges.--Customary charges means amounts which the hospital or skilled nursing facility is uniformly charging patients currently for specific services and accommodations. The most prevalent rate or charge is the rate which applies to the greatest number of semiprivate or private beds in the institution.

3101.2 Nursing and Other Services.--Nursing and other related services, use of hospital facilities, and medical social services ordinarily furnished by the hospital for the care and treatment of inpatients are covered under hospital insurance.

NOTE: The services of a private-duty nurse or other private-duty attendant are not covered. Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on his behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such noncovered services.

Where the hospital acts on behalf of a patient, the services of the private-duty nurse or other attendant under such an arrangement are not inpatient hospital services regardless of the control which the hospital may exercise with respect to the services rendered by such private-duty nurse or attendant.

A. Anesthetist Services.--If the hospital engages the services of a nurse anesthetist or other nonphysician anesthetist (either on a salary or fee-for-service basis) under arrangements which provide for billing to be made by the hospital, the cost of the service when provided to an inpatient would be covered under Part A.

B. Medical Social Services to Meet the Patient's Medically Related Social Needs.--Medical social services are services which contribute meaningfully to the treatment of a patient's condition. Such services include, but are not limited to, (a) assessment of the social and emotional factors related to the patient's illness, his need for care, his response to treatment, and his adjustment to care in the facility; (b) appropriate action to obtain case work services to assist in resolving problems in these areas; (c) assessment of the relationship of the patient's medical and nursing requirements to his home situation, his financial resources, and the community resources available to him in making the decision regarding his discharge.

3101.3 Drugs and Biologicals.--Drugs and biologicals for use in the hospital, which are ordinarily furnished by the hospital for the care and treatment of inpatients are covered.

Three basic requirements must be met for a drug or biological furnished by a hospital to be a covered hospital service.

- The drug or biological must represent a cost to the institution in rendering services to the beneficiary.
- It must either be included, or approved for inclusion, in the U.S. Pharmacopoeia, the National Formulary, or the U.S. Homeopathic Pharmacopoeia; or, except for those unfavorably evaluated, in AMA Drug Evaluations (the successor publication to New Drugs) or Accepted Dental Therapeutics (the successor publication to Accepted Dental Remedies); or be approved by the pharmacy and drug therapeutics or equivalent committee of the medical staff of the hospital for use in the hospital.
- Use of the drug or biological must be safe and effective and otherwise reasonable and necessary.

Drugs or biologicals approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective for purposes of this last requirement when used for indications specified in the labeling. Therefore, use of an FDA-approved drug or biological is covered if:

- o it was administered on or after the date of the FDA's approval;
- o it is reasonable and necessary for the individual patient; and
- o all other applicable coverage requirements are met.

Drugs and biologicals which have not received final marketing approval by the FDA are not covered unless you receive instructions from HCFA to the contrary. For specific guidelines of Group C cancer drugs and other covered/non-covered drug issues refer to the Coverage Issues Manual.

However, FDA-approved drugs are used for indications other than those specified on the labeling. As long as the FDA has not specified such use as nonapproved, coverage is determined taking into consideration the generally accepted medical practice in the community. For example, the labeling of certain chemotherapeutic drugs indicates their use in the therapy of specified types of cancer. However, based on experience and empirical evidence, physicians may prescribe these drugs for a wider range of cancer treatments than what is indicated in the labeling. Under these conditions, these drugs would be covered unless the PRO determines that such use is not medically reasonable and necessary in the individual case.

Determinations as to whether use of a drug or biological is reasonable and necessary for an individual patient are the responsibility of the Peer Review Organization (PRO).

A hospital stay solely for the purpose of use of a drug or biological that is determined not reasonable and necessary is not covered.

A. Drugs Included in the Drug Compendia.--Cover only those drugs and biologicals included, or approved for inclusion, in the latest official edition or revision of the compendia as previously listed.

Where a drug is excluded from coverage because it is unfavorably evaluated in either the AMA Drug Evaluations or Accepted Dental Therapeutics, the exclusion applies to all uses for which the drug or biological was so unfavorably evaluated.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the procedure established by the professional organization responsible for revision of the compendium.

B. Approval by Pharmacy and Drug Therapeutics Committee.--A pharmacy and drug therapeutics or equivalent committee is a medical staff committee which confers with the hospital pharmacist in the formulation of policies pertaining to drugs. Drugs and biologicals approved for use in the hospital by such a committee are covered only if the committee develops and maintains a formulary or list of drugs accepted for use in the hospital. The committee need not function exclusively as a pharmacy and drug therapeutics committee buy may also carry on other medical staff functions.

Drugs and biologicals are considered approved for use in the hospital if selected for inclusion in the hospital drug list of formulary under the procedure of the committee established for that purpose. Express approval is required; the fact that a drug or biological has not been specifically determined to be unacceptable for use in the hospital does not constitute approval.

Drugs and biologicals are covered if approved for general use in the hospital, or if approved for use by a particular patient or group of patients. Approval by a pharmacy and drug therapeutics committee is an alternative to approval for inclusion of the drug or biological in an approved drug compendium (see A above); such approval does not preclude the need for a determination of medical necessity. An investigational drug is not considered to meet the reasonable and necessary test since its efficacy has not yet been established. The decision of individual hospitals should not transcend the determinations of the Food and Drug Administration and Public Health Service in respect to the safety and effectiveness of drugs. Therefore, even if approved by an appropriate hospital committee, the reasonable cost of an investigational or other nonapproved drug or biological (e.g., Laetrile) cannot be reimbursed. This exclusion from payment applies whether or not the drug or biological is administered during the course of an otherwise covered hospital stay, since payment may not be made for items and services which are not reasonable and necessary. A hospital stay solely for the purpose of administering a drug or biological which is not reasonable and necessary, including an investigational drug or biological, is not covered and the drug or biological itself is not covered.

C. Combination Drugs.--Combination drugs are covered if the combination itself or all of the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. Any combination drug approved for use in the hospital by the pharmacy and drug therapeutics or equivalent committee is covered.

D. Drugs Specially Ordered for Inpatients.--Coverage is not limited to drugs and biologicals routinely stocked by the hospital; a drug or biological not stocked by the hospital which the hospital obtains for the patient from an outside source, such as a community pharmacy, can also be covered.

Drugs and biologicals not included in the drug list or formulary maintained by the hospital's pharmacy and drug therapeutic's committee may be covered if the hospital has a policy which permits such drugs to be furnished to a patient at the special request of a physician. However, in order to be covered, such drugs and biologicals must be included, or approved for inclusion, in one of the designated drug compendia. (In addition, a combination drug, or all of its therapeutic ingredients, would have to be included or approved for inclusion in one of the compendia.)

E. Drugs for Use Outside the Hospital.--Drugs and biologicals furnished by a hospital to an inpatient for use outside the hospital are, in general, not covered as inpatient hospital services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the hospital, and a limited supply is required until he can obtain a continuing supply, the limited supply of the drug or biological is covered as an inpatient hospital service.

3101.4 Supplies, Appliances, and Equipment.--Supplies, appliances, and equipment which are ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during his inpatient stay in the hospital are covered inpatient hospital services.

Under certain circumstances, supplies, appliances, and equipment used during the beneficiary's inpatient stay are covered under Part A even though they leave the hospital with the patient when he is discharged. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. Examples of items covered under this rule are cardiac valves, cardiac pacemakers, and artificial limbs which are permanently installed in or attached to the patient's body while he is an inpatient of the hospital; and items, such as tracheostomy or drainage tubes, which are temporarily installed in or attached to the patient's body while he is receiving treatment as an inpatient and which are also necessary to permit or facilitate the patient's release from the hospital.

Hospital "admission packs" containing primarily toilet articles, such as soap, toothbrushes, toothpaste, and combs, are covered under Part A if routinely furnished by the hospital to all its inpatients. If not routinely furnished to all patients, the packs are not covered. In that situation, the hospital may charge a beneficiary for the pack, but only if he requests it with knowledge of what he is requesting and what the charge to him will be.

Supplies, appliances, and equipment furnished to an inpatient for use only outside the hospital are not, in general, covered as inpatient hospital services. However, a temporary or disposable item which is medically necessary to permit or facilitate the patient's departure from the hospital and is required until the patient can obtain a continuing supply is covered as an inpatient hospital service.

The reasonable cost of oxygen furnished to hospital inpatients is covered under Part A as an inpatient supply.

3101.5 Other Diagnostic or Therapeutic Items or Services.--Other diagnostic or therapeutic items or services ordinarily furnished inpatients by the hospital or by others under arrangements made by the hospital are covered. This category of covered services encompasses items and services not otherwise specifically listed as covered inpatient hospital services. (See § 3101.8 for coverage of physical therapy services, § 3101.9 for occupational therapy, and § 3101.10 for respiratory therapy.)

Such services to hospital inpatients may be covered under Part A even when furnished off the hospital premises. For example, diagnostic or therapeutic services of an audiologist off the hospital premises are covered if billed for by the hospital under arrangements (see § 3007), if the services are furnished at a speech and hearing center, and if the audiologist meets the qualifications for an audiologist contained in the "Conditions of Participation for Skilled Nursing Facilities."

A. Therapeutic Items.--Therapeutic items which are covered when ordinarily furnished by the hospital to its inpatients, or when ordinarily furnished to hospital inpatients by others under arrangements with them made by the hospital, include but are not limited to the following:

1. Surgical dressings, and splints, casts, and other devices used for the reduction of fractures and dislocations;

2. Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ; and

3. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.

With respect to items that leave the hospital with the patient when he is discharged, such as splints or casts, the rules for determining whether the item is covered are the same as the rules set forth above for supplies, appliances, and equipment.

B. Diagnostic Services of Psychologists and Physical Therapists.--When a psychologist or physical therapist is a salaried member of the staff of a hospital, his diagnostic or therapeutic services to inpatients of that hospital are covered on a reasonable cost basis in the same manner as the services of other nonphysician hospital employees. The services of a psychologist or physical therapist who is not a salaried staff member are covered if furnished by the hospital as part of the services it ordinarily furnishes under arrangements which provide for billing to be handled by the hospital.

C. Diagnostic services furnished to an inpatient by an independent clinical laboratory under arrangements with the hospital are reimbursable under hospital insurance.

An independent laboratory is one which is independent both of an attending or consulting physician's office and of a hospital which meets at least the requirements to qualify as an emergency hospital, e.g., meets the requirements of § 3010A, E, and G. (A consulting physician is one whose services include history taking, examination of the patient and, in each case, furnishing to the attending physician an opinion regarding diagnosis or treatment. A physician providing clinical laboratory services for patients of other physicians is not considered to be a consulting physician.)

A laboratory which is operated by or under the supervision of a hospital (or the organized medical staff of the hospital) which does not meet at least the definition of an emergency hospital is considered to be an independent laboratory. However, a laboratory serving hospital patients and operated on the premises of a hospital which meets the definition of an emergency hospital is presumed to be subject to the supervision of the hospital or its organized medical staff and is not an independent laboratory. A laboratory which a physician or group of physicians maintains for performing diagnostic tests in connection with his own or the group practice is also not considered to be an independent laboratory.

An out-of-hospital laboratory is ordinarily presumed to be independent unless there is written evidence establishing that it is operated by or under the supervision of a hospital which meets at least the definition of an emergency hospital or of the organized medical staff of such a hospital.

Where a laboratory operated on hospital premises is claimed to be independent or where an out-of-hospital facility is designated as a hospital laboratory, the health insurance regional office makes the determination concerning the laboratory's status.

A clinical laboratory is a laboratory where microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, or pathological examinations are performed on materials derived from the human body, to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

The "Conditions of Participation for Hospitals (HIRM-1)" call for independent clinical laboratory services furnished under arrangements made by a hospital to be furnished only by a laboratory meeting the specified conditions for coverage under the program. These require that: "(1) where State or applicable local law provides for licensing of independent clinical laboratories, the laboratory is either licensed under such law or is approved as meeting the requirements for licensing by the State or local agency responsible for licensing laboratories; and (2) such laboratories also meet the health and safety requirements prescribed by the Secretary of Health and Human Services. (See "Conditions for Coverage of Services of Independent Laboratories (HIRM-1)."

Where independent laboratory services are provided patients of a participating hospital under arrangements with the hospital, the law does not require as a condition of payment in an individual case that the independent laboratory be approved under the program. In processing individual claims, the intermediary, therefore, need not verify that the services were obtained from an approved laboratory. The intermediary should make payment for laboratory services although it may know that the laboratory from which the hospital has obtained the service is not approved under the program. However, it should promptly refer this information to the appropriate Health Care Financing Administration regional office for review of the determination of the hospital's compliance with the conditions of participation and for whatever action the regional office deems appropriate.

D. Diagnostic services furnished a hospital inpatient under arrangements with the laboratory of another participating hospital are reimbursable on a cost basis under Part A to the hospital obtaining the services.

NOTE: Where a hospital obtains diagnostic laboratory services for inpatients under arrangements described in § 3101.5C or § 3101.5D, the cost to the hospital obtaining the services would be the reasonable charge for the laboratory's service.

best copy available

3101.6 Services of Interns or Residents-In-Training.--Hospital insurance covers the reasonable cost of the services of medical interns or residents-in-training under a teaching program approved by the appropriate approving body or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association.

In the case of services of interns or residents-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

Effective for accounting periods beginning after December 31, 1972, the services of interns and residents-in-training in the field of podiatry under a teaching program approved by the Council of Podiatry Education of the American Podiatry Association are covered under Part A on the same basis as the services of other interns and residents-in-training in approved teaching programs. For accounting periods beginning on or prior to December 31, 1972, coverage of these services is under Part B, on a reasonable cost basis. See §3115 for other coverage of services of hospital interns and residents under medical insurance.

3101.7 Inpatient Services in Connection with Dental Services.--When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished during the stay are covered under Part A. For example, both the professional services of the dentist and the inpatient hospital expenses are covered when the dentist reduces a jaw fracture of an individual who is an inpatient of a participating hospital. In addition, hospital inpatient services which are necessary because of or the patient's underlying medical condition and clinical status or the severity of a noncovered dental procedure are covered. The dental procedure itself is excluded from coverage if it is a service described in §3162. See also §§3030.2, 3316.1, and Coverage Issues Manual §50-26.

When the hospital services are covered, all ancillary services furnished by the hospital, such as x-rays, administration of anesthesia, use of the operating room, etc., are covered. See §3316 for required certifications, and §3316.1 for certification by dentists for admissions for non-covered dental procedures.

Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with non-covered dental services, are not covered. Thus, the services of an anesthesiologist, radiologist, or pathologist whose services are performed in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth are not covered.

3101.8 Physical Therapy Furnished by the Hospital or by Others under Arrangements with the Hospital and under its Supervision.--

A. General.--To be covered physical therapy services the services must relate directly and specifically to an active written treatment regimen established by the physician after any needed consultation with the qualified physical therapist and must be reasonable and necessary to the treatment of the individual's illness or injury.

B. Reasonable and Necessary.--To be considered reasonable and necessary the following conditions must be met:

(a) the services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition,

(b) the services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under his supervision. Services which do not require the performance or supervision of a physical therapist are not considered reasonable or necessary physical therapy services, even if they are performed or supervised by a physical therapist. (When the intermediary determines the services furnished were of a type that could have been safely and effectively performed only by a qualified physical therapist or under his supervision, it should presume that such services were properly supervised. However, this assumption is rebuttable and if in the course of processing claims, the intermediary finds that physical therapy services are not being furnished under proper supervision, the intermediary should deny the claim and bring this matter to the attention of the Division of Survey and Certification of the HCFA regional office.)

(c) there must be an expectation that the condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment made by the physician of the patient's restoration potential after any needed consultation with the qualified physical therapist or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state, and

(d) the amount, frequency, and duration of the services must be reasonable.

NOTE: Claims for physical therapy services denied because they are not considered reasonable and necessary are excluded by section 1862(a)(1) and are thus subject to consideration under the waiver of liability provisions in section 1879 of the act. (See §§ 3430ff.)

1. Restorative Therapy.--To constitute physical therapy a service must, among other things, be reasonable and necessary to the treatment of the individual's illness. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of physical therapy services required to achieve such potential the physical therapy would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. However, if

at any point in the treatment of an illness it is determined that the expectations will not materialize, the services will no longer be considered reasonable and necessary; and they, therefore, should be excluded from coverage under section 1862(a)(1).

2. Maintenance Program.--The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures, and consequently the judgment and skill of a qualified physical therapist are not required for safety and effectiveness. However, in certain instances the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program. For example, a Parkinson patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises will contribute the most to maintain the patient's present functional level.

In such situations the initial evaluation of the patient's needs, the designing by the qualified physical therapist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel, e.g., aides or nursing personnel (or family members where physical therapy is being furnished on an outpatient basis) in carrying out the program and such infrequent reevaluations as may be required would constitute physical therapy.

Where a patient has been under a restorative physical therapy program, the physical therapist should regularly be reevaluating the condition and adjusting any exercise program in which the patient is engaged. Consequently, when it is determined that no further restoration is possible, the physical therapist should have already designed the maintenance program required and instructed the patient, supportive personnel (or family members where physical therapy is being furnished on an outpatient basis) in the carrying out of the program. Therefore, where a maintenance program is not established until after the restorative physical therapy program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under § 1862(a)(1).

C. Application of Guidelines.--The following discussion illustrates the application of the above guidelines to the more common modalities and procedures utilized in the treatment of patients:

1. Hot Pack, Hydrocollator, Infra-Red Treatments, Paraffin baths and Whirlpool Baths.--Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case the skills, knowledge, and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they would be considered part of the physical therapy service.

2. Gait Training.-- Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a qualified physical therapist. However, if gait evaluation and training cannot reasonably be expected to improve significantly the patient's ability to walk, such services would not be considered reasonable and necessary. Repetitious exercises to improve gait or maintain strength and endurance and assistive walking, such as provided in support for feeble or unstable patients are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a qualified physical therapist.

3. Ultrasound, Shortwave, and Microwave Diathermy Treatments.-- These modalities must always be performed by or under the supervision of a qualified physical therapist and therefore such treatments constitute physical therapy.

4. Range of Motion Tests.-- Only the qualified physical therapist may perform range of motion tests and, therefore, such tests would constitute physical therapy.

5. Therapeutic Exercises.-- Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist or by a qualified physical therapist due either to the type of exercise employed or to the condition of the patient would constitute physical therapy. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored) and such exercises, either because of their nature on the condition of the patient, may only be performed safely and effectively by or under the supervision of a qualified physical therapist. Generally, range of motion exercises which are not related to the restoration of a specific loss of function but rather are related to the maintenance of function (see B.2.) do not require the skills of a qualified physical therapist. However, such services may, under some circumstances, be included in the physical therapy cost center. (See Section 3101.8(D).

D. Routine Services.-- Many hospital inpatients who do not require physical therapy services as defined in Section 3101.8A above do require services involving procedures which are routine in nature in the sense that they can be rendered by supportive personnel, e.g., aids or nursing personnel, without the supervision of a qualified physical therapist. Such services as well as services involving activities to promote over-all fitness and flexibility and activities to provide diversion or general motivation can be reimbursed through the physical therapy cost center even though they do not constitute physical therapy for Medicare purposes, if:

1. The services are medically necessary,

2. The treatment furnished is prescribed by a physician,

3. All services are provided by salaried employees of the physical therapy department of the provider,

4. The cost incurred is reasonable in amount (i.e., the employees' salaries are reasonably related to the level of skill and experience required to perform the services in question), and

5. Charges are equally imposed on all patients.

If all of the above conditions are met, routine restorative services can be billed as ancillary physical therapy services and their costs included in the physical therapy cost center for reimbursement purposes.

The services furnished beneficiaries must meet the definition of physical therapy where the entitlement to benefits is at issue. Since the outpatient physical therapy benefit under Part B provides coverage only of physical therapy services, payment can be made only for the services which constitute physical therapy.

3101.9 Occupational Therapy Furnished by the Hospital or by Others under Arrangements with the Hospital and under its Supervision.--

A. General.--Occupational therapy is medically prescribed treatment concerned with improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Such therapy may involve:

1. The evaluation, and reevaluation as required, of a patient's level of function by administering diagnostic and prognostic tests;

2. The selection and teaching of task-oriented therapeutic activities designed to restore physical function,, e.g., use of woodworking activities on an inclined table to restore shoulder, elbow and wrist range of motion lost as a result of burns;

3. The planning, implementing, and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness, e.g., the use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient;

4. The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function, e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke patient with functional loss resulting in a distorted body image;

5. The teaching of compensatory technique to improve the level of independence in the activities of daily living, for example:

- Teaching a patient who has lost the use of an arm how to pare potatoes and chop vegetables with one hand;
- Teaching an upper extremity amputee how to functionally utilize a prosthesis;
- Teaching a stroke patient new techniques to enable him to perform feeding, dressing and other activities as independently as possible; and
- Teaching a hip fracture/hip replacement patient techniques of standing tolerance and balance to enable him or her to perform such functional activities as dressing and homemaking tasks.

6. The designing, fabricating, and fitting of orthotic and self- help devices, e.g., making a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position or constructing a device which would enable an individual to hold a utensil and feed himself independently; and

7. Vocational and prevocational assessment and training.

Only a qualified occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, reevaluate a patient's level of function, determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function and, where appropriate, recommend to the physician a plan of treatment. However, while the skills of a qualified occupational therapist are required to evaluate the patient's level of function and develop a plan of treatment, the implementation of the plan may also be carried out by a qualified occupational therapy assistant functioning under the general supervision of the qualified occupational therapist. ("General supervision" requires initial direction and periodic inspection of the actual activity; however, the supervisor need not always be physically present or on the premises when the assistant is performing services).

B. Coverage Criteria.--To constitute covered occupational therapy for Medicare purposes the services furnished to a beneficiary must be (1) prescribed by a physician, (2) performed by a qualified occupational therapist or a qualified occupational therapy assistant under the general supervision of a qualified occupational therapist, and (3) reasonable and necessary for the treatment of the individual's illness or injury.

Occupational therapy designed to improve function is considered reasonable and necessary for the treatment of the individual's illness or injury only where an expectation exists that the therapy will result in a significant practical improvement in the individual's level of functioning within a reasonable period of time. Where an individual's improvement potential is insignificant in relation to the extent and duration of occupational therapy services required to achieve improvement, such services would not be considered reasonable and necessary and would thus be excluded from coverage by 1862(a)(1). Where a valid expectation of improvement exists at the time the occupational therapy program is instituted, the services would be covered even though the expectation may not be realized. However, in such situations the services would be covered only up to the time at which it would have been reasonable to conclude that the patient is not going to improve. Once a patient has reached the point where no further significant practical improvement can be expected, the skills of an occupational therapist or occupational therapy assistant will not be required in the carrying out of any activity and/or exercise program required to maintain function at the level to which it has been restored. Consequently, while the services of an occupational therapist in designing a maintenance program and making infrequent but periodic evaluation of its effectiveness would be covered, the services of an occupational therapist or occupational therapy assistant in carrying out the program are not considered reasonable and necessary for the treatment of illness or injury and such services are excluded from coverage under section 1862(a)(1).

Generally speaking, occupational therapy is not required to effect improvement or restoration of function where a patient suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bedrest following major abdominal surgery) which could reasonably be expected to spontaneously improve as the patient gradually resumes normal activities. Accordingly, occupational therapy furnished in such situations would not be considered reasonable and necessary for the treatment of the individual's illness or injury and the services would be excluded from coverage by 1862(a)(1).

Occupational therapy may also be required for a patient with a specific diagnosed psychiatric illness. Where such services are required they would be covered, assuming the coverage criteria set forth above are met. However, it should be noted that where an individual's motivational needs are not related to a specific diagnosed psychiatric illness, the meeting of such needs does not usually require an individualized therapeutic program. Rather, such needs can be met through general activity programs or the efforts of other professional personnel involved in the care of the patient, patient motivation being an appropriate and inherent function of all health disciplines which is interwoven with other functions performed by such personnel for the patient. Accordingly, since the special skills of an occupational therapist or occupational therapy assistant are not required, an occupational therapy program for such individuals would not be considered reasonable and necessary for the treatment of an illness or injury, and services furnished under such a program would be excluded from coverage by 1862(a)(1). See D for discussion regarding coverage of patient activity programs.

As indicated, occupational therapy includes vocational and prevocational assessment and training. When services provided by an occupational therapist and/or assistant are related solely to specific employment opportunities, work skills or work settings, they are not reasonable or necessary for the diagnosis or treatment of an illness or injury and are excluded from coverage under the program by 1862(a)(1). However, care should be exercised in applying this exclusion, because the assessment of level of function and the teaching of compensatory techniques to improve the level of function, especially in activities of daily living, are services which occupational therapists provide for both vocational and nonvocational purposes. For example, an assessment of sitting and standing tolerance might be nonvocational for a mother of young children or a retired individual living alone, but would be a vocational test for a sales clerk. Training an amputee in the use of a prosthesis for telephoning is necessary for every-day activities as well as for employment purposes. Major changes in life style may be mandatory for an individual with a substantial disability; the techniques of adjustment cannot be considered exclusively vocational or nonvocational.

C. Supplies.—Occupational therapy frequently necessitates the use of various supplies, e.g., looms, ceramic tiles, leather, etc. The cost of such supplies may be included in the occupational therapy cost center. However, to prevent possible abuse in this area these costs should be carefully reviewed by the intermediary to ensure that they are reasonable.

D. Patient Activity Programs.--In the inpatient setting, organized patient activity programs are utilized to provide diversion and general motivation to inpatients. Although occupational therapists and occupational therapy assistants may be involved in directing and supervising such programs, these activity programs are part of a generalized effort directed to the health and welfare of all patients and such programs do not constitute occupational therapy and no ancillary charges may be recognized for such services. However, since these programs do constitute an integral part of good inpatient care they would be considered covered services related to the routine care of patients, providing: (1) the program is one ordinarily furnished by the provider to its inpatients, and (2) it is of a type in which Medicare patients requiring a covered level of inpatient care may reasonably be expected to participate. For example, patients requiring the level of inpatient care covered under the program might engage in games such as checkers or chess, handicrafts such as sewing or weaving, and they might attend movies, etc. But, it would not be expected that such patients would be able to go on field trips, engage in strenuous athletics, or participate in other activities which are inappropriate for patients requiring the level of care covered under the program. (The capacities of physically healthy psychiatric patients would vary from those of patients whose ailments are physical.)

3101.10 Respiratory Therapy Furnished by the Hospital or by Others Under Arrangements with the Hospital and Under its Supervision.--

A. This section contains criteria for reviewing bills submitted by hospitals for reimbursement for respiratory therapy under Medicare.

B. Definition.--Respiratory therapy (respiratory care) is defined as those services that are prescribed by a physician for the assessment, diagnostic evaluation, treatment, management, and monitoring (as defined in §3101.10E.6.) of patients with deficiencies and abnormalities of cardiopulmonary function.

Respiratory therapy services include but are not limited to:

1. The application of techniques for support of oxygenation and ventilation in the acutely ill patient. These techniques include, but are not limited to: a) establishment and maintenance of artificial airways; b) ventilator therapy and other means of airway pressure manipulation; c) precise delivery of oxygen concentration; and d) techniques to aid removal of secretions from the pulmonary tree.

2. The therapeutic use and monitoring of medical gases (especially oxygen), bland and pharmacologically active mists and aerosols and such equipment as resuscitators and ventilators;

3. Bronchial hygiene therapy, including deep breathing and coughing exercises, IPPB, postural drainage, chest percussion and vibration, and nasotracheal suctioning;

4. Diagnostic tests for evaluation by a physician, e.g., pulmonary function tests, spirometry, and blood gas analyses;

5. Pulmonary rehabilitation techniques which include: a) exercise conditioning; b) breathing retraining; and c) patient education regarding the management of the patient's respiratory problems; and

6. Periodic assessment and monitoring of the acute and chronically ill patients for indications for, and the effectiveness of, respiratory therapy services.

Such services are performed by respiratory therapists or technicians, physical therapists, nurses and other qualified personnel. If such services are reasonable and necessary, they are covered irrespective of where they are furnished in the hospital; e.g., emergency room, ICU, etc.

To qualify for reimbursement under Medicare, such therapy (1) must qualify as a covered service, and (2) must be reasonable and necessary for the diagnosis or treatment of an illness or injury.

C. Qualification as a Covered Service.-- Respiratory therapy can be covered under Medicare in the following circumstances.

1. Hospital - When furnished by a respiratory therapist or technician, the services are covered as ancillary services under the inpatient hospital benefit. When furnished by a nurse, the services would constitute nursing services and would be covered as such under the inpatient hospital benefit.

2. Skilled nursing facility - Services furnished in the skilled nursing facility setting would be covered under the posthospital extended care benefit if furnished to the inpatients of a skilled nursing facility by a "transfer hospital" (see § 3133.8.), or if furnished by a nurse on the staff of the SNF.

3. Diagnostic testing - Although the diagnostic testing referred to in § 3101.10B.4 is considered respiratory therapy, coverage of such tests is governed by the guidelines relating to the coverage of diagnostic tests. (See §§ 3101.5, 3110A, 3133.8 and 3640.2A.1.)

D. Criteria for Reviewing Bills to Determine if Respiratory Therapy is Reasonable and Necessary.--In reviewing bills to determine if respiratory services are reasonable and necessary, intermediaries will need to assure themselves that the respiratory therapy services furnished to a beneficiary are (1) consistent with the nature and severity of the individual's complaints and diagnosis, (2) reasonable in terms of modality, amount, frequency and duration of the treatments, and (3) generally accepted by the professional medical community as being safe and effective treatment for the purpose used. More specific instructions for applying these criteria in the bill review process appear in (1) through (3) below.

1. Consistent with the Nature and Severity of the Individual's Symptoms and Diagnosis.-- A patient's primary or secondary diagnosis alone may justify the need for respiratory therapy (e.g., acute respiratory failure, pneumonitis, retained secretions, atelectasis, chronic obstructive pulmonary disease). However, there may be cases in which the primary or secondary diagnosis alone does not justify the need for respiratory therapy, but the medical evidence indicates a combination of diagnoses which may justify therapy. In such cases, the intermediary will obtain documentation from the provider which explains the medical necessity for the therapy.

2. Reasonable in Terms of Modality, Amount, Frequency and Duration of the Treatment.-- Although respiratory therapy services may be reasonable and necessary based on the nature and severity of the patient's condition, they must also be reasonable and necessary with respect to modality, amount, frequency, and duration. For example, while a patient may require a particular type of modality to accomplish a certain therapeutic objective, the reasonableness and medical necessity may be questionable where more than one type of modality is used at the same time to accomplish the same therapeutic objective; e.g., IPPB and incentive spirometry.

In most circumstances, the need for therapy would decrease with improvement of the condition, or increase if the condition worsened. Therefore, in most instances, respiratory therapy would not be considered reasonable and necessary when furnished in the same amount and/or frequency throughout the patient's hospital stay; i.e., it would be expected that the level and intensity of the care should be modified as discharge nears. Where the amount and frequency of respiratory therapy furnished throughout the hospital stay remains constant and the primary or secondary diagnosis indicates that, under normal circumstances, a decline in amount and frequency could be anticipated, intermediaries will obtain an explanation from the provider.

3. Generally Accepted by the Professional Community as Being Safe and Effective Treatment for the Purpose Used.-- In the absence of evidence to the contrary, it may be presumed that respiratory therapy is an accepted treatment and may be covered under Medicare.

E. Additional Guidelines for Applying Criteria.--While there are many conditions for which respiratory therapy may be indicated, for Medicare purposes coverage of respiratory therapy services cannot be recognized when performed on a mass basis with no distinction made as to the individual patient's actual condition and need for such services. In addition, the intermediary should make a distinction between respiratory therapy services and routine nursing services.

The following discussion illustrates some examples of the application of the above guidelines.

1. Intensive Care and Recovery Room Patients.—Intensive care and recovery room patients may require respiratory monitoring, support, and therapy. Such respiratory care services (including equipment and maintenance thereof) qualify for reimbursement when reasonable and necessary. Frequency, intensity, and duration of such monitoring and maintenance services will vary with the patient's illness, age, and underlying state of health.

2. Preoperative Bronchial Hygiene Therapy.--Bronchial hygiene therapy furnished on a routine basis to preoperative patients would be presumed not to be reasonable and necessary and would, therefore, be excluded from coverage under section 1862(a)(1). Circumstances under which preoperative bronchial hygiene therapy may be reasonable and necessary would include those situations when it is furnished to patients with acute or chronic pulmonary disease which by itself requires such therapy (see §3101.10D.1). In the absence of a presumptive condition, preoperative respiratory therapy could still be reasonable and necessary if the prescribing physician adequately documents the medical necessity for it (for example, heavy smokers with chronic cough and sputum production). In such cases, the medical necesssity for such therapy will be established if the documentation submitted adequately supports such therapy. A statement that respiratory therapy "is needed" or "is necessary based on diagnosis" would be unacceptable.

3. Postoperative Bronchial Hygiene Therapy.--Routine procedures such as deep breathing and cough instruction, frequent repositioning and early ambulation should provide for adequate bronchial hygiene in the majority of postoperative patients. Therefore, bronchial hygiene therapy services, in addition to those cited above, when

furnished on a routine basis to most postoperative patients would be presumed not to be necessary and would be excluded from coverage under section 1862(a)(1).

Respiratory therapy services aiding bronchial hygiene (e.g., IPPB, aerosol therapy, postural drainage, chest percussion and vibration, nasotracheal suctioning) may be reasonable and necessary in the postoperative patient with identifiable pulmonary complications or in patients with underlying pulmonary diseases. In addition, such therapy may be required for several postoperative days for those patients. (In such cases, the intermediary should request documentation which establishes the medical necessity for the therapy.) It would be reasonable to expect changes in modalities and decreases in frequency of therapy should pulmonary complications not be medically evident after several days of therapy postoperatively (see 3101.10D.2). Since the need for postoperative bronchial hygiene therapy cannot be identified presumptively, all such therapy must be adequately documented by the physician.

4. Setting Up Equipment and Instructing Patients in Its Use.-- When appropriate, setting up of respiratory equipment, instructing and monitoring patient progress in the use of equipment or on postural drainage, and breathing exercises by a respiratory therapist or technician are considered reasonable and necessary services even though the direct patient supervision of such therapy may be the responsibility of the nursing service.

5. Oxygen Therapy.—Oxygen therapy is administered utilizing many devices ranging from the simple nasal cannula to progressively complex techniques providing controlled oxygen concentrations. Such devices are usually applied, maintained, and monitored by respiratory therapists and technicians. These services will be covered provided the need and the effectiveness is documented.

The goal of oxygen therapy is to maintain adequate tissue and cell oxygenation while trying to minimize the danger of oxygen toxicity. Periodic measurement of the arterial PO_2 or oxygen saturation at rest and/or during exercise aids in determining the appropriate amount of oxygen to be administered, and is necessary until the patient has achieved a stable status.

If the intermediary notes the use of continuous oxygen without periodic assessment of arterial PO_2 or oxygen saturation, it should request additional documentation to determine the medical necessity for the service. The physician's order must state the oxygen device and/or the specific flow rate or concentration of oxygen desired. A prescription for "oxygen PRN" or "oxygen as needed" does not meet these requirements. An intermittent or PRN oxygen therapy order must include time limits and specific indications for initiating and terminating therapy.

6. Monitoring Services.—The term monitoring as used in the context of this instruction means: periodic checking of the equipment in actual use for the purpose of ascertaining that it is functioning properly (see 5. above); monitoring the individual patient's condition for purposes of assuring that the patient is receiving the proper mixtures of medical gases, mists and aerosols (see §3101.10B.2.); periodic checking of the acute and chronically ill patients for the purposes described in §3101.10B.6.; and checking the patient's progress for the purposes described in §3101.10E.4. Checking solely to determine if a patient is using oxygen and the amount of oxygen used is not considered the type of monitoring that requires specialized training or skills, and therefore is not a covered respiratory therapy service.

F. Patient Education Programs.—Instructing a patient in the use of equipment, breathing exercises, etc., may be considered reasonable and necessary to the treatment of the patient's condition and can usually be given a patient during the course of treatment by any of the health personnel involved therein, e.g., physician, nurse, respiratory therapist or technician. While patient activities involved in the management of respiratory problems are not ordinarily of such complexity as to warrant a structured or formal patient education program, there may be instances where such a program may be appropriate; e.g., where the patient will experience significant behavior modification or rely on mechanical support after discharge from the hospital. However, the content of structured or formal education programs must be reasonable and necessary, that is, such programs should meet but not exceed the needs of patients. For Medicare purposes, the provision of information that is over and beyond that ordinarily provided during the course of a treatment (e.g., extensive theoretical background in the pathology, etiology, and psysiological effects of the disease) is not considered reasonable and necessary to the management and treatment of illnesses.

NOTE: PSRO determinations as to medical necessity and level of care are a component of Medicare claims determinations. The PSRO's determinations are binding on those issues and must be incorporated into claims adjudication. The intermediary will continue to review claims for other determinations and initiate denials on the basis of lack of eligibility, lack of remaining benefit days, provision of items and services which are not covered under Medicare, and any of the other exclusions under title XVIII.

The intermediary must deny payment if it identifies a service for which payment is always precluded by a Medicare coverage rule and in which no medical judgment need be exercised even if the service was rendered during a PSRO-approved hospital stay or specifically approved by the PSRO. The intermediary may not deny payment for PSRO-approved services on the ground that services were not medically necessary or did not meet the applicable level of care requirements. If a judgmental medical determination is necessary to apply a coverage rule, the intermediary must ask the PSRO to make the medical determination and accept the PSRO's determinations as binding when it adjudicates the claim.

Because PSROs may differ in both the method and degree to which they assume responsibility for the review of ancillary services, intermediaries should incorporate in their approved Memorandum of Understanding with each PSRO the specific responsibilities assumed by each party in review of such services.

3101.10A. Speech Pathology Services Furnished by the Hospital or by Others Under Arrangements with the Hospital and Under Its Supervision.—

1. General.—Speech pathology services are those services necessary for the diagnosis and treatment of speech and language disorders which result in communication disabilities. They must relate directly and specifically to a written treatment regimen established by the physician after any needed consultation with the qualified speech pathologist.

2. Reasonable and Necessary.—Speech pathology services must be reasonable and necessary to the treatment of the individual's illness or injury. To be considered reasonable and necessary, the following conditions must be met:

a. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition;

b. The services must be of such a level of complexity and sophistication, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech pathologist. (See 42 CFR 405.1202(u)(1)(2).) (When the intermediary determines the services furnished were of a type that could have been safely and effectively performed only by qualified speech pathologists or under the supervision of a qualified speech pathologist, it should presume that such services were properly supervised. However, this assumption is rebuttable and, if in the course of processing claims the intermediary finds that speech pathology services are not being furnished under proper supervision, the intermediary should deny the claim and bring this matter to the attention of the Division of Health Standards and Quality of the HCFA Regional Office.)

c. There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time based on the assessment by the physician of the patient's restoration potential after any needed consultation with the qualified speech pathologist, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific disease state; and

d. The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. (The intermediary should consult with local speech pathologists or the State chapter of the American Speech-Language-Hearing Association in the development of any utilization guidelines.)

Claims for speech pathology services which are not reasonable and necessary should be considered denied under authority of section 1862(a)(1) and, therefore, are subject to the waiver of liability provisions in section 1879 of the act. (See §§ 3430ff.)

3. Application of Guidelines.—The following discussion illustrates the application of the above guidelines to the more common situations in which the reasonableness and necessity of speech services furnished is a significant issue.

a. Restorative Therapy.—If an individual's expected restoration potential would be insignificant in relation to the extent and duration of speech pathology services required to achieve such potential, the services would not be considered reasonable and necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. If at any point in the treatment of an illness or injury it is determined that the expectations will not materialize, the services will no longer constitute covered speech pathology services, as they would no longer be reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1).

b. Maintenance Program.—After the initial evaluation of the extent of the disorder or illness, if the restoration potential is judged insignificant or, after a reasonable period of trial, the patient's response to treatment is judged insignificant or at a plateau, an appropriate functional maintenance program may be established. The specialized knowledge and judgment of a qualified speech pathologist may be required if the treatment aim of the physician is to be achieved; e.g., a multiple sclerosis patient may require the services of a speech pathologist to establish a maintenance program designed to fit the patient's level of function. In such a situation, the initial evaluation of the patient's needs, the designing by the qualified speech pathologist of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient and supportive personnel (e.g., aides or nursing personnel, or family members where speech pathology is being furnished on an outpatient basis) in carrying out the program, and such infrequent reevaluations as may be required, would constitute covered speech therapy. After the maintenance program has been established and instructions have been given for carrying out the program, the services of the speech pathologist would no longer be covered, as they would no longer be considered reasonable and necessary for the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1).

If a patient has been under a restorative speech pathology program, the speech pathologist should regularly reevaluate the condition and adjust the treatment program. Consequently, during the course of treatment the speech pathologist should determine when the patient's restorative potential will be achieved and, by the time the restorative program has been completed, should have designed the maintenance program required and instructed the patient, supportive personnel, or family members in the carrying out of the program. A separate charge for the establishment of the maintenance program under these circumstances would not be recognized. Moreover, where a maintenance program is not established until after the restorative speech pathology program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage under section 1862(a)(1) since the maintenance program should have been established during the active course of treatment.

4. Types of Services.—Speech pathology services can be grouped into two main categories: services concerned with diagnosis or evaluation and therapeutic services.

a. Diagnostic and Evaluation Services.--Unless excluded by section 1862(a)(7) of the law, these services are covered if they are reasonable and necessary. The speech pathologist employs a variety of formal and informal language assessment tests to ascertain the type, causal factor(s), and severity of the speech and language disorders. Reevaluation would be covered only if the patient exhibited a change in functional speech or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated speech pathology. However, monthly reevaluations, e.g., a Porch Index of Communicative Ability (PICA) for a patient undergoing a restorative speech pathology program, are to be considered a part of the treatment session and could not be covered as a separate evaluation for billing purposes.

b. Therapeutic Services.—The following are examples of common medical disorders and resulting communication deficits which may necessitate active restorative therapy:

(i) Cerebrovascular disease such as cerebral vascular accidents presenting with dysphagia, aphasia/dysphasia, apraxia, and dysarthria;

(ii) Neurological disease such as Parkinsonism or Multiple Sclerosis may exhibit dysarthria, dysphagia, or inadequate respiratory volume/control;

(iii) Mental retardation with disorders such as aphasia or dysarthria; and

(iv) Laryngeal carcinoma requiring laryngectomy resulting in aphonia may warrant therapy of the laryngectomized patient so he can develop new communication skills through esophageal speech and/or use of the electrolarynx.

NOTE: Many patients who do not require speech pathology services as defined above do require services involving nondiagnostic, non-therapeutic, routine, repetitive, and reinforced procedures or services for their general good and welfare; e.g., the practicing of word drills. Such services do not constitute speech pathology services for Medicare purposes and would not be covered since they do not require performance by or the supervision of a qualified speech pathologist.

Inpatient Hospital Stays for Rehabilitation Care

3101.11 Inpatient Hospital Stays for Rehabilitation Care.--

A. General.-- Physicians generally agree on the circumstances that justify a medical or surgical patient's hospitalization. And, in some cases an admission to a rehabilitation hospital or to the rehabilitation service of a short-term hospital can be justified on essentially the same medical or surgical grounds. In other cases, however, a patient's medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization may nevertheless be necessary because of the patient's need for rehabilitative services.

A hospital level of care is required by a patient needing rehabilitative services if that patient needs a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his ability to function. There are two basic requirements which must be met for inpatient hospital stays for rehabilitation care to be covered:

1. The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and

2. It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as an SNF, or on an outpatient basis.

B. Preadmission Screening.—Before a patient is admitted to a rehabilitation hospital for treatment, a preadmission screening is normally done. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment.

While preadmission screening is a standard practice in most rehabilitation hospitals and may provide useful information for claims review purposes, the absence of a preadmission screening in a particular case should not be the sole reason for denying a claim. However, in a case where an inpatient assessment showed that a patient clearly was not a good candidate for an inpatient hospital program, then the presence or absence of preadmission screening information would be important in determining whether the inpatient assessment itself was reasonable and necessary. If preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program, a period of inpatient assessment could be covered, up to the point where it was determined that inpatient hospital rehabilitation was not appropriate, since preadmission screening cannot be expected to eliminate all unsuitable candidates.

C. Inpatient Assessment of Individual's Status and Potential for Rehabilitation.—

1. General.—Coverage is available for inpatient assessment of a patient's potential for benefiting from an intensive coordinated rehabilitation program only if it was reasonable and necessary to perform the assessment in the hospital. This determination should be made on the basis of information available in the patient's

medical record. It is important to note that the assessment process is not merely a paperwork review, but rather an onsite professional review of the patient's condition by the necessary disciplines. Inpatient assessments conducted by a rehabilitation team through examination of the patient usually require between 3 to 10 calendar days, but on occasion may require more. This 3-10 day period is often one where the patient is receiving therapies rather than simple screening assessments. Where more than 10 days are required, the case should be carefully reviewed to ensure that such additional time was necessary. An inpatient assessment may be covered even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program, if the patient's condition on admission was such that an extensive inpatient assessment was considered reasonable and necessary for a final decision to be made on a patient's actual rehabilitation potential. Where the initial assessment has resulted in a conclusion that the individual is a poor candidate for rehabilitation care, coverage for further inpatient hospital care is limited to a reasonable number of days needed to permit appropriate placement of the patient.

The fact that an individual received therapy prior to admission to a hospital for a rehabilitation program would not necessarily mean that the initial assessment period was not reasonable and necessary. However, if during a previous hospital stay an individual completed such a program for essentially the same condition for which inpatient hospital care is now being provided, the assessment period could be covered only if: (1) some intervening circumstance rendered such an assessment reasonable and necessary; or (2) the subsequent admission is to an institution utilizing techniques or technology not previously available or not available in the first institution.

2. Specific examples.—

a. After an inpatient hospital stay for rehabilitation care which resulted in little improvement in the patient's condition, an individual who undergoes surgery for severe contractures as a result of arthritis may require a reassessment of his rehabilitation potential in light of the surgery.

b. The fact that an individual has some degree of mental impairment would not per se be a basis for concluding that a multidisciplinary team evaluation is not warranted. Many individuals who have had CVAs suffer both mental and physical impairments. The mental impairment often results in a limited attention span and reduced comprehension with a resultant problem in communication. With an intensive rehabilitation program, it is sometimes possible to correct or significantly alleviate both the mental and physical problems.

c. Absent other complicating medical problems, the type of rehabiliitation program normally required by a patient with a fractured hip during or after the nonweightbearing period or a patient with a healed ankle fracture would not require an inpatient hospital stay for rehabilitation care. Accordingly, an inpatient assessment would not be warranted in such cases. On the other hand, an individual who has had a

CVA which has left the individual significantly dependent in the activities of daily living (even after physical therapy in a different setting) might be a good candidate for a more extensive inpatient assessment if the patient has potential for rehabilitation and his needs are not primarily of a custodial nature.

D. Inpatient Rehabilitation Hospital Care.—Rehabilitative care in a hospital, rather than in an SNF or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is generally found out of a hospital. A patient who has one or more conditions requiring intensive and multidisciplinary rehabilitation care, or who has a medical complication in addition to his primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment, would probably require a hospital level of rehabilitation care. A patient in need of rehabilitation on an inpatient hospital basis requires all of the following:

1. Close medical supervision by a physician with specialized training or experience in rehabilitation.—A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct, and medically necessary physician involvement in the patient's care; i.e., at least every 2 - 3 days during the patient's stay. This degree of physician involvement, which is greater than would normally be rendered to a patient in a SNF, is an indicator of a patient's need for services generally available only in a hospital setting. A SNF patient's care would usually require only the general supervision of a physician, rather than the close supervision which hospital patients need.

2. Twenty-four-hour rehabilitation nursing.—The patient requires the 24-hour availability of a registered nurse with specialized training or experience in rehabilitation. This degree of availability represents a higher level of care than would normally be found in an SNF. While an SNF patient may require nursing care, specialized rehabilitation nursing is generally not as readily available in such a facility.

3. A relatively intense level of rehabilitation services. The general threshold for establishing the need for inpatient hospital rehabilitation services is that the patient must require and receive at least 3 hours a day of physical and/or occupational therapy. (The furnishing of services no less than 5 days a week will satisfy the requirement for "daily" services.) While nearly all patients requiring an inpatient stay for rehabilitation need and receive at least 3 hours a day of physical and/or occupational therapy, there can be limited exceptions because individual patient's needs vary. In a few instances patients who require inpatient hospital rehabilitation services may need, for a brief period, other skilled rehabilitative modalities such as speech-language pathology services, or prosthetic-orthotic services on a priority basis and their stage of recovery makes the concurrent receipt of intensive physical therapy or occupational therapy services inappropriate. In such cases, the 3-hour a day requirement can be met by a combination of these other therapeutic services instead of or in addition to physical therapy and/or occupational therapy. In exceptional cases, an inpatient stay for rehabilitation care can also be covered even though the patient has a secondary diagnosis or medical complication that prevents him from participating in a program consisting of 3 hours of therapy a day. Inpatient hospital care in these cases may be the only reasonable means by which even a low intensity rehabilitation program may be carried out. Secure documentation of the existence and extent of complicating conditions affecting the carrying out of a rehabilitation program to ensure that inpatient hospital care for less than intensive rehabilitation care is actually needed.

4. A multidisciplinary team approach to the delivery of the program.—A multidisciplinary team usually includes a physician, rehabilitation nurse, social worker and/or psychologist, and those therapists involved in the patient's care. At a minimum, a team must include a physician, rehabilitation nurse and one therapist.

5. A coordinated program of care.—The patient's records must reflect evidence of a coordinated program, i.e., documentation that periodic team conferences were held with a regularity of at least every 2 weeks to: (1) assess the individual's progress or the problems impeding progress; (2) consider possible resolutions to such problems; and (3) reassess the validity of the rehabilitation goals initially established. A team conference may be formal or informal; however, a review by the various team members of each other's notes would not constitute a team conference. The decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the clinical record.

6. Significant practical improvement.—Hospitalization after the initial assessment is covered only in those cases where the initial assessment results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time. It is not necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that will be of practical value to the patient, measured against his condition at the start of the rehabilitation program. For example, a multiple sclerosis patient's condition may have deteriorated as a result of a secondary illness. To be restored to a level of function before the secondary illness, the patient may require an intensive inpatient hospital rehabilitation program. While such a program would not restore the level of function before multiple sclerosis developed, a return to pre-secondary illness level would be considered to be a "significant practical improvement" in the condition.

7. Realistic goals.—While there may be instances where an intense rehabilitation program may enable a Medicare patient to return to the labor market, vocational rehabilitation is generally not considered a realistic goal for most aged or severely disabled individuals. The most realistic rehabilitation goal for most Medicare beneficiaries is self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution. Thus, the aim of the treatment should be achieving the maximum level of function possible.

E. Length of the Rehabilitation Program.—Coverage should stop when further progress toward the established rehabilitation goal is unlikely or it can be achieved in a less intensive setting. In deciding whether further care can be carried out in a less intensive setting, both the degree of improvement which has occurred and the type of program required to achieve further improvement must be considered. In some cases, an individual may be expected to continue to improve under an outpatient program. There are other situations where further improvement in the individual's ability to function relatively independently in the activities of daily living can be expected only if a multidisciplinary team effort is continued.

While occasional home visits and other trips into the community are factors in determining whether continued stay in the hospital is necessary, such excursions would not alone be a basis for concluding that further hospital care is not required. Planned home visits and trips to the community are frequently used to test the individual's ability to function outside the institutional setting and assist in discharge planning for the individual.

It is also important to consider how close the patient may be to the planned end of his rehabilitation hospital stay when further progress becomes unlikely. If a patient is within a few days of discharge, it would usually not be appropriate to transfer him to a less intensive setting in another facility even though further progress in the hospital setting is unlikely. However, it could be appropriate to utilize a "swing bed" arrangement, if it exists in the same facility, for rendering necessary services to the patient pending discharge.

When discharge or transfer to another facility is appropriate, the cut-off point for coverage should not be the last day on which improvement actually occurred. Rather, coverage should continue through the time it would have been reasonable for the physician, in consultation with the rehabilitation team, to have concluded that further improvement would not occur and to initiate the patient's discharge.

Since discharge planning is an integral part of any rehabilitation program and should begin upon the patient's admittance to the facility, an extended period of time for discharge action would not be reasonable after established goals have been reached, or a determination made that further progress is unlikely, or that care in a less intensive setting would be appropriate.

Pregnancy

3101.12 Health Care Associated with Pregnancy.--Reasonable and necessary services associated with pregnancy are covered and reimbursable under the Medicare program. Because pregnancy is a condition which is sufficiently at variance with the usual state of health, it is appropriate for a pregnant woman to seek medical care. The increased possibility of illness or injury which accompanies this condition is well recognized, and medical supervision is required throughout pregnancy and for a brief period beyond. Skilled medical management is appropriate throughout the events of pregnancy, beginning with diagnosis of the condition, continuing through delivery, and ending after the necessary postnatal care. Similarly, in the event of termination of pregnancy, regardless of whether terminated spontaneously or for therapeutic reasons (i.e., where the life of the mother would be endangered if the fetus were brought to term), the need for skilled medical management and/or medical services is equally as important as in those cases carried to full term. After the infant is delivered items and services furnished to the infant cannot be covered and reimbursed under the program on the basis of the mother's eligibility.

Infertility

3101.13 Treatment for Infertility.--(Effective for services rendered on or after January 15, 1980). Reasonable and necessary services associated with treatment for infertility are covered under Medicare. Like pregnancy (see § 3101.12 above), infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally would be expected to be fertile to seek medical consultation and treatment. Contractors should coordinate with PSROs to see that utilization guidelines are established for this treatment if inappropriate utilization or abuse is suspected.

3101.14 Services Related to and Required as a Result of Services Which are Not Covered Under Medicare.--

A. Medical and hospital services are sometimes required to treat a condition that arises as a result of services which are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" noncovered services (e.g., cosmetic surgery, noncovered organ transplants, noncovered artificial organ implants, etc.), including services related to followup care and complications of noncovered services which require treatment during a hospital stay in which the noncovered service was performed, are not covered services under Medicare. Services "not related to" noncovered services are covered under Medicare. To the extent that you are responsible for making medical coverage decisions in such cases involving inpatient stays, follow the procedures established below.

B. Identify which services are related to noncovered services and which are not. Following are some examples of services "related to" and "not related to" noncovered services while the beneficiary is an inpatient:

1. A beneficiary was hospitalized for a noncovered service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear cut example of "not related to" services and are covered under Medicare.

2. A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a noncovered transplant or implant and actually received the transplant or implant during that hospital stay. When the original admission was entirely unrelated to the diagnosis that led to a recommendation for a noncovered transplant or implant, the services related to the admitting condition would be covered.

3. A beneficiary was admitted to the hospital for covered services related to a condition which ultimately led to identification of a need for transplant and receipt of a transplant during the same hospital stay. If, on the basis of the nature of the services and a comparison of the date they are received with the date on which the beneficiary is identified as a transplant candidate, the services could reasonably be attributed to preparation for the noncovered transplant, the services would be "related to" noncovered services and would also be noncovered.

C. After a beneficiary has been discharged from the hospital stay in which he received noncovered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior noncovered services may be covered when they are reasonable and necessary in all other respects. Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous noncovered procedure. Some examples of services that may be found to be covered under this policy are the reversal of intestinal bypass surgery for obesity, repair of complications from transsexual surgery or from cosmetic surgery, removal of a noncovered bladder stimulator, or treatment of an infection at the surgical site of a noncovered transplant that occurred following discharge from the hospital.

However, any subsequent services that could be expected to have been incorporated into a global fee (i.e., a single charge for a group of services) should be denied. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits should be denied. (See § 3610.12 and Hospital Manual § 415.18 for billing procedures.)

Inpatient Psychiatric Hospital Services

3102. COVERED INPATIENT PSYCHIATRIC HOSPITAL SERVICES

A patient covered under hospital insurance is entitled to have payment made for inpatient hospital services furnished to him while an inpatient of a psychiatric hospital. See § 3105 for the 190-day lifetime limitation on payment for inpatient psychiatric hospital services and §§ 3104-3104.6 for the preentitlement inpatient psychiatric benefit days reduction provision.

3102.1 Active Treatment in Psychiatric Hospitals.--Payment for inpatient psychiatric hospital services is to be made only for "active treatment" which can reasonably be expected to improve the patient's condition. To assure that payment is made only under such circumstances, the law includes certain requirements which must be met before the services furnished in a psychiatric hospital can be covered.

First, the certification that a physician must provide with respect to inpatient psychiatric hospital services is required to include a statement that the services furnished can reasonably be expected to improve the patient's condition (§ 3320). Second, the law provides that payment may be made for these services only if they were being furnished while the patient was receiving either active treatment or admission and related services necessary for diagnostic study.

In the context of inpatient psychiatric hospital services emphasis is placed on the presence of "active treatment" and, therefore, this determination is the crucial one. Simply applying the skilled care definition for general hospitals (§ 3159.1B) is not sufficient for determining whether payment may be made since that definition does not take into account the patient's potential for improvement nor was it designed to permit the more sophisticated judgments required by the concept of active treatment. See § 3605.2 for bill review guidelines in determining active treatment in psychiatric hospitals.

A. Definition of Active Treatment.--The term "active treatment" is defined in a manner designed to reflect and implement the physician certification requirement described above. For services in a psychiatric hospital to be designated as "active treatment," they must be: (a) provided under an individualized treatment or diagnostic plan, (b) reasonably expected to improve the patient's condition or for the purpose of diagnosis, and (c) supervised and evaluated by a physician. Such factors as diagnosis, length of hospitalization, and the degree of functional limitation, while useful as general indicators of the kind of care most likely being furnished in a given situation, are not controlling in deciding whether the care was active treatment. The following is a discussion of each element of the above definition of active treatment:

1. Individualized Treatment or Diagnostic Plan.--The services must be provided in accordance with an individualized program of treatment or diagnosis developed by a physician in conjunction with staff members of appropriate other disciplines on the basis of a thorough evaluation of the patient's restorative needs and potentialities. Thus, an isolated service, e.g., a single session with a psychiatrist, or a routine laboratory test not furnished under a planned program of therapy or diagnosis would not constitute active treatment, even though the service was therapeutic or diagnostic in nature. The plan of treatment must be recorded in the patient's medical record in accordance with section 405.1037(a)(8) of the regulations on Conditions of Participation for Hospitals.

2. Services Expected to Improve the Condition or for Purpose of Diagnosis.--The service must reasonably be expected to improve the patient's condition or must be for the purpose of diagnostic study. It is not necessary that a course of therapy have as its goal the restoration of the patient to a level which would permit discharge from the institution although the treatment must, at a minimum, be designed both to reduce or control the patient's psychotic or neurotic symptoms which necessitated hospitalization and improve the patient's level of functioning.

The kinds of services which meet the above requirements would include not only psychotherapy, drug therapy, and shock therapy, but also such adjunctive therapies as occupational therapy, recreational therapy, and milieu therapy, provided the adjunctive therapeutic services are expected to result in improvement (as defined above) in the patient's condition. If, however, the only activities prescribed for the patient are primarily diversional in nature, i.e., to provide some social or recreational outlet for the patient, it would not be regarded as treatment to improve the patient's condition. In many large hospitals these adjunctive services are present and part of the life experience of every patient. In a case where milieu therapy (or one of the other adjunctive therapies) is involved, it is particularly important that this therapy be a planned program for the particular patient and not one where life in the hospital is designated as milieu therapy.

In accordance with the above definition of "improvement," the administration of antidepressant or tranquilizing drugs which are expected to significantly alleviate a patient's psychotic or neurotic symptoms would be termed active treatment (assuming that the other elements of the definition are met). However, the administration of a drug or drugs does not of itself necessarily constitute active treatment. Thus, the use of mild tranquilizers or sedatives solely for the purpose of relieving anxiety or insomnia would not constitute active treatment.

3. Services Supervised and Evaluated by a Physician.--Physician participation in the services is an essential ingredient of active treatment. The services of qualified individuals other than physicians, e.g., social workers, occupational therapists, group therapists, attendants, etc., must be prescribed and directed by a physician to meet the specific psychiatric needs of the individual. In short, the physician must serve as a source of information and guidance for all members of the therapeutic team who work directly with the patient in various roles. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed. Such evaluation should be made on the basis of periodic consultations and conferences with therapists, reviews of the patient's medical record, and regularly scheduled patient interviews--at least once a week.

Although in an institutional setting the services of a physician may be readily available, the general pattern is for the physician to visit the patient only periodically, delegating to nursing personnel the responsibility for intensive observation of patients, where it is necessary. Such periodic visits to a patient do not in themselves constitute active treatment. Conversely, when the physician periodically evalutes the therapeutic program to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed based on consultations and conferences with therapists, review of the patient's progress as recorded on his medical record and his periodic conversations with the patient, active treatment would be indicated. The treatment furnished the patient should be documented in the medical record in such a manner and with such frequency as to provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it. (See section 405.1037(a)(9) and (10) of the regulations on Conditions of Participation for Hospitals.)

A finding that a patient is not receiving active treatment will not in itself preclude payment for physicians' services under Part B. As long as the professional services rendered by the physician are reasonable and necessary for the care of the patient, such services would be reimbursable under the medical insurance program.

B. Principles for Evaluating a Period of Active Treatment.--As indicated, the period of time covered by the physician's certification is referred to as a "period of active treatment." This period should include all days on which inpatient psychiatric hospital services were provided because of the individual's need for active treatment--not just the days on which specific therapeutic or diagnostic services were rendered. For example, a patient's program of treatment may necessitate the discontinuance of therapy for a period of time or it may include a period of observation, either in preparation for or as a followup to therapy, while only maintenance or protective services are furnished. If such periods were essential to the overall treatment plan, they would be regarded as part of the period of active treatment.

The fact that a patient is under the supervision of a physician does not necessarily mean that he is getting active treatment. For example, medical supervision of a patient may be necessary to assure the early detection of significant changes in his condition; however, in the absence of a specific program of therapy designed to effect improvement, a finding that the patient is receiving active treatment would be precluded.

The program's definition of active treatment does not automatically exclude from coverage services rendered to patients who have conditions which ordinarily result in progressive physical and/or mental deterioration. Although patients with such diagnoses will most commonly be receiving custodial care, they may also receive services which meet the program's definition of active treatment. This might be the case, for example, where a patient with Alzheimer's or Pick's disease received services designed to alleviate the effects of paralysis, epileptic seizures, or some other neurological symptom, or where a patient in the terminal stages of any disease received life-supportive care. A period of hospitalization during which services of this kind were furnished would be regarded as a period of active treatment. See §§ 3605.2-3605.3 regarding the evaluation of conditions which generally require custodial care only.

3102.2 Nonpsychiatric Care in a Psychiatric Hospital.--Inpatient hospital services are covered where a patient receives medical or surgical care in a psychiatric hospital, but does not satisfy the requirements dealing with active psychiatric treatment (see § 3102.1) if:

A. the medical or surgical service requires a hospital level of care; and

B. hospitalization in a psychiatric institution, rather than a general hospital, is appropriate because of some factor related to the patient's mental condition; and

C. a physician certifies that these conditions are met.

The patient's past history of psychiatric problems or the possibility that he has a current psychiatric condition could furnish a proper base for the exercise of medical judgment in concluding that admission to the psychiatric hospital is "medically necessary."

Duration of Covered Inpatient Hospital Services

3103. INPATIENT HOSPITAL BENEFIT DAYS

A patient having hospital insurance coverage is entitled to have payment made on his behalf for up to 90 days of covered inpatient hospital services in each spell of illness. (For coinsurance provision, see § 3203.) Also, he has a lifetime reserve of 60 additional days (see § 3106).

3103.1 Counting Inpatient Days.--The number of days of care charged to a beneficiary for inpatient hospital services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in counting days of care for Medicare reporting purposes even if the hospital uses a different definition of day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, the day of discharge, death, or a day on which a patient begins a leave of absence is not counted as a day. (Charges for ancillary services on the day of discharge or death or the day on which a patient begins a leave of absence are covered.) If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day. (For billing when a patient is discharged, dies, or is transferred to another participating provider before midnight of the day of admission, see § 3611.)

A patient occupying the labor/delivery room ancillary service area at the census-taking hour is counted in the inpatient census for the maternity routine care area even if she has not entered that area. An inpatient day should not be recorded in the ancillary area. If she is admitted as an inpatient with the expectation of remaining overnight, incurs false labor, and is subsequently released the same day prior to the census-taking hour, a day of inpatient maternity routine care is counted.

Also, where an inpatient is occupying any other ancillary area such as surgery or radiology at the census-taking hour prior to occupying an inpatient bed, the patient's occupancy in the ancillary area should not be recorded as an inpatient day in the ancillary area. However, such patient must be included in the inpatient census of the routine care area. See § 3101 for definition of an inpatient and more information regarding covered inpatient hospital services.

3103.2 Late Discharge.--When a patient chooses to continue to occupy his hospital accommodations beyond the check-out time for personal reasons, the hospital may charge the beneficiary for his continued stay. Such a stay beyond the check-out time, for the comfort or convenience of the patient, is not covered under the program and the hospital's agreement to participate in the program does not preclude the hospital from charging the patient. However, it is expected that hospitals will not impose late charges on a beneficiary unless he has been given reasonable notice (for example, 24 hours) of his impending discharge.

Where the patient's medical condition is the cause of the stay past the check-out time (e.g., the patient needs further services, is bedridden and awaiting transportation to his home or to a skilled nursing facility, or dies in the hospital), the stay beyond the discharge hour is covered under the program and the hospital may not charge the patient. (See § 3620, Item 19, Accommodations.)

The imposition of a late charge by a hospital does not affect the counting of days for: (a) ending a spell of illness; (b) the 3-day prior hospitalization requirement for coverage of extended care services and Part A home health services; and (c) the number of days of inpatient care available to the individual. (See §§ 3035, 3107, 3121.1B, and 3131.1.)

3103.3 Leave of Absence.--The day on which the patient began a leave of absence is treated as a day of discharge and is not counted as an inpatient day unless he returns to the hospital by midnight of the same day. The day the patient returns to the hospital from a leave of absence is treated as a day of admission and is counted as an inpatient day if he is present at midnight of that day.

3103.4 Discharge or Death on First Day of Entitlement or Participation.--
In the following special situations program payment is not made for accommodations on the day of discharge or death, but may be made for ancillary services (under Part A) provided on that day: (a) where a patient is admitted prior to the first day of his entitlement and dies or is discharged from a participating hospital on the first day of his entitlement; and (b) where a patient in a noncovered stay in a nonparticipating hospital dies or is discharged on the first day the hospital becomes a participating hospital. For a late discharge on such a day, the rules in § 3103.2 will be followed. Although in these situations a day of utilization is not counted, a spell of illness begins and any charges for covered services are applied against the inpatient hospital deductible. (See § 3611 for billing in these cases.)

3104. INPATIENT PSYCHIATRIC BENEFIT DAYS REDUCTION

If an individual is in a participating psychiatric hospital on the first day of his entitlement to hospital insurance, the number of inpatient benefit days in the first spell of illness is subject to reduction. The days (not necessarily consecutive) on which he was an inpatient of a psychiatric hospital in the 150-day period immediately before the first day of entitlement, must be subtracted from the 150 days of inpatient hospital services for which he would otherwise be eligible in his first spell of illness. Days spent in a general hospital for diagnosis or treatment of a psychiatric condition prior to entitlement will not reduce the patient's 150 inpatient benefit days in his initial spell of illness.

The reduction applies only to inpatient hospital services received in a psychiatric hospital, or in a general hospital if the individual is an inpatient of the general hospital primarily for the diagnosis or treatment of mental illness. Thus, for example, if a patient in a psychiatric hospital has no benefit days remaining because of the reduction, he may nevertheless be entitled to have payment made for up to 150 days of inpatient hospital services for a non-mental illness during his first spell of illness.

See § 3104.5 for the effect of this provision on the coinsurance provision.

Prior to 1/1/68, the above reduction in benefit days also applied to an individual who was an inpatient of a participating tuberculosis hospital on his first day of entitlement. However, the days that were subtracted are restored to such an individual if he is still in his first spell of illness after December 31, 1967, and as a result he is eligible for up to 150 days of any inpatient hospital services furnished after December 31, 1967.

Prior to 1968, the reduction applied to all inpatient hospital services in the initial spell of illness, whether received in a psychiatric, tuberculosis, or general hospital.

3104.1 Patient Status on Day of Entitlement.--A patient who is in a participating psychiatric hospital on the first day of his entitlement is subject to this reduction. The reduction applies to patients admitted to or discharged from such a hospital on their first day of entitlement, or who begin or end a leave of absence on that day. Where only a distinct part of an institution is participating as a psychiatric hospital, the provision applies only to patients who, on their first day of entitlement, are inpatients of that part.

3104.2 Institution's Status in Determining Days Deducted.--The status of a psychiatric hospital (or a distinct part of such a hospital) as of the individual's first day of entitlement is controlling in determining whether days spent there during the preceding 150 days are to be deducted. Thus, deductions would be made for days spent in a hospital (or distinct part) which was participating as of the individual's first day of entitlement even though it was not participating during all or part of the preceding 150 days. However, where an institution is not participating as of the individual's first day of entitlement, deductions would not be made for days spent in that institution during the preceding 150 days, even though the institution is later certified for participation as a psychiatric hospital.

Where a participating psychiatric hospital is a distinct part of an institution, deductions are made only for days spent in the wards, floors, wings, etc., included in the participating distinct part as of the individual's first day of entitlement, even though it was not participating during all or part of the preceding 150 days. Deductions are not made for days spent in a part of the institution not included in the participating distinct part as of the individual's first day of entitlement, e.g., days spent in a custodial section of the institution or days spent in a general medical-surgical facility participating as a general hospital.

3104.3 Days of Admission, Discharge, and Leave.--In determining the number of days to be deducted, include days of admission and days on which the patient returned from leave of absence. Do not count days of discharge, days on which the patient began a leave of absence, or days of leave during all of which the individual is absent from the hospital.

3104.4 Reduction for Psychiatric Services in General Hospitals.--When an individual subject to a reduction in days is an inpatient in a general hospital after December 31, 1967, the intermediary will apply the reduction only if it has determined that the individual was an inpatient primarily for the diagnosis or treatment of mental illness.

The intermediary will make a tentative decision based on the admitting diagnosis (Item 16, Form SSA-1453). This decision will be subject to change, however, based on reports from the hospital or other information received by the intermediary. Hospitals should notify the intermediary of any subsequent developments that might cause the intermediary to modify the initial decision. Where the patient receives treatment not only for mental illness but also for another condition, the intermediary will determine for which condition the individual was primarily an inpatient.

The intermediary will also examine the discharge diagnosis when the bill is received to see if a change occurred during the period of hospitalization. The reduction will not be applied where the primary discharge diagnosis is not related to mental illness, even though the reduction was tentatively applied based on the admitting diagnosis.

If the intermediary needs more information to make the required determination, it should obtain it from the hospital, the attending physician, or other appropriate source. In some cases, it may be helpful to consult with the intermediary's medical staff. Any case in which a reasonable question persists about whether the individual was an inpatient "primarily for the diagnosis or treatment of mental illness" should be resolved in favor of not applying the reduction.

The term "mental illness," is defined as the specific psychiatric conditions described in the American Psychiatric Association's *Diagnostic and Statistical Manual--Mental Disorders*.

3104.5 *Determining Days Available-Date of Entitlement After 1967*.--Since payment can be made only for the number of days remaining after the reduction is applied, the following steps should be taken to determine the number of days available in the first spell of illness for which payment can be made for inpatient psychiatric hospital services and inpatient services in a general hospital for the treatment of mental illness:

1. determine how many days in the 150-day pre-entitlement period the patient spent in a psychiatric hospital

2. subtract these from 150.

Payment should be made for the remaining days in the following order of priority:

a. the 60 full benefit days,

b. the 30 regular coinsurance days,

c. the 60 lifetime reserve coinsurance days.

Benefit days, including lifetime days, not available to the patient because of the psychiatric reduction nevertheless remain available for use in hospitalization not subject to the reduction: a general hospital stay for a nonpsychiatric condition or a tuberculosis hospital stay. The lifetime days not previously used also remain available for any inpatient stays (including psychiatric hospital stays) in subsequent spells of illness.

EXAMPLE 1: The patient was an inpatient of a participating psychiatric hospital on his first day of entitlement on February 1, 1973. He had been in such a hospital in the pre-entitlement period for 20 days. Therefore, 130 days are payable. Payment would be made in the following order: 60 full benefit days; 30 $18 coinsurance days; 40 $36 coinsurance (lifetime) days.

EXAMPLE 2: The same facts in example 1, except that the patient had been in a psychiatric hospital in the pre-entitlement period for 70 days. Therefore, 80 days are payable. Payment would be made in the following order: 60 full benefit days; 20 $18 coinsurance days.

EXAMPLE 3: The same facts as in example 1, except that the patient had been in a psychiatric hospital in the pre-entitlement period for 110 days. Therefore, 40 days are payable. Payment would be made for these 40 days as full benefit days.

3104.6 Determining Days Available-Date of Entitlement Before 1968-Patient Still In First Spell of Illness.--

A. Preentitlement Stay In Tuberculosis Hospital.--An individual who after December 31, 1967, is still in his first spell of illness and was subject to a reduction in benefit days prior to 1968 because he was in a participating tuberculosis hospital at the time of entitlement will have those days restored for any inpatient hospital services furnished after December 31, 1967. The reduction provision no longer applies to such an individual for services furnished after 1967. Thus, for example, an individual who was an inpatient of a tuberculosis hospital on his date of entitlement and for the 90-day period preceding entitlement, would be eligible on January 1, 1968, for up to 150 days of any inpatient hospital services in his first spell of illness.

B. Preentitlement Stay in Psychiatric Hospital.--A beneficiary who after December 31, 1967, is still in his first spell of illness and was subject to a reduction in benefit days prior to 1968 because he was in a participating psychiatric hospital upon entitlement, may be entitled to additional benefit days beginning January 1, 1968.

1. On January 1, 1968, the individual becomes eligible for 60 lifetime reserve days. Before these days can be used for psychiatric hospital stays or general hospital stays for the treatment of mental illness, an investigation of the 91st to 150th day period preceding entitlement must be made. Any days spent in a psychiatric hospital during this period will have to be subtracted from the 60 lifetime reserve days available for use in the first spell of illness.

Prior to 1968, the number of benefit days available in the patient's first spell of illness was determined on the basis of the 90-day period preceding entitlement. The rules in § 3104.5 do not apply and a new determination will not be made for this period. Payment, if any, for psychiatric hospital stays and general hospital stays for the treatment of mental illness on or after January 1, 1968, will be made for any days still payable under the prior determination and then for any lifetime reserve days available as determined above. (However, a new determination for the 90 day preentitlement period will be required if there is evidence that tuberculosis hospital days were included in the prior determination. See C. below.)

EXAMPLE 1: An individual was in a participating psychiatric hospital when he became entitled to benefits on December 1, 1967, and remained in the hospital following entitlement. Since he had been in the hospital for all of the 90-day preentitlement period, he was not entitled to benefits for the services he received in 1967. On January 1, 1968, he became entitled to 60 lifetime reserve days. An investigation of the 91st to 150th day preceding entitlement disclosed he was in a psychiatric hospital for 30 days in that period. He may use 30 lifetime days for his stay in the psychiatric hospital beginning January 1, 1968.

EXAMPLE 2; Same facts as example 1, except that in the 90-day preentitlement period the individual was in a psychiatric hospital only 30 days. He was, therefore, eligible under prior law for payment of 60 full benefit days. On January 1, 1968, 31 of the 60 full days had been used. On January 1, 1968, he is eligible to have payment made for 29 full benefit days and then 30 lifetime days.

2. Any unused benefit days plus the number of days for which the beneficiary's eligibility was previously reduced plus 60 lifetime reserve days are available for general hospital stays for a nonpsychiatric condition or for tuberculosis hospital stays in the first spell of illness.

C. Preentitlement Stays In Both Psychiatric and Tuberculosis Hospitals.--Days spent in a tuberculosis hospital in the preentitlement period do not count as reduction for services received after 1967 and such days are restored. This is true not only for a beneficiary who was in a tuberculosis hospital when he became entitled but also for a beneficiary who was in a psychiatric hospital at the time of entitlement after having spent some of his preentitlement days in a tuberculosis hospital. However, in the latter situation, a presumption may be made in the absence of evidence to the contrary that all days in the preentitlement period were psychiatric hospital days. (Where there is evidence a new determination for this period is required, see B.1. above.)

3105. INPATIENT PSYCHIATRIC HOSPITAL SERVICES--LIFETIME LIMITATION

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. The limitation applies only to services furnished in a psychiatric hospital. The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though preentitlement days may have been counted against the 150 days of eligibility in the first spell of illness.

3106. LIFETIME RESERVE DAYS.

A. Summary of Provision.-- Each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services to draw upon after he or she has used 90 days of inpatient hospital services in a spell of illness. Payment will be made for such additional days of hospital care after the 90 days of benefits have been exhausted unless the individual elects not to have such payment made (and thus saves the reserve days for a later time).

A coinsurance amount equal to one-half of the inpatient hospital deductible applies to lifetime reserve days. See §§3201 and 3211 for the inpatient hospital deductible amount.

B. Effect of Reserve Days on Guarantee of Payment Provision.-- Under the guarantee of payment provisions (§§3714ff.) a hospital may be paid, under certain conditions, for inpatient services furnished to a beneficiary whose eligibility for inpatient benefit days has been exhausted, including exhaustion of the 190-day lifetime limitation on inpatient psychiatric hospital services. The guarantee of payment provisions are not applicable until the individual has exhausted his or her 60 lifetime reserve days of inpatient hospital services except where the beneficiary is deemed to have elected not to use lifetime reserve days. (See C below and §§3106.2A and 3106.2D(2).)

C. Reserve Days Not Available Where Average Charges Do Not Exceed One-Half Inpatient Hospital Deductible.-- A beneficiary will be deemed to have elected not to use the lifetime reserve days where the average daily charge for covered services furnished during a lifetime reserve days billing period is equal to or less than the coinsurance amount for the lifetime reserve days. Such days are treated as noncovered days rather than potential lifetime reserve days since the beneficiary would be required to pay for all of the hospital charges regardless of his or her election and therefore would not benefit from use of lifetime reserve days. This rule applies to hospitals reimbursed on the basis of reasonable cost and to hospitals in areas with special reimbursement rules (such as Maryland, New Jersey, and Rochester and the Finger Lakes areas of New York). See §§3106.2D(2) for deemed election under PPS.

D. Availability of Reserve Days Where Psychiatric Limitations Are Involved.-- A beneficiary's reserve days are not available to the extent that he or she is subject to the 150-day psychiatric hospital reduction provision, i.e., where the beneficiary has been in a psychiatric hospital during the 150-day period immediately preceding the first day of entitlement to hospital insurance benefits and is still in a psychiatric hospital on the first day of entitlement. (See §3104.) The reserve days are available, however, if such a beneficiary receives nonpsychiatric services in a general hospital or if the beneficiary starts a new spell of illness. The reserve days are also not available to a beneficiary who is in a psychiatric hospital after using 190 days of inpatient psychiatric hospital care during his or her lifetime. (See §3105.)

E. Availability of Reserve Days for Hospital Emergency Services.-- The reserve days are available for emergency services furnished in nonparticipating hospitals.

F. Physician Certification.-- Physician certification requirements are applicable to lifetime reserve days. (See §§3315-3324.)

3106.1 When Payment Will Be Made for Reserve Days.-- When a patient receives services after exhaustion of 90 days of coverage, benefits will be paid for available reserve days on the basis of the patient's request for payment, unless the patient has indicated in writing that he or she elects not to have the program pay for such services.

3106.2 Election Not To Use Lifetime Reserve Days.--

A. General.-- An election not to use lifetime reserve days may be made by the beneficiary (or by someone acting on his or her behalf) at the time of admission to a hospital or at any time thereafter, subject to the limitations on retroactive elections described in paragraph (C) of this section.

Hospitals are required to notify patients who have already used or will use 90 days of benefits in a spell of illness that they can elect not to use their reserve days for all or part of a stay. The hospital notice should be given when the beneficiary has five regular coinsurance days left and is expected to be hospitalized beyond that period. Where the hospital discovers the patient has fewer than five regular coinsurance days left, it should immediately notify the patient of this option. The hospital should annotate its records at the time that it informed the patient of this option. In addition, it should make available an appropriate election statement or form to be included in the patient's hospital record if he or she elects not to use reserve days. (See §3106.4 for sample election format). If a patient elects not to use reserve days, covered Part B services are billed on an HCFA-1450. A Medicare beneficiary who is eligible for medical assistance (Medicaid) under a State plan should be advised that such assistance will not be available if he or she elects not to use the lifetime reserve days. However, this restriction on medical assistance payments does not apply to cases where the beneficiary is deemed to have elected not to use lifetime reserve days.

In the following situations a beneficiary will be deemed to have elected not to use lifetime reserve days:

(1) The average daily charge for covered services furnished during a lifetime reserve billing period is equal to or less than the coinsurance amount for lifetime reserve days and (a) the hospital is reimbursed on a cost reimbursement basis or (b) the hospital is reimbursed under the prospective payment system and lifetime reserve days are needed to pay for all or part of the outlier days. (See §§3106C and 3106.2D(2)(a).)

(2) For the nonoutlier portion of a stay in a hospital reimbursed under the prospective payment system, if the beneficiary has one or more regular (non-lifetime reserve) days remaining in the benefit period upon admission to the hospital. (See §3106.2D(2)(a).)

(3) The beneficiary has no regular days available at the time of admission to a hospital reimbursed under the prospective payment system and the total charges for which the beneficiary would be liable if he does not use lifetime reserve days are equal to or less than the charges for which the beneficiary would be liable if he used lifetime reserve days, i.e., the sum of the coinsurance amounts for the lifetime reserve days that would be used plus the total charges for outlier days, if any, for which no lifetime reserve days would be available because lifetime reserve days are exhausted. (See §3106.2D(2)(b).)

Exception: Even though a beneficiary would otherwise be deemed to have elected not to use lifetime reserve days, he or she will not be so deemed where benefits are available from another third party payer to pay some or all of the charges and the third party requires as a condition for payment that lifetime reserve days be used. In such cases, lifetime reserve days will be used unless the beneficiary specifically elects not to use them.

B. Election Made Prospectively.-- Ordinarily, an election not to use reserve days will apply prospectively. If the election is filed at the time of admission to a hospital, it may be made effective beginning with the first day of hospitalization or with any day thereafter. If the election is filed later, it may be made effective beginning with any day after the day it is filed.

C. Retroactive Election.-- A beneficiary may retroactively elect not to use reserve days provided: (1) the beneficiary (or some other source) offers to pay the hospital for any of the services not payable under Part B; and (2) the hospital agrees to accept the retroactive election. In these cases, the hospital will use corrected bill procedures. (The debit-credit procedure in §3816 should be used by the intermediary if HCFA has not rejected the prior bill. Otherwise, the intermediary should correct the original bill.)

A retroactive election not to use the lifetime reserve days must be filed within 90 days following the beneficiary's discharge from the hospital unless benefits are available from a third party payer to pay for the services and the hospital agrees to the retroactive election. In that case, the beneficiary may file an election not to use the lifetime reserve days later than 90 days following discharge.

EXAMPLE 1:

Prior to July 1, A had used 90 days of inpatient hospital services in a spell of illness. Beginning July 1, A was hospitalized for 10 additional days in that same spell of illness. A was informed of his election right on July 1 at the time of admission and indicated that he wanted to use his reserve days for that stay. One month after being discharged from the hospital, A informed the hospital's billing office that he now wished to save his reserve days for a future stay. A agreed to pay the hospital for the services he received during the 10 days of hospitalization which were not payable under Part B and was permitted to file a retroactive election not to use his reserve days, effective July 1.

EXAMPLE 2:

On July 1, 1983, B was discharged from a hospital after being hospitalized for 105 days. The hospital billed Medicare for 90 regular days plus 15 lifetime reserve days. On October 20, 1983 (more than 90 days following discharge) B learned that a private insurer could pay for the last 15 days of the stay. B informed the hospital that he wished to file a retroactive election not to use lifetime reserve days for the last 15 days of the stay. The hospital agreed to the request, and B filed an election form. The hospital refunded the Medicare payment and billed the private carrier instead.

D. Period Covered by Election.

(1) Hospitals Not Reimbursed Under Prospective Payment System.—A beneficiary election not to use reserve days for a particular hospital stay may apply to the entire stay or to a single period of consecutive days in the stay but cannot apply to selected days in a stay. If an election (whether made prospectively or retroactively) not to use reserve days is made effective with the first day for which reserve days are available, it may be terminated at any time. After termination of the election, all hospital days would be covered to the extent that reserve days are available. (Thus, an individual who has private insurance which covers hospitalization beginning with the first day after 90 days of benefits have been exhausted may terminate the election as of the first day not covered by the insurance plan.) If an election not to use reserve days is made effective beginning with any day after the first day for which reserve days are available, it must remain in effect until the end of that stay unless the entire election is revoked in accordance with §3106.5.

(2) Hospitals Reimbursed Under Prospective Payment System.

(a) Beneficiary Has One or More Regular Benefit Days Available at Time of Admission.--If the beneficiary has one or more regular benefit (non-lifetime reserve) days remaining in the benefit period upon entering the hospital, Medicare will pay the entire prospective payment amount for nonoutlier days. Therefore, there will be no advantage to a beneficiary in using any of his lifetime reserve days for nonoutlier days if at least one day of his regular 90 days of coverage remains when he enters the hospital. In this situation, the beneficiary will be deemed to have elected not to use any of his lifetime reserve days for the nonoutlier part of the stay. The beneficiary may also elect not to use lifetime reserve days for outlier days but such an election must apply to all outlier days.

EXAMPLE 3:

> C was admitted to a hospital on April 1, 1984 and discharged on June 29, 1984, utilizing 89 regular days of inpatient care. On August 1, 1984, C entered the hospital again. For this DRG, outlier days would have begun August 26, but C was discharged on August 23, prior to the commencement of outlier days. Since the first 2 days of the second stay were regular coverage days, Medicare will reimburse the hospital the prospective reimbursement amount for the entire stay. Since no outlier days are involved, there is no advantage to the beneficiary in using lifetime reserve days. Therefore, C will be deemed to have elected not to use any lifetime reserve days for that stay.

Even though lifetime reserve days are not used for nonoutlier days where the beneficiary has at least one regular day available at the time of admission, payment will be made for outlier days occurring after regular coverage days have been exhausted unless (a) the beneficiary elects not to use lifetime reserve days for the outlier days or (b) the beneficiary is deemed to have elected not to use lifetime reserve days for the outlier days. A beneficiary is deemed to have elected not to use lifetime reserve days for outlier days if the average daily charge for the outlier days for which lifetime reserve days would otherwise be available is equal to or less than the daily coinsurance amount for the lifetime reserve days. In that situation, the beneficiary would be required to pay for all of the hospital's charges for such outlier days regardless of his or her election and therefore would not benefit from the use of lifetime reserve days. If the beneficiary elects not to use lifetime reserve days for outlier days, such an election must apply to all outlier days. If the beneficiary elects not to use lifetime reserve days for outlier days Medicare will pay for the non-outlier portion of the stay and will make no payment for the outlier days.

EXAMPLE 4:

D, who had never used any of his lifetime reserve days, was admitted to the hospital on April 1, 1984 and discharged on June 29, 1984, utilizing 89 regular days of covered inpatient care. On August 1, 1984, D entered the hospital again and was discharged on September 5. For this DRG, outlier days began on August 26. Medicare will reimburse the hospital the prospective payment amount for the non-outlier portion of the stay. The average daily charges were $200 for the outlier portion of the stay. The lifetime reserve day coinsurance amount is $178. Since the average daily charge for the outlier days is more than the daily coinsurance amount for lifetime reserve days, there is no deemed election not to use lifetime reserve days for the outlier portion of the stay. For outlier days D has the option: (1) to make no lifetime reserve election, in which case Medicare will pay for the nonoutlier portion of the stay and for the 10 outlier days, August 26 through Sept. 4, and D will have utilized 10 lifetime reserve days; or (2) to elect not to use his lifetime reserve days for the 10 outlier days, in which case Medicare will pay only for the nonoutlier portion of the stay, and D will not have used any lifetime reserve days.

(b) Beneficiary Has No Regular Days Available at Time of Admission.—If the beneficiary enters the hospital after he has completely exhausted his regular benefit days, available lifetime reserve days will be used automatically for each day of the stay unless the beneficiary elects not to use lifetime reserve days or he or she is deemed to have elected not to use lifetime reserve days. A beneficiary is deemed to have elected not to use lifetime reserve days, if the total charges for the stay, i.e., the charges for which the beneficiary would be liable if he does not use lifetime reserve days are equal to or less than the charges for which the beneficiary would be liable if he used lifetime reserve days. In the latter case, charges equal the sum of the coinsurance amounts for the lifetime reserve days that would be used plus the total charges for outlier days, if any, for which no lifetime reserve days would be available because lifetime reserve days are exhausted. (See 3106.2A(3).)

In the case of a hospital reimbursed under the prospective payment system, an election by a beneficiary not to use lifetime reserve days must apply to the entire hospital stay. If the beneficiary elects not to use lifetime reserve days, Medicare will not pay for any portion of the stay. Similarly, a deemed election not to use lifetime reserve days must apply to the entire stay and will preclude any payment for the stay.

EXAMPLE 5:

F was admitted to a hospital on March 10, 1984 and discharged on June 8, 1984, utilizing 90 regular days of coverage. On August 1, 1984, F entered the hospital again and was discharged on September 8. For this DRG, outlier days began on August 26. At the time of the second admission, F still had 60 lifetime reserve days available. The hospital charges for this stay were $7,000. The sum of the coinsurance amounts for the lifetime reserve days needed to pay for this stay is $6,784 ($178 per day X 38 days). Since the charges for the stay are greater than the sum of lifetime reserve days coinsurance amounts, there is no deemed election not to use lifetime reserve days. F has the option: (1) to make no lifetime reserve election, in which case Medicare will pay for the entire stay including the outlier days, and F will use 38 lifetime reserve days; or (2) to elect not to use lifetime reserve days, in which case Medicare will not pay for any portion of the stay.

EXAMPLE 6:

Same facts as Example 5 except the beneficiary has only 35 lifetime reserve days available at the time of the second admission and total charges for the stay are $6,500. Included in the hospital charges is $300 for the last 3 days of the stay. The sum of the coinsurance amounts for the lifetime reserve days that could be used is $6,230 ($178 per day X 35 days). Since the charges for the entire stay, $6,500, are less than $6,530 (the sum of the coinsurance amounts for days for which lifetime reserve days are available ($6,230) plus the total charges for the outlier days for which lifetime reserve days are not available ($300)), the beneficiary is deemed to have elected not to use any lifetime reserve days for the stay.

E. Election Where Beneficiary Incapacitated.-- If a beneficiary is physically or mentally unable to file an election not to use reserve days, certain other individuals may file the election on his behalf: (1) If the charges will be paid by other hospital insurance or if some other person agrees to pay the hospital for the services, an election not to use reserve days may be filed by any of the individuals who may sign a Request for Payment on behalf of the beneficiary (e.g., relative, legal guardian) (see S3302.5); (2) If an incapacitated beneficiary does not have other hospital insurance, and no other person agrees to pay the hospital for the services, only the beneficiary's legal representative may file an election on his or her behalf.

3106.3 Content of Election.-- A beneficiary's election not to use reserve days should specify the name of the hospital and the starting date of the election.

Where the hospital is not reimbursed under the prospective payment system, the starting date of the election may be any day after regular benefits are exhausted. Where the hospital is reimbursed under the prospective payment system, the starting date of the election depends on whether the beneficiary has regular benefit days remaining upon entering the hospital. If the beneficiary has regular benefit days remaining upon entering the hospital, the starting date of the election must be the first outlier day after regular benefits are exhausted. If the beneficiary has no regular benefits remaining upon entering the hospital, the starting date of the election must be the first day of the hospital stay.

The election may specify a termination date before the last day of the stay only if the hospital is not reimbursed under the prospective payment system and the election is made effective beginning with the first day for which reserve days are available (S3106.2D(1)). Where the hospital is under the prospective payment system, (S3106.2D(2) applies) the election may not specify a termination date because the election remains in effect until the last day of the stay.

3106.4 Election Format.—The following model election language may be used:

Election Not To Use Lifetime Reserve Days

I do not wish to have Medicare benefits paid on my behalf under the lifetime reserve provisions of section 1812(b) of the Social Security Act for services furnished me by (name of hospital) beginning (date).

WHERE THE ELECTION MAY TERMINATE BEFORE THE END OF THE STAY IN ACCORDANCE WITH SECTION 3106.3, THE FOLLOWING MAY BE INCLUDED:

The last day to which this election applies is (date).

I understand that I will be responsible for all of the hospital's charges not reimbursed by Medicare because of this election, except those covered under Medicare Part B. Where Medicare Part B payments may be made for services furnished during the period covered by the election, I will be responsible for the deductible and 20 percent coinsurance amounts.

______________ ____________
(signature) (date)

____
(HI claim number)

3106.5 Revocation of Election.-- An election not to use reserve days may be revoked in whole or in part, provided a claim has not been filed for Part B ancillary services furnished on the hospital days in question. (An election may be revoked in part subject to the restriction on elections in §3106.2D(1).) The revocation must be submitted to the hospital in writing and should be made part of the patient's hospital record. (See §3106.6 for sample revocation format.) If a beneficiary is incapacitated, any of the individuals who are permitted to sign the Request for Payment may file the revocation on the beneficiary's behalf. However, an election not to use reserve days may not be revoked after the beneficiary dies.

A revocation of election not to use lifetime reserve days must be made within 90 days following the beneficiary's discharge from the hospital with the following exception: The election may be revoked later than 90 days after discharge if benefits are available from a private insurer to pay the lifetime reserve coinsurance amounts and the insurer requires as a condition for payment that lifetime reserve days be used.

3106.6 Revocation Format.-- The revocation of an election not to use reserve days should specify the name of the hospital, the admission date of the stay to which it applies and, if appropriate, the effective date of revocation. The following model language is suggested:

Revocation of Election Not To Use Lifetime Reserve Days

I wish to revoke the election previously made by me or on my behalf not to use lifetime reserve days to pay for the inpatient hospital services furnished me by (name of hospital) during my stay there beginning (admission date). (If appropriate add: I wish to revoke my election not to use lifetime reserve days for the period from _____ to _____.) I understand that my lifetime reserve days will be used for these services (to the extent that I have such days available) but that I will still be responsible to pay the Medicare coinsurance amounts and any charges for services not covered under the Medicare program.

__________ (signature) __________ (date)

__________ (HI claim number)

3107. INPATIENT SERVICE DAYS COUNTING TOWARD BENEFIT MAXIMUMS.

A. 90-Day Benefit Limitation.--Inpatient hospital (including psychiatric hospital) services count toward the maximum of 90 benefit days payable per benefit period only if:

- payment for the services is made, or

- payment for the services would be made if a request for payment and claim were filed properly and timely, a physician certified that the services were necessary, if required, and the provider submitted all necessary evidence. (See § 3302.6 for patient's refusal to file, § 3315.1 for physician's refusal to certify, § 3600.1 for provider's failure to submit evidence, and § 3610.1 for billing procedures in these situations). Where payment cannot be made because of the inpatient deductible or coinsurance requirements, the inpatient day(s) used in satisfying these requirements nevertheless counts toward the beneficiary's maximum inpatient days.

B. Lifetime Reserve Days.--Inpatient hospital services count toward the maximum of 60 lifetime reserve days under the same conditions as in subsection A except that days are not counted if:

- the individual elects not to have payment made (§ 3106.2), or

- the daily charge does not exceed the coinsurance rate (§ 3106C).

C. Lifetime Inpatient Psychiatric Hospital Limitation.--Inpatient psychiatric hospital services count toward the 190-day lifetime limitation on inpatient psychiatric hospital services only if the conditions in subsection A are met.

Hospital Services Covered Under Part B

3110. MEDICAL AND OTHER HEALTH SERVICES FURNISHED TO INPATIENTS OF PARTICIPATING HOSPITALS.

Payment may be made under Part B for the following medical and other health services (i.e, when they are reasonable and necessary) when furnished by a participating hospital (either directly or under arrangements) to an inpatient of the hospital, but only if payment for these services cannot be made under Part A. In PPS hospitals, this means that Part B payment could be made for these services if:

- no Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission,

- the admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made),

- the day or days of the otherwise covered stay during which the services were provided were not reasonable and necessary (and no payment was made under waiver of liability), o the patient was not otherwise eligible for or entitled to coverage under Part A (See § 3101.14 for Services Related to and Required as a Result of Services Which are Not Covered Under Medicare); or

o no Part A day outlier payment is made for one or more outlier days due to patient exhaustion of benefit days after admission but before the case's arrival at outlier status or because outlier days are otherwise not covered and waiver of liability payment is not made.

Part B payment may be made for the following medical and other health services furnished at any time during the stay if no Part A payment is made. However, if only day outlier payment is denied under Part A, Part B payment may be made for only the services furnished on the denied outlier days.

In non-PPS hospitals, Part B payment may be made for the following covered services delivered on any day for which Part A payment is denied (i.e., because of patient exhaustion of benefit days, patient or services were not at the hospital level of care, patient was not otherwise eligible or entitled to payment under Part A).

o Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests;

o X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

o Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

o Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices;

o Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;

o Outpatient physical therapy, outpatient speech pathology services, and outpatient occupational therapy (see §§ 3147ff); and

o Ambulance services.

See §§ 3698ff for processing claims of nonparticipating hospitals.

In order to be covered under Part A or Part B, a hospital must furnish nonphysician services to its inpatients directly or under arrangements. A nonphysician service is one which does not meet the criteria defining physicians' services specifically provided for in regulation at 42 CFR 405.550(b). Services "incident to" physicians' services (except for the services of nurse anesthetists employed by anesthesiologists) are nonphysician services for purposes of this provision. This provision is applicable to all hospitals participating in Medicare, including those reimbursed under alternative arrangements such as State cost control systems and to emergency hospital services furnished by nonparticipating hospitals. (Exception: Part B payment may be made for nonphysician services provided to a hospital inpatient even if the service is not provided directly by the hospital or under arrangements in hospitals where the HCFA has found that a hospital has allowed Part B billing by outside suppliers so extensively prior to October 1, 1982, that failure to continue to allow it would threaten the stability of patient care. Specific criteria and procedures related to this waiver, which is available only until October 1, 1986, are referred to in §3618C.)

In all hospitals not falling within the above exception, every service provided to a hospital inpatient (other than the three (3) discussed below) must be treated as an "inpatient hospital service" to be paid for under Part A, if Part A coverage is available for the stay and the beneficiary. This is the case since, as noted above, every hospital, other than those granted the above described exception, must provide directly or arrange for any nonphysician service rendered to its inpatients and a hospital can be paid under Part B for a service provided in this manner only if Part A coverage does not exist.

Note: There are three services which, when provided to a hospital inpatient, may be covered under Part B, even though the patient has Part A coverage for the hospital stay. These services are: (1) physicians services (including the services of residents and interns in unapproved teaching programs); and (2) pneumoccocal vaccine and its administration, and (3) hepatitis B vaccine and its administration. However, it is noted again that unless a waiver has been specifically granted to a hospital consistent with §3618C, in order to have any Medicare coverage at all (Part A or Part B) any nonphysician service rendered to a hospital inpatient (including pneumoccocal and hepatitis B vaccine services) must be provided directly or arranged for by the hospital.

3110.3 Surgical Dressings, and Splints, Casts, and Other Devices Used for Reduction of Fractures and Dislocations.--Surgical dressing are limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions either on the skin or opening to the skin required as the result of a surgical procedure performed by a physician. (Items such as ace bandages, elastic stockings, and support hose, Spenco boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets, and pressure garments for the arms and hands are generally used as secondary coverings and therefore would not be covered as surgical dressings.) Surgical dressings are usually applied first by a physician but may be reapplied by others including the patient or a member of his family. Dressings required for purposes other than a surgical lesion, e.g., bedscores, are not covered. Splints and casts, etc., include dental splints.

Prior to October 30, 1972, a colostomy bag and necessary accountrements required for its attachment were covered as a surigcal dressing, but irrigation equipment and supplies used in treating a colostomy were not. (See §3110.4 below for statement regarding coverage of such items as prosthetic devices effective October 30, 1972.)

3110.4 Prosthetic Devices.--Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered when furnished on a physician's order. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates the condition will be of long and indefinite duration, the test of permanence will be considered met. (Such a device could also be covered as a supply when furnished incident to a physician's service.)

Examples of prosthetic devices would include cardiac pacemakers, prosthetic lenses (see subsection B), breast prostheses (including a surgical brassiere) for postmastectomy patients, maxillofacial devices and devices which replace all or part of the ear or nose. A urinary collection and retention system with or without a tube would be a prosthetic device replacing bladder function in case of permanent urinary incontinence. The Foley catheter would also be considered a prosthetic device when ordered for a patient with permanent urinary incontinence. However, chucks, diapers, rubber sheets, etc., are supplies that are not covered under this provision. (Although hemodialysis equipment is a prosthetic device, reimbursement and coverage for the rental or purchase of such equipment for use in the home will be made only under the provisions for payment applicable to durable medical equipment (§3113ff) or the special rules that apply to the ESRD program.)

NOTE: Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that will make necessary the use of the device. For example, a separate Part B payment would not be made for an intraocular lens or a pacemaker that a physician dispenses to a patient during an office visit, prior to the patient's hospitalization for performance of the procedure that will cause the device to be used. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner would not be considered reasonable and necessary for the treatment of the patient's condition.

Colostomy (and other ostomy) bags and necessary accoutrements required for attachment are covered as prosthetic devices. This coverage also includes irrigation and flushing equipment and other items and supplies directly related to ostomy care, whether or not the attachment of a bag is required.

If payment cannot be made on an inpatient's behalf under Part A, hemodialysis equiment, supplies, and services required by such patient could be covered under Part B as a prosthetic device which replaces the function of a kidney. See §3113.1B1 and the Coverage Issues Manual §§60-1 and 60-2 for payment for hemodialysis equipment used in the home. See §3101B for additional instructions on hospitalization for renal dialysis.

Accessories and/or supplies which are used directly with an enteral or parenteral device in order to achieve the therapeutic benefit of the prosthesis or to assure the proper functioning of the device are covered under the prosthetic device benefit subject to the additional guidelines in the Coverage Issues Manual §§65-10 - 65-10.3. Covered items include catheters, filters, extension tubing, infusion bottles, pumps (either food or infusion), intravenous (I.V.) pole, needles, syringes, dressings, tape, Heparin Sodium (parenteral only), volumetric monitors (parenteral only), and parenteral and enteral nutrient solutions. Baby food and other regular grocery products that can be blenderized and used with the enteral system are not covered. Note that some of these items, e.g., a food pump and an I.V. pole, qualify as DME. Although coverage of the enteral nutrition (EN) and total parenteral nutrition (TPN) therapy systems is provided on the basis of the prosthetic device benefit, the reimbursement rules relating to rental or purchase of DME apply to such items. (see §3113). When a hospital supplies TPN or EN systems which meet the criteria for coverage as a prosthetic device to an inpatient whose stay is not covered under Part A, the hospital must bill one of the two carriers designated to process claims for TPN and EN systems.(See §3661.)

(See §3111 where a hospital furnishes TPN or EN to an individual who is not an inpatient.)

The coverage of prosthetic devices includes replacement of and repairs to such devices as explained in subsection C below.

A. Prosthetic Lenses.--The term "internal body organ" includes the lens of an eye. Prostheses replacing the lens of an eye include postsurgical lenses customarily used during convalescence from eye surgery in which the lens of the eye was removed. In addition, permanent lenses are also covered when required by an individual lacking the natural lens of the eye because of surgical removal or congenital absence. Prosthetic lenses obtained on or after the beneficiary's date of entitlement to supplementary medical insurance benefits can be covered even though the surgical removal of the natural lens occurred before entitlement.

Payment may be made for one of the following combinations of prosthetic lenses when determined to be medically necessary by a physician (including on and after October 30, 1972, a doctor of optometry, see §3030.5) to restore essentially the vision provided by the natural lens of the eye:

1. prosthetic bifocal lenses in frames; or

2. prosthetic lenses in frames for far vision, and prosthetic lenses in frames for near vision; or

3. when a prosthetic contact lens(es) for far vision is prescribed (including cases of binocular and monocular aphakia), payment can be made for the contact lens(es) and prosthetic lenses in frames for near vision to be worn at the same time as the contact lens(es); and prosthetic lenses in frames to be worn when the contacts have been removed.

Payment may be made for prosthetic lenses which have ultraviolet absorbing or reflecting properties, in lieu of payment for the regular (untinted) prosthetic lenses mentioned in 1, 2 and 3 above, if it has been determined that such lenses are medically reasonable and necessary for the individual patient.

Payment cannot be made for cataract sunglasses obtained in addition to the regular (untinted) prosthetic lenses, since the sunglasses duplicate the restoration of vision function performed by the regular prosthetic lenses.

B. Dentures are excluded from coverage. However, when a denture or a portion thereof is an integral part (built-in) of a covered prosthesis (e.g., an obturator to fill an opening in the palate) it is covered as part of that prosthesis.

C. Supplies, Repairs, Adjustments, and Replacements.--Payment may be made for supplies that are necessary for the effective use of a prosthetic device (e.g., the batteries needed to operate an artificial larynx). Adjustment of prosthetic devices required by wear or by a change in the patient's condition are covered when ordered by a physician. To the extent applicable the provisions relating to the repair and replacement of durable medical equipment in §3113.3 should be followed with respect to the repair and replacement of prosthetic devices. Necessary supplies, adjustments, repairs, and replacements are covered even when the device had been in use before the user enrolled in Part B, so long as the device continues to be medically required. (See the Coverage Issues Manual §65-10.)

3110.5 Leg, Arm, Back, and Neck Braces, Trusses, and Artificial Legs, Arms, and Eyes.-- These appliances are covered under Part B when furnished incident to physicians' services or on a physician's order. A brace includes rigid and semi-rigid devices which are used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. Elastic stockings, garter belts, and similar devices do not come within the scope of the definition of a brace. Back braces include, but are not limited to, special corsets, sacroiliac, sacrolumbar, dorsolumbar corsets and belts. A terminal device (e.g., hand or hook) is covered under this provision whether or not an artificial limb is required by the patient.

Stump stockings and harnesses (including replacements) are also covered when these appliances are essential to the effective use of the artificial limb.

Adjustments to an artificial limb or other appliance required by wear or by a change in the patient's condition are covered when ordered by a physician. To the extent applicable the provisions relating to the repair and replacement of durable medical equipment in §3113.3 should be followed with respect to the repair and replacement of artificial limbs, braces, etc. Adjustments, repairs, and replacements are covered even when the item had been in use before the user enrolled in Part B so long as the device continues to be medically required.

3111. TOTAL PARENTERAL NUTRITION AND ENTERAL NUTRITION FURNISHED TO INDIVIDUALS WHO ARE NOT INPATIENTS.

Total parenteral nutrition (TPN) systems and enteral nutrition (EN) systems are covered as prosthetic devices when the criteria in §§ 65-10 - 65-10.3 of the Coverage Issues Manual are met. When these criteria are met, the medical equipment and medical supplies (together with nutrients) being used comprise covered prosthetic devices rather than durable medical equipment, however, reimbursement rules relating to DME will continue to apply to such items. (See § 3113.) When a hospital supplies TPN or EN systems which meet the criteria for coverage as a prosthetic device to an individual who is not an inpatient, the hospital must bill one of the two carriers designated to process claims for TPN and EN systems. (See § 3661.)

(See § 3110.4 where a hospital furnishes TPN or EN to an inpatient whose care is not covered under Part A.)

3112. OUTPATIENT HOSPITAL SERVICES.

Hospitals provide two distinct types of services to outpatients: services that are diagnostic in nature, and other services that aid the physician in the treatment of his patient. Both the diagnostic and the therapeutic services furnished by hospitals to outpatients are covered by Part B. The following rules pertaining to the coverage of outpatient hospital services are not applicable to physical therapy, speech pathology, occupational therapy, or end stage renal disease (ESRD) services furnished by hospitals to outpatients. See §§ 3147ff for rules on the coverage of outpatient physical therapy, occupational therapy and speech pathology furnished by a hospital.

3112.1 Outpatient Defined.--A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital. Where a tissue sample, blood sample, or specimen is taken by personnel that are neither employed nor arranged for by the hospital and is sent to the hospital for performance of tests, the tests are not outpatient hospital services since the patient does not directly receive services from the hospital. Similarly, supplies provided by a hospital supply room for use by physicians in the treatment of private patients are not covered as an outpatient service since the patients receiving the supplies are not outpatients of the hospital. (See § 3103.1 for definition of "inpatient.")

Where the hospital uses the category "day patient," i.e., an individual who receives hospital services during the day and is not expected to be lodged in the hospital at midnight, classify the individual as an outpatient. For billing for outpatient services furnished before admission as an inpatient, see § 3610.3.

The inpatient of a SNF may be considered the outpatient of a participating hospital. However, the inpatient of a participating hospital cannot be considered an outpatient of that or any other hospital.

Outpatient hospital services furnished in the emergency room to a patient classified as "dead on arrival" are covered up through pronouncement of death if the hospital considers such patients as outpatients for record-keeping purposes and follows its usual outpatient billing practice for such services to all patients, both Medicare and non-Medicare. This coverage does not apply if the patient was pronounced dead prior to arrival at the hospital.

3112.2 Distinguishing Outpatient Hospital Services Provided Outside the Hospital.--Diagnostic services are covered when provided by the hospital whether furnished in the hospital or at other locations. Outpatient therapeutic services, furnished incident to physician's services, are covered when furnished outside the hospital only if there is direct personal supervision by a physician. Thus, it may be necessary to distinguish between diagnostic and therapeutic services when services are provided outside the hospital. Outpatient physical therapy, occupational therapy, and speech pathology services are not subject to the direct physician supervision requirement. See §§ 3147ff. for coverage of outpatient physical therapy, occupational therapy, and speech pathology services.

Where the rules of coverage require a distinction between diagnostic and therapeutic services the hospital may accept the physician's designations. Normally, however, the physician does not separate the services and need not be asked to do so.

3112.3 Outpatient Diagnostic Services.--

A. Diagnostic Services Defined.--A service is "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic X-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests and other tests given to determine the nature and severity of an ailment or injury.

B. Coverage of Outpatient Diagnostic Services.--Covered diagnostic services to outpatients include the services of nurses, psychologists, and technicians, drugs and biologicals necessary for diagnostic study, and the use of supplies and equipment. When a hospital sends hospital personnel and hospital equipment to a patient's home to furnish a diagnostic service, cover the service as if the patient had received the service in the hospital outpatient department.

Hospital personnel may provide diagnostic services outside the hospital premises without the direct personal supervision of a physician. For example, if a hospital laboratory technician is sent by the hospital to a patient's home to obtain a blood sample for testing in the hospital's laboratory, the technician's services are a covered hospital service even though a physician was not with the technician.

Payment may not be made for outpatient diagnostic services unless the same service would be covered as an inpatient hospital service if furnished to a hospital inpatient.

C. Outpatient Diagnostic Services under Arrangements.--When the hospital makes arrangements with others for diagnostic services, such services are covered under Part B as diagnostic tests whether furnished in the hospital or in other facilities.

Independent laboratory services furnished to an outpatient under arrangements with the hospital are covered only under the "diagnostic laboratory tests" provisions of Part B (see § 3110A), but are to be billed along with other services to outpatients. See § 3101.5B for (1) the definition of an independent clinical laboratory; (2) the requirements which such a laboratory must meet; and (3) instructions to the intermediary when it is not approved. The "cost" to the hospital for diagnostic laboratory services for outpatients obtained under arrangements is the reasonable charge by the laboratory.

Laboratory services may also be furnished to a hospital outpatient under arrangements by (1) the laboratory of another participating hospital, or (2) the laboratory of an emergency hospital or participating skilled nursing facility which meets the hospital conditions of participation relating to laboratory services.

D. Preadmission Diagnostic Services.--(Effective only for services performed after December 4, 1980, and before July 19, 1984.) Preadmission diagnostic services are those otherwise covered outpatient diagnostic services which are reasonable and necessary for the administration and interpretation of a diagnostic test, study or procedure and that are furnished by, or under arrangements made by, a participating hospital to an outpatient within 7 days before the day of the patient's admission to the same hospital as an inpatient. (See § 3101 for definition of "inpatient.") Furthermore, the services involved must be ones which would have to be performed after the admission if they had not been performed prior to admission and the results of the testing must be available to the hospital and physician at the time of the patient's admission. Preadmission diagnostic services can include services provided by a participating hospital to an outpatient who is being admitted for medical and/or surgical treatment in connection with an already diagnosed condition, as well as those services provided an outpatient whose condition has not been fully diagnosed and who is being admitted for a medically necessary inpatient diagnostic study. Such services as taking patients' histories or performing routine physical examinations are not "preadmission diagnostic services."

Where covered outpatient diagnostic services are reimbursed under Part B as "preadmission diagnostic services," payment may be made regardless of whether inpatient benefits are payable (e.g., when the beneficiary has used up all his inpatient hospital benefit days). Preadmission diagnostic services are reimbursed under Part B at 100 percent of reasonable costs; such services are not subject to the Part B coinsurance. The Part B deductible, however, does apply. Outpatient diagnostic services which do not meet the definition of "preadmission diagnostic services," but are otherwise covered and are reasonable and necessary, are subject to the Part B deductible and coinsurance. For purposes of these instructions, "preadmission diagnostic services" do not include outpatient hospital services furnished to an individual (with Part A coverage) on the day of or the day immediately preceding that individual's admission to the same hospital as an inpatient. Such services are treated as inpatient hospital services (see §§ 3608 and 3637.19).

3112.4 Outpatient Therapeutic Services.--

A. Coverage of Outpatient Therapeutic Services.--Therapeutic services which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians in the treatment of patients. Such services include clinic services and emergency room services.

To be covered as incident to physicians' services, the services and supplies must be furnished as an integral, although incidental, part of the physician's professional service in the course of diagnosis or treatment of an illness or injury. The services and supplies must be furnished on a physician's order by hospital personnel and under a physician's supervision. This does not mean that each occasion of service by a nonphysician need also be the occassion of the actual rendition of a personal professional service by the physician. However, during any course of treatment rendered by auxiliary personnel, the physician must personally see the patient periodically and sufficiently often to assess the course of treatment and the patient's progress and, where necessary, to change the treatment regimen. A hospital service or supply would not be considered incident to a physician's service if the attending physician merely wrote an order for the services or supplies and referred the patient to the hospital without being involved in the management of that course of treatment. The physician supervision requirement is generally assumed to be met where the services are performed on hospital premises; the hospital medical staff that supervises the services need not be in the same department as the ordering physician. However, if the services are furnished outside the hospital, they must be rendered under the direct personal supervision of a physician who is treating the patient. For example, if a hospital therapist, other than a physical or speech therapist, goes to a patient's home to give treatment and no physician accompanies him, the therapist's services would not be covered. See § 3147ff. for outpatient physical therapy and speech pathology coverage conditions.

B. Drugs and Biologicals.--For definitions of drugs and biologicals and combination drugs, see § 3101.3. Except for those drugs and biologicals which must be put directly into an item of durable medical equipment or a prosthetic device (see §§ 3110.4C and 3113.4), drugs and biologicals furnished to outpatients for therapeutic purposes are includable only if they are of a type which cannot be self-administered.

Whether a drug or biological is of a type which cannot be self-administered is based on the usual method of administration of the form of that drug or biological as furnished by the physician. Thus, where a physician gives a patient pills or other oral medication, these are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a physician gives a patient an injection which is usually self-injected (thus far insulin is the only drug determined to fall in this category), this drug is excluded from coverage, unless administered to the patient in an emergency situation (e.g., diabetic coma). Where, however, a physician injects a drug which is not usually self-injected, this drug is not subject to the self-administrable drug exclusion (regardless of whether the drug may also be available in oral form) since it is not self-administrable in the form in which it was furnished to the patient. (Of course, such injections could not be reasonable and necessary where injection is not considered an indicated method of administration according to accepted standards of medical practice for the condition for which given.)

1. Less Than Effective Drugs.--Payment may not be made for a less than effective drug. This is a drug that has been determined by the Food and Drug Administration (FDA) to lack substantial evidence of effectiveness for all labeled indications. Also, a drug that has been the subject of a Notice of an Opportunity for a Hearing (NOOH) published in the Federal Register before being withdrawn from the market, and for which the Secretary has not determined there is a compelling justification for its medical need, is considered less than effective. This will include any other drug product that is identical, similar, or related.

Because the FDA has not yet completed its identification of drug products that are still on the market, existing FDA efficacy decisions must be applied to all similar products once they are identified. The complete FDA listing comprises, for the most part, self-administered drugs. The listing that follows includes only those drugs which cannot be self-administered and which therefore could otherwise be covered under the Medicare program.

DESI DRUG PRODUCTS AND KNOWN RELATED DRUG PRODUCTS THAT LACK SUBSTANTIAL EVIDENCE OF EFFECTIVENESS AND ARE SUBJECT TO A NOTICE OF OPPORTUNITY FOR HEARING

TRADE NAME	ACTIVE INGREDIENT	DOSAGE FORM/ROUTE	FIRM
Vasodilan	Isoxsuprine Hydrochloride	Sol/IM	Mead Johnson

2. Hemophilia Clotting Factors. - Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors are covered under Part B. Coverage is effective for such items and services purchased on or after July 18, 1984. Prior to the enactment of the Deficit Reduction Act of 1984 (P.L. 98-369), all drugs and biologicals which were of the type that could be self-administered were excluded from coverage. The coverage of blood clotting factors is an exception to the exclusion.

The amount of clotting factors determined to be necessary to have on hand and thus covered under this provision will be based on the historical utilization pattern or profile developed by the carrier for each patient. It is expected that the treating source; e.g., a family physician or Comprehensive Hemophilia Diagnostic and Treatment Center, will have such information. From this data, the contractor should be able to make reasonable projections concerning the quantity of clotting factors anticipated to be needed by the patient over a specific period of time. Unanticipated occurrences involving extraordinary events, such as automobile accidents, inpatient hospital stays, etc., will change this base line data and should be appropriately considered. In addition, changes in a patient's medical needs over a period of time will require adjustments in the profile.

Payment under this provision may be conditioned by the Part B blood deductible, see § 3235.2.

3. Immunosuppresive Drugs.—For a period of one year following discharge from a hospital for a Medicare-covered organ transplant, immunosuppressive drugs are covered under Part B. (We interpret "one year period after the date of transplant procedure" to mean 365 days from the day on which an inpatient is discharged from the hospital.) However, coverage is limited to those immunosuppressive drugs that have been specifically labeled and approved for marketing as such by the FDA. (This is an exception to the standing drug policy which permits coverage of FDA approved drugs for nonlabeled uses, where such uses are found to be reasonable and necessary in an individual case.)

To date the FDA has identified and approved for marketing only four specifically labeled immunosuppressive drugs. They are Sandimmune (cyclosporine), Sandoz Pharmaceutical; Imuran (azathioprine), Burroughs Wellcome; Atgam (antithymocyte globulin), Upjohn; and Orthoclone OKT3 (Muromonab-CD3), Ortho Pharmaceutical. You must keep informed of FDA additions to the list of immunosuppressive drugs.

For coverage of immunizations, etc., see § 3157.

C. Other Covered Services and Items.--Covered services and items provided by the hospital in connection with the clinic visit or the physician's treatment of outpatients include the use of hospital facilities, including the use of the emergency room; services of nurses, nonphysician anesthetists, psychologists, technicians, therapists, and other aides; and medical supplies such as gauze, oxygen, ointments and other supplies used by physicians or hospital personnel in the treatment of outpatients. Additional examples of covered items are surgical dressings; slints, casts, and other devices used for reduction of fractures and dislocations; prosthetic devices; leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. (See §§ 3110.3-3-3110.5 for details on coverage of these items and § 3101.9B for additional coverage rules for occupational therapy.)

3112.5 Sleep Disorder Clinics.--Sleep disorder clinics are facilities in which certain conditions are diagnosed through the study of sleep. Such clinics are primarily for research. Nevertheless, sleep disorder clinics may provide some diagnostic or therapeutic services which are covered under Medicare. These clinics may be affiliated either with a hospital or a freestanding facility. Whether a clinic is hospital-affiliated or freestanding, coverage for diagnostic services would under some circumstances be covered under provisions of the law different from those for coverage of therapeutic services.

A. Criteria for Coverage of Diagnostic Services.--All reasonable and necessary diagnostic tests given for the medical conditions listed in B. below are covered when the following criteria are met:

1. The clinic is either affiliated with a hospital or is under the direction and control of physicians and a physician is present whenever diagnostic tests are performed.

2. Patients are referred to the sleep disorder clinic by their attending physicians and the clinic maintains a record of the attending physician's orders. In the case of diagnostic nocturnal penile tumescence testing, see the coverage guidelines in B.3. below.

3. The need for diagnostic testing is confirmed by medical evidence, e.g., physician examinations and laboratory tests.

Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered.

B. Medical Conditions for Which This Testing is Covered.--Diagnostic testing can be covered only if the patient has the symptoms or complaints of one of the conditions listed below. Most of the patients who undergo the diagnostic testing are not considered inpatients, although they may come to the facility in the evening for testing and then leave after their tests are over. The overnight stay would be considered an integral part of these tests.

1. Narcolepsy.--This term refers to a syndrome that is characterized by abnormal sleep tendencies, e.g., excessive daytime sleepiness or disturbed nocturnal sleep. Related diagnostic testing is covered if the patient has inappropriate sleep episodes or attacks (e.g., while driving, in the middle of a meal, in the middle of a conversation), amnesiac episodes or continuous disabling drowsiness. The sleep disorder clinic must submit documentation that this condition is severe enough to interfere with the patient's well-being and health before Medicare benefits may be provided for diagnostic testing. A maximum of three "sleep naps" to confirm a diagnosis of narcolepsy may be covered.

2. Sleep Apnea.--This is a potentially lethal condition where the patient stops breathing during sleep. Three types of sleep apnea have been described—central, obstructive and mixed. The nature of the apnea episodes can be documented by appropriate diagnostic testing. A maximum of one night stay per patient may be allowed.

3. Impotence.--Diagnostic nocturnal penile tumescence testing may be covered, under limited circumstances, to determine whether erectile impotence in men is organic or psychogenic. Although impotence is not a sleep disorder, the nature of the testing requires that it be performed during sleep. The tests ordinarily would be covered only where necessary to confirm the treatment to be given—whether surgical, medical or psychotherapeutic. A maximum of two nights of diagnostic testing may be covered. The contractor's medical staff should review questionable cases to ensure that the tests are reasonable and necessary for the individual. (See § 35-24 of the Coverage Issues Appendix for policy on coverage of diagnosis and treatment of impotence.)

C. Coverage of Therapeutic Services.--Sleep disorder clinics may at times render therapeutic as well as diagnostic services. Although only the diagnostic services indicated above are covered under Medicare, therapeutic services may be covered provided they are standard and accepted services and are reasonable and necessary for the patient.

1. In a Hospital Outpatient Setting

2. In a Free-Standing Facility

3112.6 Intermittent Peritoneal Dialysis Services.-- Maintenance intermittent peritoneal dialysis (IPD) is dialysis used to sustain ESRD patients by using the patient's peritoneum as an artificial kidney. Dialysate is administered into the peritoneal cavity to dialyze the patient's blood. While maintenance IPD is usually accomplished in sessions of 10-12 hours duration, three times per week, it is sometimes accomplished in fewer sessions of longer duration. The payment screens applicable to maintenance IPD as well as the facility's actual reimbursement for maintenance IDP, depends on the length of the dialysis session, and the number of sessions furnished per week. If additional dialysis beyond the usual weekly maintenance dialysis is required because of special circumstances, the facility's claim to the intermediary for these extra services must be accompained by a medical justification. Under these circumstances additional reimbursement may be made. In all cases the Part B deductible and coinsurance apply.

A. Maintenance Intermittent Peritoneal Dialysis Sessions of Less Than 20 Hours Duration.-- The payment screen applicable to a facility for maintenance intermittent peritoneal dialysis (IPD) sessions of less than 20 hours duration is the same as the payment screen applicable to that facility for hemodialysis. However, in addition to the per dialysis payment screen there is also a weekly maintenance IPD screen equal to three times the per treatment hemodialysis screen. For example, if the applicable hemodialysis reimbursement screen for a facility is $150, then its maintenance IPD payment screen would be $150 per dialysis session, and $450 per week. Therefore, if the facility furnished two 12-hour IPD sessions to a patient in a week, its reimbursement would be based on a $300 payment screen for that week. If the facility furnished three or more 12-hour IPD sessions to a patient in a week, reimbursement would be based on a $450 weekly payment screen for that week.

B. Maintenance Intermittent Peritoneal Dialysis Sessions of More Than 20 but Less Than 30 Hours Duration.-- Where maintenance intermittent peritoneal dialysis (IPD) is accomplished in sessions of 20 hours or more duration but less than 30 hours, reimbursement is made in accordance with the same weekly payment screen as described in A above. However, the individual dialysis session screen is equal to one and one-half times the individual dialysis session screen derived in paragraph A, above. Therefore, if the facility in the above example furnishes one 20 hour IPD session to a patient in a week, its reimbursement would be based on a $225 screen; reimbursement for two 20 hour maintenance IPD sessions to a patient in a week would be based on a $450 screen for that week.

C. Maintenance Intermittent Peritoneal Dialysis Sessions of 30 Hours or More Duration.-- Medical consultants indicate that patients undergoing intermittent dialysis (IPD) should be dialyzed more often than once per week. However, sometimes geographical considerations or other exigencies require a compromise to be made between optimum medical practice and patient convenience. In recognition of these special cases, IPD sessions of 30 hours or more duration are reimbursed in accordance with the weekly payment screen described in paragraph A above. Therefore, if the facility in the above example furnished one 30 hour IPD session to a patient, it would be reimbursed in accordance with a $450 screen for that week.

D. Training.-- Intermittent peritoneal self-dialysis training sessions are reimbursed similarly to hemodialysis self-dialysis training; i.e., the same rate of reimbursement applies as the facility's maintenance intermitten IPD session rate, with an additional $20 per session for training. Therefore, if the facility's physicians are on the initial method of reimbursement, the facility provides laboratory services, and its maintenance IPD reimbursement rate is $150 per session, then its intermittent peritoneal self-dialysis training rate would be $170 per training dialysis session. The maximum weekly reimbursement would be three times the per session rate, or $510.

Accelerated intermittent peritoneal self-dialysis training programs offering five training sessions per week, 8 hours per session are also covered. Reimbursement for this accelerated schedule is made according to the following scale:

Facilities who physicians are paid by the initial method may be reimbursed for its five sessions per week, 8 hours per session, intermittent peritoneal self-dialysis training program on the basis of a rate which does not exceed $120 per session, or a total of $600 per week, for each patient for the duration of that patient's training period. Facilities whose physicians are reimbursed under the alternative monthly method may be reimbursed for such a training program based on a rate which does not exceed $112 per session, or a total of $560 per week, for each patient for the duration of that patient's training period. This rate reflects a reduction by a prorated amount of the usual $12 per session reduction in facility reimbursement when its physicians are paid under the alternative method. If the facility does not provide laboratory services, then the screen is reduced by $5, i.e., $115 per session under the initial method or $107 per session under the alternative method.

3112.7 Outpatient Hospital Psychiatric Services.—

A. General.—There is a wide range of services and programs that a hospital may provide to its outpatients who need psychiatric care, ranging from a few individual services to comprehensive, full-day programs; from intensive treatment programs to those that provide primarily supportive, protective or social activities. Because of this diversity, ensure that payment is made only for covered services that meet the requirements of the outpatient hospital benefit.

In general, to be covered the services must be: (1) incident to a physician's service (see §3112.4A), and (2) reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

B. Coverage Criteria.—The services must meet the following criteria:

1. Individualized Treatment Plan.—Services must be prescribed by a physician and provided under an individualized written plan of treatment established by a physician after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency, and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

2. Physician Supervision and Evaluation.—Services must be supervised and periodically evaluated by a physician to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff, review of medical records, and patient interviews. Physician entries in medical records must support this involvement. The physician must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or emphasis are needed.

3. Reasonable Expectation of Improvement.--Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected. Do not deny claims automatically because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, evaluate each case in terms of the criteria discussed above, and deny only where the evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment.

C. Partial Hospitalization.--Partial hospitalization is a general term that encompasses a variety of outpatient psychiatric programs; each of which can vary in their functions, the populations that they serve, their treatment goals and in the services that they provide. Depending on their functions, they may also be called day hospital/day treatment centers, or day care/night care centers. Within the same facility, there may be a number of programs operating, each of which may be aimed at a different population with a different level-of-care treatment program.

The Medicare law does not provide for the coverage of partial hospitalization programs per se. However, under the outpatient hospital benefit, those portions of the programs that fall within the requirements of the law may be covered. For coverage purposes, the key to whether a particular type or group of services and activities may be covered will depend primarily on the services provided in the program, and how the services are being used in the care of patients.

D. Application of Criteria.--The following discussion illustrates the application of the above guidelines to the more common modalities and procedures used in the treatment of psychiatric patients; and some factors to consider in determining whether the coverage criteria are met.

1. Covered Services.--Services generally covered for the treatment of psychiatric patients are:

a. Individual and group therapy with physicians, psychologists or other mental health professionals authorized by the State.

b. Occupational therapy services are covered if they meet the criteria in §3101.9. The services must require the skills of a qualified occupational therapist, and be performed by or under the supervision of a qualified occupational therapist or by an occupational therapy assistant.

c. Services of social workers, trained psychiatric nurses and other staff trained to work with psychiatric patients.

d. Drugs and biologicals furnished to outpatients for therapeutic purposes, but only if they are of a type which cannot be self-administered. (See §3112.4B.)

e. Activity therapies but only those that are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

f. Family counseling services. Counseling services with members of the household are covered only where the primary purpose of such counseling is the treatment of the patient's condition. (See Coverage Issues Manual §35-14.)

g. Patient education programs, but only where the educational activities are closely related to the care and treatment of the patient. (See Coverage Issues Manual §80-1.)

h. Diagnostic services for the purpose of diagnosing those individuals for whom an extended or direct observation is necessary to determine functioning and interactions, to identify problem areas, and to formulate a treatment plan.

2. Noncovered Services.--The following are generally not covered except as indicated:

a. Meals and transportation.

b. Activity therapies, group activities or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

"Geriatric day care" programs are available in both medical and nonmedical settings. They provide social and recreational activities to older individuals who need some supervision during the day while other family members are away from home. Such programs are not covered since they are not considered reasonable and necessary for a diagnosed psychiatric disorder, nor do such programs routinely have physician involvement.

c. Psychosocial programs. These are generally community support groups in nonmedical settings for chronically mentally ill persons for the purpose of social interaction. Partial hospitalization programs may include some psychosocial components; and to the extent these components are not primarily for social or recreational purposes, they would be covered. However, if an individual's outpatient hospital program consists entirely of psychosocial activities, it would not be covered.

d. Vocational training. While occupational therapy may include vocational and prevocational assessment and training, when the services are related solely to specific employment opportunities, work skills or work settings, they are not covered. (See §3109.9B.)

3. Frequency and Duration of Services.--There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment; among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with his/her individualized treatment plan, and the frequency of services is within accepted norms of medical practice, coverage should be continued.

If a patient reaches a point in his/her treatment where further improvement does not appear to be indicated, evaluate the case in terms of the criteria discussed in §3112.7B.3 to determine whether with continued treatment there is a reasonable expectation of improvement.

3112.8 Outpatient Observation Services.--Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. Observation services usually do not exceed 24 hours. However, there is no hourly limit on the extent to which they may be used.

NOTE: Observation services may exceed 24 hours in some cases. They are not explicitly limited in duration by this instruction. However, hospitals are not expected to substitute outpatient observation services for medically appropriate inpatient admissions. (See §3101 regarding coverage of inpatient admissions.)

The following types of services are not covered as observation services:

o Services which are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient or a physician.

o Services which are covered under Part A or as part of another Part B benefit, such as services which are defined as facility services and subject to the ambulatory surgical center (ASC) payment rates or, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovering afterwards.

The following examples illustrate the application of this policy, including example 4, when a decision to admit the patient is clearly justified.

EXAMPLE 1: A patient comes to the emergency room complaining of difficulty in breathing. The patient is seen by the physician on duty, who orders laboratory tests, including a blood gas analysis, and an injection to help the patient breathe more easily. The physician then has the patient placed in an outpatient observation unit to determine whether this intervention produces normal breathing. Six hours later the patient is again seen by the physician, who determines from the patient's chart and his own observation that the patient's vital signs are normal and the patient has resumed normal breathing. The patient is released. Under these circumstances, the outpatient observation services are covered, and the bill submitted by the hospital may include charges for those services.

EXAMPLE 2: A patient comes to a hospital's outpatient department to undergo a scheduled surgical procedure which is not a covered ASC surgical procedure. After surgery, the patient is taken to the recovery room, where he exhibits difficulty in awakening from anesthesia and an elevated blood pressure. These conditions persist, and the patient is seen by a physician, who has him placed on observation. The physician leaves orders for the nursing staff to monitor the patient's condition and note any continued abnormalities that could indicate a drug reaction or other post-surgical complications. After a few hours, the patient no longer is lethargic, has a normal blood pressure and shows no other signs of post-surgical complications. The physician, upon being advised of these conditions, orders the patient released from the hospital. Under these circumstances, coverage of outpatient observation services begins when the patient was placed in the observation bed. Services received in the hospital's outpatient surgical suite and recovery room cannot be covered as observation services, since they are otherwise covered under Part B.

EXAMPLE 3: A patient is scheduled to have an uncomplicated cataract extraction on an outpatient basis. The patient expresses a preference for spending the night following the procedure at the hospital despite the fact that the procedure does not require an overnight stay. The hospital may register and treat the patient on an outpatient basis and permit the patient to remain at the hospital overnight. The overnight stay cannot be covered as observation services because it is not medically necessary. (When this is the case, the patient must be notified that the overnight stay is not medically necessary and may be charged for the additional services. If unforeseen complications necessitate inpatient admission, the patient is admitted and a Part A claim is submitted.)

EXAMPLE 4: A patient comes to the emergency room in the evening with complaints of sudden severe flank pain which radiates to the inner thigh, nausea, vomiting, and urinary frequency and urgency. Examination reveals soreness over the kidney area, spasm of the abdominal muscles and microscopic hematuria. Additionally, an X-ray reveals the presence of a stone in the ureter. The patient was admitted to the hospital as an inpatient at 11 P.M. He is treated with I.V. fluids, IM Morphine and an antispasmodic every 4 hours. Further diagnostic studies were scheduled for the following morning. During the night the patient passed a stone through the urethra without complications. The patient was then comfortable without nausea or urinary symptoms. Therefore, the patient was discharged at 9 a.m. and scheduled for follow-up in the physician's office. Although the patient was able to be discharged in less than 24 hours, the admission was appropriate, because it was reasonable to expect at the time of admission that the presenting problem would require more than 24 hours to resolve.

3113. RENTAL AND PURCHASE OF DURABLE MEDICAL EQUIPMENT

A participating provider of service may be reimbursed under Part B on a reasonable cost basis for durable medical equipment which it rents or sells to a beneficiary for use in his home if the following three requirements are met:

A. The equipment meets the definition of durable medical equipment (§ 3113.1); and

B. The equipment is necessary and reasonable for the treatment of the patient's illness or injury or to improve the functioning of his malformed body member (§ 3113.2); and

C. The equipment is used in the patient's home (§ 3113.6).

Payment may also be made under this provision for repairs, maintenance, and delivery of equipment as well as for expendable and nonreusable items essential to the effective use of the equipment subject to the conditions in § 3113.3.

See § 3643 and its appendix for coverage guidelines and screening list of durable medical equipment. See Coverage Issues Appendix, 60-1, for hemodialysis equipment and supplies.

3113.1 Definition of Durable Medical Equipment.--For purposes of coverage under Part B, durable medical equipment is equipment which (1) can withstand repeated use, and (2) is primarily and customarily used to serve a medical purpose, and (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment.

A. Durability.--An item is considered durable if it can withstand repeated use; i.e., the type of item which could normally be rented. Medical supplies of an expendable nature such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical face masks, irrigating kits, sheets and bags are not considered "durable" within the meaning of the definition. There are other items which, although durable in nature, may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs, and eyes.

B. Medical Equipment.--Medical equipment is equipment which is primarily and customarily used for medical purposes and is not generally useful in the absence of illness or injury. In most instances, no development will be needed to determine whether a specific item of equipment is medical in nature. However, some cases will require development to determine whether the item constitutes medical equipment. This development would include the advice of local medical organizations (hospitals, medical schools, medical societies) and specialists in the field of physical medicine and rehabilitation. If the equipment is new on the market, it may be necessary, prior to seeking professional advice, to obtain information from the supplier or manufacturer explaining the design, purpose, effectiveness and method of using the equipment in the home as well as the results of any tests or clinical studies that have been conducted.

1. Equipment Presumptively Medical.--Items such as hospital beds, wheelchairs, hemodialysis equipment, iron lungs, respirators, intermittent positive pressure breathing machines, medical regulators, oxygen tents, crutches, canes, trapeze bars, walkers, inhalators, nebulizers, commodes, suction machines and traction equipment presumptively constitute medical equipment. (Although hemodialysis equipment is a prosthetic device (§ 3110.4), it also meets the definition of durable medical equipment, and reimbursement for the rental or purchase of such equipment for use in the beneficiary's home will be made only under the provisions for payment applicable to durable medical equipment. See 60-1 and 60-2 of the Coverage Issues Appendix for coverage of hemodialysis in the home.)

NOTE: There is a wide variety in types of respirators and suction machines. Intermediary's medical staff should determine whether the apparatus specified in the claim is appropriate for home use.

2. Equipment Presumptively Nonmedical.--Equipment which is primarily and customarily used for a nonmedical purpose may not be considered "medical" equipment for which payment can be made under the medical insurance program. This is true even though the item has some remote medically related use. For example, in the case of a cardiac patient, an air conditioner might possibly be used to lower room temperature to reduce fluid loss in the patient and to restore an environment conducive to maintenance of the proper fluid balance. Nevertheless, because the primary and customary use of an air conditioner is a nonmedical one, the air conditioner cannot be deemed to be medical equipment for which payment can be made.

Other devices and equipment used for environmental control or to enhance the environmental setting in which the beneficiary is placed are not considered covered durable medical equipment. These include, for example, room heaters, humidifiers, dehumidifiers, and electric air cleaners. Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the patient, such as elevators, stairway elevators, and posture chairs, do not constitute medical equipment. Similarly, physical fitness equipment, e.g., an exercycle; first-aid or precautionary-type equipment, e.g., preset portable oxygen units; self-help devices, e.g., safety grab bars; and training equipment, e.g., speech teaching machines and braille training texts, are considered nonmedical in nature.

3. Special Exception Items.--Specified items of equipment may be covered under certain conditions even though they do not meet the definition of durable medical equipment because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:

a. Gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who has bed sores or there is medical evidence indicating that he is highly susceptible to such ulceration; and

b. Heat lamps for a medical rather than a soothing or cosmetic purpose, e.g., where the need for heat therapy has been established.

In establishing medical necessity (§ 3113.2) for the above items, the evidence must show that the item is included in the physician's course of treatment and a physician is supervising its use. (See also Appendix to § 3643.)

Note: The above items represent special exceptions and no extension of coverage to other items should be inferred.

3113.2 Necessary and Reasonable.—Although an item may be classified as durable medical equipment, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member. These considerations will bar payment for equipment which cannot reasonably be expected to perform a therapeutic function in an individual case or will permit only partial payment when the type of equipment furnished substantially exceeds that required for the treatment of the illness or injury involved.

A. Necessity for the Equipment.--Equipment is necessary when it can be expected to make a meaningful contribution to the treatment of the patient's illness or injury or to the improvement of his malformed body member. In most cases the physician's prescription for the equipment and other medical information available to the intermediary will be sufficient to establish that the equipment serves this purpose.

B. Reasonableness of the Equipment.--Even though an item of durable medical equipment may serve a useful medical purpose, the intermediary must also consider to what extent, if any, it would be reasonable for the Medicare program to pay for the item prescribed. The following considerations should enter into the determination of reasonableness:

1. Would the expense of the item to the program be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the equipment?

2. Is the item substantially more costly than a medically appropriate and realistically feasible alternative pattern of care?

3. Does the item serve essentially the same purpose as equipment already available to the beneficiary?

Claims for payment for the relatively few billed items of equipment found to be out of line with tests of "reasonableness" should be denied in full except in the following case: Where it is determined that there exists a medically appropriate and realistically feasible alternative pattern of care for which payment could be made, payment should be based on the reasonable charge for this alternative.

The following example points up the need to take account of the reasonableness of the services rendered.

EXAMPLE: The median price of standard whirlpool bath equipment is about $600 plus plumbing expenses necessary to install it in the patient's home. Program coverage of such equipment in the patient's home should be limited to those cases where it is prescribed for conditions where the whirlpool bath can be expected to provide a substantial therapeutic benefit justifying its cost. For example, bursitis or chronic osteoarthritis would not generally justify Medicare payment for whirlpool bath equipment in the home since it would not be reasonable to expect that a whirlpool bath would be significantly more beneficial than a normal warm bath. Moreover, where the patient is not homebound, payment for this item in the patient's home should be restricted to the cost of providing the service elsewhere, e.g., an outpatient department of a participating hospital, if that alternative is less costly.

C. Payment Consistent With What is Necessary and Reasonable.—Where a claim is filed for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition or where there exists a reasonably feasible and medically appropriate alternative pattern of care which is less costly than the equipment furnished, the amount payable is based on the reasonable costs for the equipment or alternative treatment which meets the patient's medical needs.

The provider may not charge the beneficiary for features not medically required by his condition and which cannot be considered in determining the provider's allowable costs unless the beneficiary or his representative has specifically requested the excessive or deluxe items or services with knowledge of the amount he is to be charged.

3113.3 Repairs, Maintenance, Replacement, and Delivery.-- Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically required durable medical equipment which the beneficiary owns or is purchasing, including equipment which had been in use before the user enrolled in Part B. Since renters of equipment usually recover from the rental charge the expenses they incur with respect to maintaining in working order the equipment they rent out, separately itemized charges for repair, maintenance, and replacement of rented equipment are not covered.

A. Repairs.-- Repairs to equipment which a beneficiary is purchasing or already owns are covered when necessary to make the equipment serviceable. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess. (See C below where claims for repairs suggest malicious damage or culpable neglect.)

B. Maintenance.-- Routine periodic servicing, such as testing, cleaning, regulating and checking of the beneficiary's equipment is not covered. Such routine maintenance is generally expected to be done by the owner rather than by a retailer or some other person who would charge the beneficiary. Normally, purchasers of durable medical equipment are given operating manuals which describe the type of servicing an owner may perform to properly maintain the equipment. Thus, hiring a third party to do such work would be for the convenience of the beneficiary and would not be covered.

However, more extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, would be covered as repairs. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary.

C. Replacement.-- Replacement of equipment which the beneficiary owns or is purchasing is covered in cases of loss or irreparable damage or wear and when required because of a change in the patient's condition Expenses for replacement required because of loss or irreparable damage may be reimbursed without a physician's order when in the judgment of the intermediary the equipment as originally ordered, considering the age of the order, would still fill the patient's medical needs. However, claims involving replacement equipment necessitated because of wear or a change in the patient's condition should be supported by a current physician's order. (See § 3152D in regard to payment for equipment replaced under a warranty).

Cases suggesting malicious damage, culpable neglect or wrongful disposition of equipment as discussed in § 3113.5 should be investigated and denied where the intermediary determines that it would be unreasonable to make program payment under the circumstances. The intermediary should refer such cases to the program integrity specialist in the RO.

D. Delivery.-- Reasonable costs for delivery of durable medical equipment whether rented or purchased are covered if the provider customarily makes separate charges for delivery and this is a common practice among the other local providers.

3113.4 Coverage of Supplies and Accessories.-- Reimbursement may be made for supplies, e.g., oxygen, that are necessary for the effective use of durable medical equipment. Such supplies include those drugs and biologicals which must be put directly into the equipment in order to achieve the therapeutic benefit of the durable medical equipment or to assure the proper functioning of the equipment, e.g., tumor chemotherapy agents used with an infusion pump or heparin used with a home dialysis system. However, the coverage of such drugs or biologicals does not preclude the need for a determination that the drug or biological itself is reasonable and necessary for treatment of the illness or injury or to improve the functioning of a malformed body member.

Reimbursement may be made for replacement of essential accessories such as hoses, tubes, mouth pieces, etc., for necessary durable medical equipment, only if the beneficiary owns or is purchasing the equipment.

3113.5 Miscellaneous Issues Included in the Coverage of Equipment.-- Payment can be made for the purchase of durable medical equipment even though rental payments may have been made for prior months. This could occur where, because of a change in his condition, the beneficiary feels that it would be to his advantage to purchase the equipment rather than to continue to rent it. When such a situation occurs, the provider may deduct all or part of the rentals paid from the purchase price of the equipment.

A beneficiary may sell or otherwise dispose of equipment for which he has no further use, for example, because of recovery from the illness or injury which gave rise to the need for the equipment. (There is no authority for the program to repossess the equipment.) If after such disposal there is again medical need for similar equipment, payment can be made for the rental or purchase of that equipment.

However, where an arrangement is motivated solely by a desire to create artificial expenses to be met by Medicare and to realize a profit thereby, such expenses would not be covered under Medicare. The resolution of questions involving the disposition and subsequent acquisition of durable medical equipment must be made on a case-by-case basis.

Cases where it appears that there has been an attempt to create an artificial expense and realize a profit thereby should be developed and when appropriate denied by the intermediary. After adjudication the intermediary should refer such cases to the program integrity specialist in the RO.

When payments stop because the beneficiary's condition has changed and the equipment is no longer medically necessary, he is responsible for the remaining noncovered charges. Similarly, when payments stop because the beneficiary dies, his estate is responsible for the remaining noncovered charges.

NOTE: Intermediaries should not get involved in issues relating to ownership or title of propertly.

3113.6 Definition of Beneficiary's Home.--For purposes of rental and purchase of durable medical equipment, a beneficiary's home may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a beneficiary's home if it:

A. Meets at least the basic requirement in the definition of a hospital (§ 3010A), i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

B. Meets at least the basic requirement in the definition of a skilled nursing facility (§ 3020), i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described in A or B above, he is not entitled to have payment made for rental or purchase of durable medical equipment since such an institution may not be considered his home. (See § 3113.7B when beneficiary is in an institution for part of a month.)

3113.7 Payment for Durable Medical Equipment.—

A. The Decision to Rent or Purchase.—A beneficiary may elect to rent an item of equipment rather than purchase it even though it may appear that purchase would be more economical for the program. However, the intermediary will determine in accordance with the guidelines below the method of payment to be used by the program in making reimbursement for equipment that is purchased. In both rental and purchase on a periodic payment basis, the monthly amount payable to the provider is converted to estimated costs by using the established outpatient cost reimbursement rate. (See § 3615 for interim reimbursement procedures.)

1. Rental Payments.--Where a provider rents durable medical equipment to a beneficiary, the provider will be reimbursed 80 percent of the reasonable cost of making the equipment available, less any unmet deductible. The provider must submit an HCFA-1483 for each month's rental charge. The patient is responsible to the provider for any unmet deductible and the monthly coinsurance.

2. Purchase of Equipment.--When equipment is purchased, the intermediary determines in accordance with the following guidelines whether program payment is to be made in a lump sum or in periodic payments.

a. Lump-Sum Payment for Inexpensive Equipment.—Payment for inexpensive equipment will be made in a lump sum subject to the deductible and coinsurance when it is determined to be less costly or more practical to do so. Inexpensive equipment is any item of durable medical equipment for which the reasonable charge is $50 or less. A presumption should be made that it is less costly and more practical to pay a lump sum for inexpensive equipment. However, this presumption would not apply where the estimated period of medical need is relatively short. For example, a walkerette (purchase price $47.50) rents for $5 a month. If the physician estimates that the item would be needed 4 months, it would be less costly to make four periodic payments than to pay a lump-sum amount based on the reasonable purchase price.

Where an intermediary has decided to make payment for inexpensive equipment on a periodic basis, it may in its discretion combine the periodic payments and pay a single amount at the time of initial adjudication, e.g., where the estimated period of medical necessity is only 2 months. Certain equipment will be so inexpensive that it would never be administratively less costly or more practical to pay for it on a periodic basis, e.g., a cane.

b. Periodic Payment.--Where payment is not made in a lump sum, benefits will be paid in monthly installments equivalent to the payment that would have been made had the equipment been rented. However, periodic payments may be made only for the established period of medical necessity for the item or until the total program payments to the provider equal 80 percent of the estimated cost of the item, whichever comes first. The periodic payments are subject to the deductible and coinsurance provisions. While periodic payments will be made on a monthly basis, a single payment can be made for periodic payments which have accrued. (See § 3642 for additional guidelines on periodic payments.)

B. Incurred Expenses for Durable Medical Equipment.--The first month's expense for the rental of durable medical equipment is incurred as of the date of delivery of the equipment for purposes of crediting the deductible and reimbursement. Expenses for subsequent months are incurred on the same day of the month. Where equipment is purchased, the periodic monthly benefits will be payable on the same basis. Providers may submit claims as of the date expenses are incurred. If the date of delivery is not specified on the bill, the intermediary should assume, in the absence of evidence to the contrary, that the date of purchase was the date of delivery.

Example: In 8/77, Mr. Thomas, a paraplegic whose SMI coverage began on 1/1/77, signed an agreement to purchase a wheelchair for $200. The wheelchair was delivered to him on 9/8/77, and he immediately submitted his claim and an itemized bill to the intermediary. The reasonable rental charge is $20 a month. Since he had no other covered Part B expenses during the year, periodic payments for 9/77, 10/77, and 11/77 are withheld to satisfy the deductible. The first installment would become payable on 12/8/77. Since $40 of the deductible was met in the last quarter of 1977, only payment for 1/78 would need to be withheld to satisfy the deductible for 1978. Periodic payments would resume 2/8/78.

Except for the 3-month tolerance rule for ESRD DME in § 3113.7E, no payment may be made for the rental or purchase of DME for any month throughout which the patient is in an institution which does not qualify as his or her home (see § 3113.6) or is outside the U.S. (See § 3154.) If the patient is at home for part of a month and, for part of the same month is in an institution which cannot qualify as his or her home, or is outside the U.S., rental or purchase payments may be made for the entire month. Similarly, if an item of rental DME is returned to the provider before the end of a payment month because the beneficiary died in that month or because the equipment became unnecessary in that month, payment may be made for the entire month, unless the provider charged for only part of a month, or the intermediary is aware that the provider customarily follows such a practice, in which case payment is to be made on a prorated basis. If the individual is outside the U.S. for more than 30 days and then returns to the U.S., determine medical necessity as in an initial case before resuming payments.

[illegible] No Payment for Purchased [illegible] States or Before Beneficiary's Coverage [illegible]--[illegible] equipment, the beneficiary must have been in the United States and must have had SMI coverage at the time the item was delivered. Therefore, where a purchased item of durable medical equipment was delivered to an individual outside the United States or before his coverage period began, the entire expense of the item would be excluded from coverage whether it was paid for in its entirety at the time of purchase, or on a deferred or installment basis. Payment cannot be made in such cases even though the individual later uses the item inside the United States or after his coverage begins.

D. Determining Months for Which Periodic Payments May be Made for Purchased Equipment Used in an Institution.--If a patient uses purchased equipment in an institution which does not qualify as his or her home, the rules for determining months for which periodic payments may be made are as follows:

1. The use months during which the beneficiary was institutionalized are not covered but are charged as periodic payment months determined per § A.2.b. above. Only those remaining installments (if any) attributable to months during all or part of which the patient was in his home may be considered covered for purposes of crediting the deductible and for reimbursement. The following situation illustrates the application of this policy.

Example: On February 1, while confined to a participating skilled nursing facility, Mr. Smith who had already met his deductible purchased a wheelchair for which the reasonable charge is $150 and the reasonable rental charge is $15 per month. He remained in the facility until June 10, when he was discharged to his home. The intermediary determines that 10 monthly installments of $12 each (80 percent of $15) would ordinarily be paid beginnning with the month of February. Since Mr. Smith was institutionalized February through May, no payments can be made for those months. However, the payments at $12 each for the remaining 6 months, June through November, would be made if medical need continued throughout this period.

2. A different rule applies where equipment is purchased by a patient for use in his home and he is subsequently admitted to a hospital which meets the requirements in § 3010A or an SNF which meets the requirements in § 3020a. (See § 3113.6 for definition of the beneficiary's home.) In this case, payments should be simply suspended. Upon return of the patient to his home, payments should resume without loss of monthly installments because of the institutionalization. Assuming the deductible is met, payments would continue as long as the equipment is medically necessary or until 80 percent of the reasonable purchase price has been reimbursed, whichever occurs first. The following example illustrates the application of this policy.

Example: Mrs. Jones, [illegible] wheelchair on February 1, which she used in her home until her admission to the hospital on April 15. She was discharged from the hospital to her home on June 15 and continued to need the wheelchair. The reasonable charge for the wheelchair was $150 and the reasonable rental charge was $15 per month. The intermediary scheduled 10 monthly payments of $12 each (80 percent of $15) and payment was made for February, March, and April. Since Mrs. Jones was hospitalized for the entire month of May, the fourth installment is suspended. This installment would become the June payment, and payments would continue through December rather than November, as originally scheduled.

(See §§ 3154ff. where purchased or rented durable medical equipment involves a beneficiary outside the United States.)

E. Establishing the Period of Medical Necessity.--Generally, the period of time an item of durable medical equipment will be considered to be medically necessary should be based on the physician's estimate of the time that his patient will need the equipment. (See §§ 3640.6, Item 13, and 3642 for the information which the physician must give the provider and which the provider must include in Item 13 of form HCFA-1483.)

Where additional information is required regarding medical necessity or the period of medical necessity, request the provider to obtain this information form the patient's physician. In some cases, development to obtain a physician 's estimate will not be necessary, e.g., in the case of certain items of "inexpensive equipment" development may not be practical. In other cases, the intermediary may already have sufficient information for a reasonable judgement as to the period of medical necessity, e.g., when a paraplegic either rents or purchases a wheelchair it can generally be assumed that he will need the equipment for the rest of his life. A similar assumption can be made about breathing assistance apparatus required for a beneficiary with advanced pulmonary emphysema. Where there is a question, resolve in favor of development.

When the physician estimates that the patient will need an item of durable medical equipment "indefinitely," or the intermediary, on the basis of all the evidence available, has estimated that the period of medical necessity will be more than 6 months, a reevaluation of medical necessity should be made no later than the sixth month for which reimbursement is made. Usually payments in such cases should not be stopped pending receipt of information or a reevaluation of the case, unless there is a strong indication that medical need for the equipment no longer exists. If other records do not reflect a continuing medical need for the equipment, obtain additional information on the medical necessity question. Subsequent reevaluation must be made at intervals of not more than 6 months.

The period of medical necessity for home dialysis equipment will generally be "indefinite." The nature of the patient's condition is such that there may be periods of temporary non-use of equipment. Several situations which may occur causing temporary non-use of equipment are:

a. Beneficiary requires in-facility treatment either for restabilization or as a result of some acute condition but there is expectation that he will return to home dialysis.

b. Beneficiary temporarily is without a suitable home dialysis assistant.

c. Beneficiary is temporarily away from home but expects to return.

d. Beneficiary is a transplant candidate and is taken off home dialysis preparatory to transplant. (If the transplant cannot occur, or if the transplant is not successful, the patient will very likely resume home dialysis and an evaluation can be made whether it will be within the immediate or foreseeable future.)

Under such circumstances intermediaries may determine that medical necessity exists and pay for a period of up to three months after the month the home dialysis equipment was last used. This instruction does not eliminate the necessity for periodic reevaluation of medical necessity but rather is intended to provide a tolerance to avoid frequent reevaluation in renal dialysis situations and provide for continuity of payments, where this is economically advantageous.

3114. AMBULANCE SERVICE

Ambulance service is covered only under Part B. The cost of oxygen and its administration in connection with and as part of the ambulance service is also covered. (See § 3322 for the required certification for ambulance service.)

The Part A intermediary is responsible for the processing of claims for ambulance service furnished by participating hospitals, extended care facilities and home health agencies and has the responsibility to determine the compliance of the provider's ambulance and crew. Where a provider furnishes ambulance service "under arrangements" with a supplier of ambulance services, such services can be covered only if the supplier's vehicles and crew meet the requirements discussed in 1. and 2. below. Where the "under arrangement" supplier also supplies ambulance services to other patients, i.e., nonprovider related patients, contact the Part B carrier to ascertain whether it has already determined whether the crew and ambulance requirements are met. In such a situation, the intermediary should accept the carrier's determination without pursuing its own investigation.

A. Vehicle and Crew Requirements.--

1. Vehicle.--The vehicle must be a specially designed and equipped automobile or other vehicle (in come areas of the United States this might be a boat or plane) for transporting the sick or injured. It must have customary patient care equipment including a stretcher, clean linens, first aid supplies, oxygen equipment, and it must also have such other safety and lifesaving equipment as is required by State or local authorities.

2. Crew.-- The ambulance crew must consist of a least two members. Those crew members charged with the care or handling of the patient must include one individual with adequate first aid training; i.e., training at least equivalent to that provided by the standard and advanced Red Cross first aid courses. Training "equivalent" to the standard and advanced Red Cross first aid training courses includes ambulance service training and experience acquired in military service, successful completion by the individual of a comparable first aid course furnished by or under the sponsorship of State or local authorities, an educational institution, a fire department, a hospital, a professional organization, or other such qualified organization. On-the-job training involving the administration of first aid under the supervision of or in conjunction with trained first aid personnel for a period of time sufficient to assure the trainee's proficiency in handling the wide range of patient care services that may have to be performed by a qualified attendant can also be considered as "equivalent training."

3. Equipment and Supplies.--As mentioned above, the ambulance must have customary patient care equipment and first aid supplies. Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the general ambulance service and would be included in the cost of the trip. On the other hand, a separate cost based on actual quantities used may be recognized for nonreusable items and disposable supplies such as oxygen, gauze and dressings required in the care of the patient during his trip.

B. Necessity and Reasonableness.--To be covered, ambulance service must be medically necessary and reasonable.

1. Necessity for the Service.—Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case, in which some means of transportation other than an ambulance could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.

2. Reasonableness of the Ambulance Trip.--A claim may be denied on the ground that the use of ambulance service was unreasonable in the treatment of the illness or injury involved (§ 3151) notwithstanding the fact that the patient's condition may have contraindicated the use of other means of transportation. The intermediary should use discretion when applying this principle. It is expected that generally its application will be limited to those instances where a supplier or provider repeatedly demonstrates a pattern of uneconomical practice and to those individual claims where the excess cost is large.

C. The Destination.--As a general rule, only local transportation by ambulance is covered. This means that the patient must have been transported to an institution (i.e., a hospital or a skilled nursing facility) whose locality (see paragraph 4 below) encompasses the place where the ambulance transportation of the patient began and which would ordinarily be expected to have the appropriate facilities for the treatment of the injury or illness involved. In exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported,. full payment may be made for such services only if the evidence clearly establishes that such institution is the nearest one with appropriate facilities (see paragraph 5 below).

The institution to which a patient is transported need not be a participating institution, but must meet at least the requirements of § 3010A. (in the case of a hospital) or § 3020a (in the case of a nursing facility).

A claim for ambulance service to a participating hospital or extended care facility should not be denied on the grounds that there is a nearer nonparticipating institution having appropriate facilities.

1. Institution to Beneficiary's Home.—Ambulance service from an institution to the beneficiary's home is covered when his home is within the locality of such institution or where the beneficiary's home is outside of the locality of such institution and the institution in relation to his home is the nearest one with appropriate facilities.

2. Institution to Institution.—Occasionally, the institution to which the patient is initially taken is found to have inadequate facilities for treating him and he is then transported to a second institution having

appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered provided the institution to which he is being transferred is determined to be the nearest one with appropriate facilities. In these cases, transportation from such second institution to the patient's home could be covered if his home is within the locality serviced by that institution or by the first institution to which he was taken.

3. Round-Trip for Specialized Services.--(Effective with services furnished on or after March 15, 1978.) Round-trip ambulance services are covered if a hospital inpatient goes to another hospital to obtain necessary specialized diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) and the following requirements are met:

a. The patient's condition is such that use of any other method of transportation is contraindicated (§ 3114.B1);

b. The services are not available in the hospital in which the individual is an inpatient; and

c. The hospital furnishing the services is the nearest one with such facilities.

Perform a periodic postpayment review with appropriate medical staff assistance to determine whether the frequency of such ambulance services for a particular patient together with his medical condition indicates that transfer to the second hospital is the preferred medical course. Do not request such a transfer, but deny such ambulance services claims in the future.

4. Partial Payment.--(See § 3647.2 for partial reimbursement guidelines for otherwise covered ambulance service which exceeded the limits defined in C, C1, and C2 above.)

5. Locality.--The term "locality" with respect to ambulance service means the service area surrounding the institution from which individuals normally come or are expected to come for hospital or skilled nursing services.

Example: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community but they regularly provide hospital services to the community's residents. The community is within the "locality" of the metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

6. Appropriate Facilities.--The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. It is the institution, its equipment, its personnel and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities.

Example: Mr. A becomes ill at home and requires ambulance service to the hospital. The hospitals servicing the community in which he lives are capable of providing general hospital care. However, Mr. A requires immediate kidney dialysis but the needed equipment is not available in any of these hospitals. The service area of the nearest hospital having dialysis equipment does not encompass the patient's home. Nevertheless, in this case, ambulance service beyond the locality to the hospital with the equipment would be covered since it is the nearest one with appropriate facilities.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." However, a legal impediment barring a patient's admission would permit a finding that the institution did not have "appropriate facilities." For example, the nearest tuberculosis hospital may be in another State and that State's law precludes admission of nonresidents.

An institution is not considered an appropriate facility if there is no bed available. The intermediary, however, will presume that there are beds available at the local institutions unless evidence is furnished that none of these institutions had a bed available at the time the ambulance service was provided.

The individual physician who practices in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or a physician in a specific specialty does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

7. Ambulance Service to a Physician's Office Is Not Covered.--There may be situations, however, where in the course of transporting a patient to a hospital, the ambulance stops at a physician's office because of the patient's dire need for professional attention and immediately thereafter the ambulance continues the trip to the hospital. In such cases, the patient will be deemed not to have been transported to the physician's office and payment may be made for the entire trip.

8. Transportation Requested by a Home Health Agency.--Where a home health agency finds it necessary to have a beneficiary transported by ambulance to a hospital or skilled nursing facility to obtain home health services not otherwise available to the individual, the trip is covered as a Part B service only if the above coverage requirements are met. Such transportation is not covered as a home health service.

9. Coverage of Ambulance Service Furnished a Deceased Beneficiary.--An individual is considered to have expired as of the time he is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician. Therefore, if the beneficiary was pronounced dead by a legally authorized individual before the ambulance was called, no program payment may be made. Where the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to the point of pickup is covered. If otherwise covered ambulance services were furnished to a beneficiary who was pronounced dead while enroute to or upon arrival at the destination, the entire ambulance service is covered.

10. Ambulance Transportation to a Renal Dialysis Facility Located on the Premises of a Hospital.--A renal dialysis facility may be approved to participate in the end-stage renal disease program as a part of a hospital or as a nonprovider. Where the facility has been approved as a part of a hospital, it meets the destination requirements of an institution. Even where the facility has been approved as a nonprovider, it may be determined to meet the destination requirements for purposes of ambulance service coverage under the following circumstances:

a. The renal dialysis facility is located on or adjacent to the premises of a hospital;

b. The renal dialysis facility furnishes services to patients of the hospital, referred to in a. above, e.g., on an outpatient or emergency basis, even though the dialysis facility is primarily in operation to furnish dialysis services to its own patients; and

c. There is an ongoing professional relationship between the two facilities. For example, the hospital and the renal dialysis facility have an agreement that provides for physician staff of the renal dialysis facility to abide by the by-laws and regulations of the hospital's medical staff.

A prior determination that the renal dialysis facility is a nonprovider for approval purposes should not be reopened or changed, even though it is found to be sufficiently related to the hospital to meet the destination requirement for ambulance service coverage, unless there has been a significant change in the relationship between the hospital and the renal dialysis facility since the facility's certification.

A beneficiary receiving maintenance dialysis on an outpatient basis is not ordinarily ill enough to require ambulance transportation for dialysis treatment. This would be so whether the renal dialysis facility is an independent enterprise or part of a hospital. Thus, if a claim for ambulance service furnished to a maintenance dialysis patient does not show that the patient's condition requires ambulance service, it should be disallowed. However, if the documentation submitted with the claim shows that ambulance service is required, then determine whether the dialysis facility meets the destination requirements under the ambulance service benefit described above.

11. Air Ambulance Service.--In some areas, transportation by airplane might qualify as ambulance service. Air ambulance services are covered only where:

a. The point of pickup is inaccessible by land vehicle; or

b. Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities and speedy admission is essential, i.e., in cases where transportation by land ambulance is contraindicated; and

c. All other conditions for coverage in §§ 3114ff. are met. The first two conditions could be met in places such as Hawaii, Alaska, and in other remote or sparsely populated areas of the continental United States. Air ambulance service can be covered in the relatively rare instances where the beneficiary's condition and the other circumstances of the case necessitated the use of this type transportation. However, where land ambulance service would have sufficed, payment should be based on the amount payable for land ambulance if this is less costly.

3115 SERVICES OF INTERNS AND RESIDENTS

A. General.--For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools. Where a senior resident has a staff or faculty appointment or is designated, for example, a "fellow," it does not change the resident's status for the purposes of Medicare coverage and reimbursement. As a general rule, services of interns and residents are paid as provider services by the intermediary.

B. Services Furnished by Interns and Residents Within the Scope of an Approved Training Program.--Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services. Effective with services furnished on or after July 1, 1987, this includes services furnished in a setting which is not part of the provider where a hospital has agreed to incur all or substantially all of the costs of training in the nonprovider facility. You are required to notify the Medicare carrier of such agreements. Where the provider does not incur all or substantially all of the training costs and the services are performed by a licensed physician, the services are reimbursable on a reasonable charge basis by the carrier. Prior to July 1, 1987, the covered services of interns and residents were reimbursed by the carrier on a reasonable charge basis as physician services if furnished by a licensed physician off the provider premises regardless of who incurred the training costs.

C. Services Furnished by Interns and Residents Outside the Scope of an Approved Training Program--Moonlighting.--Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed outside the facility where they have their training program, are covered as physicians' services and paid on a reasonable charge basis where the requirements in 1 and 2, below, are met. Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed in an outpatient department or emergency room of the hospital where they have their training program, are covered as physicians' services and paid on a reasonable charge basis where the following criteria are met:

1. the services are identifiable physicians' services, the nature of which requires performance by a physician in person and which contributes to the diagnosis or treatment of the patient's condition;

2. the intern or resident is fully licensed to practice medicine, osteopathy, dentistry or podiatry by the State in which the services are performed; and

3. the services performed can be separately identified from those services that are required as part of the training program.

When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not in their capacity as interns and residents.

Covered and Noncovered Home Health Agency Services

3116. CONDITIONS TO BE MET FOR COVERAGE OF HOME HEALTH SERVICES

Home health agency services are covered by Medicare when the following criteria are met:

- o The person to whom the services are provided is an eligible Medicare beneficiary.

- o The home health agency which is providing the services to the beneficiary has in effect a valid agreement to participate in the Medicare program.

- o The beneficiary qualifies for coverage of home health services as described in §3117.

- o The services for which payment is claimed are covered as described in §§3118 and 3119.

- o Medicare is the appropriate payer.

- o The services for which payment is claimed are not otherwise excluded from payment.

3116.1 Reasonable and Necessary Services.--

A. Background.--In enacting the Medicare program, Congress recognized that the physician would play an important role in determining utilization of services. The law requires that payment can be made only if a physician certifies the need for services and establishes a plan of care. The Secretary is responsible for ensuring that the claimed services are covered by Medicare, including determining whether they are "reasonable and necessary."

B. Determination of Coverage.--The beneficiary's health status and medical need as reflected in the home health plan of care and medical record provide the basis for determinations as to whether services provided are reasonable and necessary. A finding that services are reasonable and necessary must be based on information available in these documents, although clear inferences may be drawn from information provided in the plan of care (form HCFA 485) or in supplementary forms (forms HCFA 486, 487, 488).

A finding that care is not reasonable and necessary must be based on information provided on the forms and in the medical record with respect to the unique medical condition of the individual beneficiary. That is, a coverage denial may not be made based solely on the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but must be based upon objective clinical evidence regarding the patient's individual need for care.

Both payment and denial decisions may be based on summary information contained in the relevant HCFA data forms; however, additional information from the medical records (either via Form 488 or a copy of the medical record) must be requested when medical information needed to support a decision is not clearly present. The following examples illustrate this statement.

Examples of cases in which development of the case is needed:

EXAMPLE 1: A plan of care provides for daily skilled nursing visits for care of a pressure sore, but the description of the pressure sore and the dressing which is contained on the form causes the reviewer to question why daily skilled care is needed. The intermediary would not reduce the number of visits but would either request additional information to support the need for daily care or would request the nursing notes to determine if the beneficiary required daily skilled care.

EXAMPLE 2: A beneficiary with a diagnosis of congestive heart failure (CHF) has been hospitalized for 5 days. Posthospital skilled nursing care is ordered 3 x wk x 60 days for skilled observation, teaching of diet medication compliance and signs and symptoms of the disease. The documentation on the HCFA 485-486 shows that the patient has had CHF for 10 years with an exacerbation requiring recent hospitalization. The medications are not shown as changed or new. The clinical findings are contradictory. There is a possibility that this beneficiary requires skilled observation and teaching although the documentation does not give a clear picture of the beneficiary's needs. Therefore, the case would be developed further to determine if the criteria for coverage were met.

Examples of cases which would be denied without further development:

EXAMPLE 3: A plan of care calls for vitamin B12 injections 1 x mo x 60 days for a beneficiary who has been discharged from the hospital following a recent hip fracture. The beneficiary has generalized weakness but there is no diagnosis or clinical symptoms shown which support the Medicare requirements governing coverage of skilled nursing care for B12 injections are met. The claim would be denied without development for further information since there is no support for coverage of the skilled nursing care for the B12 injections.

EXAMPLE 4: A beneficiary has a primary diagnosis of back sprain for which he was hospitalized for 7 days. The beneficiary also has a secondary diagnosis of emphysema with an onset 2 years prior to the start of care. Following the hospitalization, the physician ordered skilled nursing 2 x wk x 4 weeks for skilled observation of vital signs and response to medication and aide services 2 x wk x 4 weeks for personal care. The documentation on the HCFA 485-486 shows that the beneficiary is up as tolerated, is able to walk

10 feet without resting and is alert. Clinical facts show normal vital signs, and no reference to emphysema. The beneficiary is on phenobarbital PO 30 mg TID. The documentation clearly does not support the medical necessity for skilled nursing care and the claim for the services would be denied without development.

Examples of cases in which payment may be made without further development:

EXAMPLE 5: A beneficiary with a diagnosis of congestive health failure has been hospitalized for five days. Post-hospital skilled nursing care is ordered 3 x wk x 60 days for skilled observation, teaching of a new diet regimen, compliance with multiple new medications, and signs and symptoms of the disease state. The documentation on the HCFA 485-486 shows the beneficiary had had an acute exacerbation of a pre-existing CHF condition which required the recent acute hospitalization. The beneficiary is discharged from the hospital with a medication regimen changed from previous medications. The HCFA forms documenting the clinical evidence of the recent acute exacerbation of the beneficiary's cardiac condition combined with changed medications support the physician's order for care. Payment may be made without further development.

EXAMPLE 6: A plan of care provides for physical therapy treatments 3 x wk x 45 days for a beneficiary who has been discharged from the hospital following a recent hip fracture. The beneficiary was discharged using a walker 7 days before the start of home care. The HCFA form 485 and supplementary form HCFA 486 shows that the beneficiary was discharged from the hospital with restricted mobility in ambulation, transfers, and climbing of stairs. The beneficiary had an unsafe gait which indicated a need for gait training and the beneficiary had not been instructed in stair climbing and a home exercise program. The goal of the physical therapy was to increase strength, range of motion and to progress from walker to cane with safe gait. Information on the relevant HCFA forms also indicates that the beneficiary had a previous functional capacity of full ambulation, mobility, and self care. The claim may be paid without further development, since there are no objective clinical factors in the medical evidence to contradict the order of the beneficiary's treating physician.

3116.2 Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services.--Where the Medicare criteria for coverage of home health services are met, beneficiaries are entitled by law to coverage of reasonable and necessary home health services.

Therefore, a beneficiary is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available in the home to furnish them. However, where a family member or other caring person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for home health agency personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the home health agency unless the beneficiary or family indicates otherwise, and objects to the provision of the services by the home health agency, or unless the home health agency has first hand knowledge to the contrary.

EXAMPLE: A beneficiary, who lives with an adult daughter and who otherwise qualifies for Medicare coverage of home health services, requires the assistance of a home health aide for bathing and assistance with an exercise program to improve endurance. The daughter is unwilling to bathe her elderly father and assist him with the exercise program. Home health aide services to provide these services would be reasonable and necessary.

Similarly, a beneficiary is entitled to have the costs of reasonable and necessary home health services reimbursed by Medicare even if the beneficiary would qualify for institutional care (e.g., hospital care or skilled nursing facility care).

EXAMPLE: A beneficiary who is being discharged from a hospital with a diagnosis of osteomyelitis and who requires continuation of the IV antibiotic therapy that was begun in the hospital was found to meet the criteria for Medicare coverage of skilled nursing facility services. If the beneficiary also meets the qualifying criteria for coverage of home health services, payment may be made for the reasonable and necessary home health services the beneficiary needs, notwithstanding the availability of coverage in a skilled nursing facility.

Medicare payment should be made for reasonable and necessary home health services where the beneficiary is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

EXAMPLE: A patient who needs skilled nursing care on an intermittent basis also hires an LPN to provide nighttime assistance while family members sleep. The care provided by the LPN, as respite to the family members, does not require the skills of a licensed nurse (as defined in §3118.1) and therefore has no impact on the beneficiary's eligibility for Medicare payment of home health services even though another third party insurer may pay for that nursing care.

3116.3 Use of Utilization Screens and "Rules of Thumb".--Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.

3117. CONDITIONS THE BENEFICIARY MUST MEET TO QUALIFY FOR COVERAGE OF HOME HEALTH SERVICES

To qualify for Medicare coverage of any home health services, the beneficiary must meet each of the criteria specified in this section. Beneficiaries who meet each of these criteria are eligible to have payment made on their behalf for services which are discussed in §§3118 and 3119.

3117.1 Confined to the Home.--

A. Patient Confined to His Home.--In order for a beneficiary to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the beneficiary is confined to his home. An individual does not have to be bedridden to be considered as confined to his home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving their homes would require a considerable and taxing effort. If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment. Absences attributable to the need to receive medical treatment include attendance at adult day centers to receive medical care, ongoing receipt of out-patient kidney dialysis, and the receipt of outpatient chemotherapy or radiation therapy. It is expected that in most instances absences from the home which occur will be for the purpose of receiving medical treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, would not necessitate a finding that the individual is not homebound so long as the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Generally speaking, a beneficiary will be considered to be homebound if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of supportive devices such as crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person or if he has a condition which is such that leaving his home is medically contraindicated. Some examples of homebound patients which are illustrative of the factors to be taken into account in determining whether a homebound condition exists would be: (1) a beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk; (2) a beneficiary who is blind or senile and requires the assistance of another person in leaving his place of residence; (3) a beneficiary who has lost the use of his upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and, therefore, requires the assistance of another individual in leaving his place of residence; (4) a patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, his actions may be restricted by his physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.; and (5) a patient with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity, and (6) a patient with a psychiatric problem if his illness is manifested in part by a refusal to leave his home environment or is of such a nature that it would not be considered safe for him to leave his home unattended, even if he has no physical limitations.

The aged person who does not often travel from his home because of feebleness and insecurity brought on by advanced age would not be considered confined to his home for purposes of receiving home health services unless he meets one of the above conditions. A patient who requires speech therapy but does not require physical therapy or nursing services must also meet one of the above conditions in order to be considered as confined to his home.

Although a patient must be confined to his home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required which cannot be made available there. If the services required by an individual involve the use of such equipment, the home health agency may make arrangements with a hospital, skilled nursing facility (SNF), or a rehabilitation center to provide these services on an outpatient basis. (See §3119.6.) However, even in these situations, for the services to be covered as home health services the patient must be considered as confined to his home; and to receive such outpatient services it may be expected that a homebound patient will generally require the use of supportive devices, special transportation, or the assistance of another person to travel to the appropriate facility.

If for any reason a question is raised as to whether an individual is confined to his home, the agency will be requested to furnish the intermediary with the information necessary to establish that the beneficiary is homebound as defined above.

B. Patient's Place of Residence.--A patient's residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if it:

1. Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

2. Meets at least the basic requirement in the definition of an extended care facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. All nursing homes that participate in Medicare and/or Medicaid as skilled nursing facilities, and most facilities that participate in Medicaid as intermediate care facilities meet this basic requirement. In addition, many nursing homes which do not choose to participate in Medicare or Medicaid meet this test. Acquire from your HCFA regional office a list of nursing facilities that cannot be considered a place of residence for the provision of home health services.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described above, he is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered his residence.

When a patient remains in a participating SNF following his discharge from active care, the facility may not be considered his residence for purposes of home health coverage.

3117.2 Services Are Provided Under a Plan of Care Established and Approved by a Physician.--

A. Content of the Plan of Care.--The plan of care must contain all pertinent diagnoses, including the beneficiary's mental status, the types of services, supplies and equipment ordered, the frequency of the visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures to protect against injury, discharge plans, and any additional items the home health agency or physician choose to include.

NOTE: This manual uses the term "plan of care" to refer to the medical treatment plan established by the treating physician with the assistance of the home health care nurse. The term we used in the past was "plan of treatment." However, the term we used in the past was changed to "plan of care" in the Omnibus Budget Reconciliation Act of 1987 (OBRA'87) without a change in definition. It is anticipated that a discipline-oriented plan of care will be established, where appropriate, by a home health agency nurse regarding nursing and home health aide services and by skilled therapists regarding specific therapy treatment. These plans of care may be incorporated within the physician's plan of care or separately prepared.

B. Specificity of Orders.--The orders on the plan of care must indicate the type of services to be provided to the beneficiary, both with respect to the professional who will provide them and with respect to the nature of the individual services, as well as the frequency of the services.

EXAMPLE: SN x 7/wk x 1 wk; 3/wk x 4 wk; 2/wk x 3 wk, (skilled nursing visits 7 times per week for 1 week; 3 times per week for 4 weeks; and two times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile change consists of . . . (detail of procedure).

Orders for care can indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided to home health beneficiaries. When a range of visits is ordered the upper limit of the range is to be considered the specific frequency.

EXAMPLE: SN x 2-4/wk x 4 wk; 1-2/wk x 4 wk for skilled observation and evaluation of the surgical site. . . .

Example of inappropriate specificity: Skilled nursing visits 3 times per week and PRN as needed. (This order is not specific because: 1) the number of weeks is not specified; 2) "PRN" is open-ended; and 3) the nature of the service is not specified.)

C. Who Signs the Plan of Care.--The physician who signs the plan of care must be qualified to sign the physician certification as described in 42 CFR 424 subpart B.

D. Timeliness of Signature.--The plan of care must be signed before the bill is submitted to the intermediary for payment.

E. Use of Verbal Orders.--

(1) Services which are provided from the beginning of the certification period and before the physician signs the plan of care are considered to be provided under a plan of care established and approved by the physician where there is a verbal order for the care prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

EXAMPLE: The HHA acquires a verbal order for venipuncture for a beneficiary to be performed on August 1. The HHA provides the venipuncture on August 1 and evaluates the beneficiary's need for continued care. The physician signs the plan of care for the venipuncture on August 15. Since the HHA had acquired a verbal order prior to the delivery of services, the visit is considered to be provided under a plan of care established and approved by the physician.

(2) Services which are provided in the subsequent certification period are considered to be provided under the subsequent plan of care where there is a verbal order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services which are provided after the expiration of a plan of care, but before the acquisition of a verbal order or a signed plan of care, cannot be considered to be provided under a plan of care.

EXAMPLE 1: The beneficiary is under a plan of care in which the physician orders venipuncture every 2 weeks. The last day covered by the initial plan of care is July 31. The beneficiary's next venipuncture is scheduled for August 5th, and the physician signs the plan of treatment for the new period on August 1st. The venipuncture on August 5th was provided under a plan of care established and approved by the physician.

EXAMPLE 2: The beneficiary is under a plan of care in which the physician orders venipuncture every 2 weeks. The last day covered by the plan of care is July 31. The beneficiary's next venipuncture is scheduled for August 5th, and the physician does not sign the plan of treatment until August 6th. The HHA acquires a verbal order for the venipuncture before the August 5th visit, and therefore the visit is considered to be provided under a plan of care established and approved by the physician.

EXAMPLE 3: The beneficiary is under a plan of care in which the physician orders venipuncture every 2 weeks. The last day covered by the plan of care is July 31. The beneficiary's next venipuncture is scheduled for August 5th, and the physician does not sign the plan of treatment until August 6th. The HHA does not acquire a verbal order for the venipuncture before the August 5th visit, and therefore the visit cannot be considered to be provided under a plan of care established and approved by the physician. The prior plan of care expired and neither a verbal order nor a signed plan of care was in effect on the date of the service. The visit is not covered.

(3) Any increase in the frequency of services or addition of new services during a certification period must be authorized by a physician by way of a verbal order or written order prior to the provision of the increased or additional services.

F. Periodic Review of the Plan of Care.--The plan of care must be reviewed and signed by a physician no less frequently than every 2 months. The physician who reviews and signs the plan of care must be qualified under 42 CFR 424 subpart B to sign the physician certification and plan of care.

3117.3 Under the Care of a Physician.--The patient must be under the care of a physician who is qualified to sign the physician certification and plan of care in accord with 42 CFR 424 subpart B.

A beneficiary is expected to be under the care of the physician who signs the plan of care and the physician certification. It is expected, but not required for coverage, that the physician who signs the plan of care will see the patient, but there is no specified interval of time within which the patient must be seen.

3117.4 Needs Skilled Nursing Care on an Intermittent Basis, or Physical Therapy or Speech Therapy or Has a Continued Need for Occupational Therapy.--The patient must need one of the following types of services:

- o Skilled nursing care which:
    - Is reasonable and necessary as defined in §3118.1 A and B, and
    - Is needed on an "intermittent" basis as defined in §3118.1C, or
- o Physical therapy as defined in §3118.2A and B, or
- o Speech therapy as defined in §3118.2A and C, or
- o Have a continuing need for occupational therapy as defined in §3118.2A and D.

The beneficiary has a continued need for occupational therapy when:

The services which the beneficiary requires meet the definition of "occupational therapy" services of §3118.2 A and D, and

The beneficiary's eligibility for home health services has been established by virtue of a prior need for skilled nursing care, speech therapy, or physical therapy in the current or prior certification period.

EXAMPLE: A beneficiary who is recovering from a CVA has an initial plan of care that called for physical therapy, speech therapy, and home health aide services. In the next certification period, the physician orders only occupational therapy and home health aide services because the beneficiary no longer needs the skills of a physical therapist or a speech therapist, but needs the services provided by the occupational therapist. The beneficiary's need for occupational therapy qualifies him or her for home health services, including home health aide services (presuming that all other qualifying criteria are met).

3117.5 Physician Certification.--The home health agency must be acting upon a physician certification which is part of the plan of care (HCFA form 485) and which meets the requirements of this section for home health agency services to be covered.

A. Content of the Physician Certification.--The physician must certify that:

1. The home health services are or were needed because the beneficiary is or was confined to his home as defined in §3117.1;

2. The beneficiary needs or needed skilled nursing services on an intermittent basis or physical therapy or speech therapy, or continues or continued to need occupational therapy after the need for skilled nursing care or physical therapy or speech therapy ceased;

3. A plan of care has been established and is periodically reviewed by a physician; and

4. The services are or were furnished while the individual is or was under the care of a physician.

B. Periodic Recertification.--The physician certification may cover a period less than but not greater than 62 days (2 months).

C. Who May Sign the Certification.--The physician who signs the certification must be permitted to do so by 42 CFR 424 subpart B.

3118. COVERAGE OF SERVICES WHICH ESTABLISH HOME HEALTH ELIGIBILITY

For any home health services to be covered by Medicare, the beneficiary must meet the qualifying criteria as specified in §3117, including having a need for skilled nursing care on an intermittent basis, physical therapy, speech therapy or a continuing need for occupational therapy as defined in this section.

3118.1 Skilled Nursing Care.--To be covered as skilled nursing services, the services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the beneficiary's illness or injury as discussed in §3118.1A and B, and must be intermittent as discussed in §3118.1C.

A. General Principles Governing Reasonable and Necessary Skilled Nursing Care.--

1. A skilled nursing service is a service which must be provided by a registered nurse, or a licensed practical nurse or a licensed vocational nurse under the supervision of a registered nurse to be safe and effective. In determining whether a service requires the skills of a nurse, consider both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice.

Some services may be classified as a skilled nursing service on the basis of complexity alone, e.g., intravenous and intramuscular injections or insertion of catheters, and if reasonable and necessary to the treatment of the beneficiary's illness or injury, would be covered on that basis. However, in some cases the condition of the beneficiary may cause a service which would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the beneficiary's condition is such that the service can be safely and effectively provided only by a skilled nurse.

EXAMPLE 1: The presence of a plaster cast on an extremity generally does not indicate a need for skilled care. However, the patient with a pre-existing peripheral vascular or circulatory condition might need skilled nursing and skilled rehabilitation personnel to observe for complications, to monitor medication administration for pain control and to teach proper ambulation techniques to ensure proper bone alignment and healing.

EXAMPLE 2: The condition of a beneficiary who has irritable bowel syndrome, or who is recovering from rectal surgery, may be such that he can be given an enema safely and effectively only by a skilled nurse. If the enema is necessary to treat the illness or injury, then the visit would be covered as a skilled nursing visit.

2. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. Where a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service although a skilled nurse actually provides the service. Similarly, the unavailability of a competent person to provide a nonskilled service, notwithstanding the importance of the service to the beneficiary, does not make it a skilled service when the skilled nurse provides it.

EXAMPLE 1: Giving a bath does not ordinarily require the skills of a licensed nurse and therefore would not be covered as a skilled nursing service unless the beneficiary's condition is such that the bath could be given safely and effectively only by a licensed nurse (as discussed in §3118.1A.1. above).

EXAMPLE 2: A beneficiary with a well-established colostomy absent complications may require assistance changing the colostomy bag because he cannot do it himself and there is no one else to change it. Notwithstanding the need for the routine colostomy care, the care does not become a skilled nursing service when it is provided by the licensed nurse.

3. A service which, by its nature, requires the skills of a licensed nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family or other caregivers. Where the beneficiary needs the skilled nursing care and there is no one trained, able and willing to provide it, the services of a skilled nurse would be reasonable and necessary to the treatment of the illness or injury.

EXAMPLE: A beneficiary was discharged from the hospital with an open draining wound which requires irrigation, packing and dressing twice each day. The home health agency has taught the family to perform the dressing changes. The home health agency continues to see the patient for the wound care that is needed during the time that the family is not available and willing to provide it. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as it is required by the patient.

4. The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the beneficiary's illness or injury within the context of the beneficiary's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the beneficiary's illness or injury, the services must be consistent with the nature and severity of the illness or injury, his or her particular medical needs, and accepted standards of medical and nursing practice. A beneficiary's overall medical condition is a valid factor in deciding whether skilled services are needed. A beneficiary's diagnosis should never be the sole factor in deciding that a service the beneficiary needs is either skilled or not skilled.

The determination of whether the services are reasonable and necessary should be made in consideration that a physician has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

EXAMPLE 1: A physician has ordered skilled nursing visits for a patient with a hairline fracture of the hip. In the absence of any underlying medical condition or illness, nursing visits would not be reasonable and necessary for treatment of the patient's hip injury.

EXAMPLE 2: A physician has ordered skilled nursing visits for injections of insulin and teaching of self-administration and self management of the medication regimen for a beneficiary with diabetes mellitus. Insulin has been shown to be a safe and effective treatment for diabetes mellitus, and therefore, the skilled nursing visits for the injections and the teaching of self-administration and self management of the treatment regimen would be reasonable and necessary.

The determination of whether a beneficiary needs skilled nursing care should be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal or expected to extend over a long period of time. In addition, skilled care may, dependent upon the unique condition of the beneficiary, continue to be necessary for beneficiaries whose condition is stable.

EXAMPLE 1: Following a cerebral vascular accident (CVA), a beneficiary has an in-dwelling foley catheter because of urinary incontinence, and is expected to require the catheter for a long and indefinite period. Periodic visits to change the catheter as needed, to treat the symptoms of catheter malfunction and to teach proper patient care would be covered as long as they are reasonable and necessary, although the beneficiary is stable and there is an expectation that the care will be needed for a long and indefinite period.

EXAMPLE 2: A beneficiary with advanced multiple sclerosis undergoing an exacerbation of the illness needs skilled teaching of medications, measures to overcome urinary retention, and the establishment of a program designed to minimize the adverse impact of the exacerbation. The skilled nursing care the beneficiary needs for a short period would be covered despite the chronic nature of the illness.

EXAMPLE 3: A beneficiary with malignant melanoma is terminally ill, and requires skilled observation, assessment, teaching, and treatment. The beneficiary has not elected coverage under Medicare's hospice benefit. The skilled nursing care that the beneficiary requires would be covered, notwithstanding that his condition is terminal, because the services he needs require the skills of a licensed nurse.

B. Application of the Principles to Skilled Nursing Services.--The following discussion of skilled nursing services applies the foregoing principles to specific skilled nursing services about which questions are most frequently raised.

1. Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status.--Observation and assessment of the beneficiary's condition by a licensed nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures

until the beneficiary's treatment regimen is essentially stabilized. Where a beneficiary was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Information from the beneficiary's medical history may support the likelihood of a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond 3-week period. Moreover, such indications as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these indications are such that it is likely that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered. There are cases where beneficiaries who are stable continue to require skilled observation and assessment (see example in section 3118.1 B. 13. d.). However, observation and assessment by a skilled nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the beneficiary's condition, and there is no attempt to change the treatment to resolve them.

EXAMPLE 1: A beneficiary with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the drug regimen should be modified or whether other therapeutic measures should be considered until the patient's treatment regimen is essentially stabilized.

EXAMPLE 2: A beneficiary has undergone peripheral vascular disease treatment including a revascularization procedure (bypass). The incision area is showing signs of potential infection (e.g., heat, redness, swelling, drainage); patient has elevated body temperature. Skilled observation and monitoring of the vascular supply of the legs and the incision site is required until the signs of potential infection have abated and there is no longer a reasonable potential of infection.

EXAMPLE 3: A patient was hospitalized following a heart attack and, following treatment but before mobilization, is discharged home. Because it is not known whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated until the patient's treatment regimen is essentially stabilized.

EXAMPLE 4: A frail 85 year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the home health agency for monitoring of fluid and nutrient intake, and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed.

EXAMPLE 5: A patient with glaucoma and a cardiac condition has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmias. Skilled observation and monitoring of the drug actions is reasonable and necessary until the patient's condition is stabilized.

EXAMPLE 6: A patient with hypertension suffered dizziness and weakness. The physician found that the blood pressure was too low and discontinued the hypertension medication. Skilled observation and monitoring of the patient's blood pressure is required until the blood pressure remains stable and in a safe range.

2. Management and Evaluation of a Patient Care Plan.--Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential nonskilled care is achieving its purpose. For skilled nursing care to be reasonable and necessary for management and evaluation of the beneficiary's plan of care, the complexity of the necessary unskilled services which are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the beneficiary's overall condition.

EXAMPLE 1: An aged beneficiary with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized.

EXAMPLE 2: An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to the bed as a result of this debilitated condition and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create a high probability of a relapse. In this situation, skilled oversight of the nonskilled services would be reasonable and necessary pending the elimination of the chest congestion to ensure the patient's medical safety.

Where visits by a licensed nurse are not needed to observe and assess the effects of the nonskilled services being provided to treat the illness or injury, skilled nursing care would not considered reasonable and necessary to treat the illness or injury.

EXAMPLE: A physician orders one skilled nursing visit every 2 weeks and three home health aide visits each week for bathing and washing hair for a beneficiary whose recovery from a cerebral vascular accident has left him with residual weakness on the left side. The beneficiary's cardiovascular condition is stable, and the beneficiary has reached the maximum restoration potential. There are no underlying conditions which would necessitate the skilled supervision of a licensed nurse in assisting with bathing or hair washing. The skilled nursing visits are not necessary to manage and supervise the home health aide services and would not be covered.

3. Teaching and Training Activities.--Teaching and training activities which require skilled nursing personnel to teach a beneficiary, the beneficiary's family or caregivers how to manage his treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the beneficiary's functional loss, or his illness or injury.

Where it becomes apparent after a reasonable period of time that the patient, family or caregiver will not or is not able to learn or be trained, then further teaching and training would cease to be reasonable and necessary. The reason that the patient, family or caregiver will not or is not able to learn or be trained should be documented in the record. Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the beneficiary's illness, functional loss or injury.

EXAMPLE 1: A physician has ordered skilled nursing care for teaching a diabetic who has recently become insulin dependent. The physician has ordered teaching of self injection and management of insulin, signs and symptoms of insulin shock and actions to take in emergencies. The teaching services are reasonable and necessary to the treatment of the illness or injury.

EXAMPLE 2: A physician has ordered skilled nursing care to teach a beneficiary to follow a new medication regimen (in which there is a significant probability of adverse drug reactions due to the nature of the drug and the beneficiary's condition), signs and symptoms of adverse reactions to new medications and necessary dietary restrictions. After it becomes apparent that the beneficiary remains unable to take the medications properly, cannot demonstrate awareness of potential adverse reactions, and is not following the necessary dietary restrictions, skilled nursing care for further teaching would not be reasonable and necessary, since the beneficiary has demonstrated an inability to be taught.

EXAMPLE 3: A physician has ordered skilled nursing visits to teach self-administration of insulin to a beneficiary who has been self injecting insulin for 10 years and there is no change in the beneficiary's physical or mental status that would require reteaching. The skilled nursing visits would not be considered reasonable and necessary since the beneficiary has a longstanding history of being able to perform the service.

EXAMPLE 4: A physician has ordered skilled nursing visits to teach self-administration of insulin to a beneficiary who has been self injecting insulin for 10 years because the beneficiary has recently lost the use of the dominant hand and must be retrained to use the other hand. Skilled nursing visits to reteach self-administration of the insulin would be reasonable and necessary.

In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitutes a reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents the initial instruction. Where the teaching represents initial instruction, the complexity of the activity to be taught and the unique abilities of the beneficiary are to be considered. Where the teaching constitutes a reinforcement, an analysis of the patient's retained knowledge and anticipated learning progress is necessary to determine the appropriate number of visits. Skills taught in a controlled institutional setting often need to be reinforced when the beneficiary returns to his or her home and does not have the advantage of the controlled environment. Where the patient needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.

EXAMPLE 5: A patient recovering from pneumonia is being sent home requiring IV infusion of antibiotics 4 times per day. The patient's spouse has been shown how to administer the drug during the last few days of hospitalization and has been told the signs and symptoms of infection. The physician has also ordered home health services for a skilled nurse to teach the administration of the drug and the signs and symptoms requiring immediate medical attention. Teaching by the skilled nurse in the home would be reasonable and necessary to continue that begun in the hospital, since the home environment, and the nature of the supplies used in the home, differ from that in the hospital.

Reteaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the beneficiary's condition that requires reteaching, or where the patient, family or caregiver is not properly carrying out the task. The medical record should document the reason that the reteaching or retraining is required.

EXAMPLE 6: A well established diabetic who loses the use of his or her dominant hand would need to be retrained in self-administration of insulin.

EXAMPLE 7: A spouse who has been taught to perform a dressing change for a post surgical beneficiary may need to be retaught wound care if the spouse demonstrates improper performance of wound care.

NOTE: There is no requirement that the beneficiary, family or other caregiver be taught to provide a service if they cannot or choose not to provide the care.

Teaching and training activities which require the skills of a licensed nurse include, but are not limited to the following:

o Teaching the self-administration of injectable medications, or a complex range of medications;

o Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia;

o Teaching self-administration of medical gases;

o Teaching wound care where the complexity of the wound, the overall condition of the beneficiary or the ability of the caregiver makes teaching necessary.

o Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;

o Teaching self-catheterization;

o Teaching self-administration of gastrostomy or enteral feedings;

o Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;

o Teaching bowel or bladder training when bowel or bladder dysfunction exists;

o Teaching how to perform the activities of daily living when the beneficiary or caregiver must use special techniques and adaptive devices due to a loss of function;

o Teaching transfer techniques, e.g., from bed to chair, which are needed for safe transfer;

o Teaching proper body alignment and positioning, and timing techniques of a bed-bound beneficiary;

- Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;

- Teaching prosthesis care and gait training;

- Teaching the use and care of braces, splints and orthotics and associated skin care;

- Teaching the proper care and application of any specialized dressings or skin treatments (for example, dressings or treatments needed by beneficiaries with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration from radiation treatments);

- Teaching the preparation and maintenance of a therapeutic diet; and

- Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.

4. Administration of Medications.--Although drugs and biologicals are specifically excluded from coverage by the statute (§1816(m)(5) of the Social Security Act), the services of a licensed nurse which are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.

a. Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively. Where these services are reasonable and necessary to treat the illness or injury, they may be covered. For these services to be reasonable and necessary, the medication being administered must be accepted as safe and effective treatment of the beneficiary's illness or injury, and there must be a medical reason that the medication cannot be taken orally. Moreover, the frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances which justify the need for the additional injections.

(1) Vitamin B 12 injections are considered specific therapy only for the following conditions:

- Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia

- Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome,

- Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

For an individual with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injection of vitamin B 12 at a dose of from 100 to 1000 micrograms no more frequently than once monthly is the accepted reasonable and necessary dosage schedule for maintenance treatment. More frequent injections would be appropriate in the initial or acute phase of the disease until it has been determined through laboratory tests that the patient can be sustained on a maintenance dose.

(2) Insulin Injections.—Insulin is customarily self-injected by patients or is injected by their families. However, where a beneficiary is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the beneficiary, the injections would be considered a reasonable and necessary skilled nursing service.

EXAMPLE: A beneficiary who requires an injection of insulin once per day for treatment of diabetes mellitus, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional tremors, and vision loss which cause her not to be able to fill syringes or to self inject the insulin she needs. If there is no able and willing caregiver to inject her insulin, skilled nursing care would be reasonable and necessary for the injection of the insulin.

The prefilling of syringes with insulin (or other medication which is self-injected) does not require the skills of a licensed nurse, and therefore is not considered to be a skilled nursing service. If the beneficiary needs someone only to prefill syringes (and therefore needs no skilled nursing care on an intermittent basis, or physical therapy or speech therapy), the beneficiary, therefore, does not qualify for any Medicare coverage of home health care. Prefilling of syringes for self administration of insulin or other medications is considered to be assistance with medications which are ordinarily self-administered and is an appropriate home health aide service. (See §3119.2.) However, where State law requires that a licensed nurse prefill syringes, a skilled nursing visit to prefill syringes is paid as a skilled nursing visit (if the beneficiary otherwise needs skilled nursing care or physical therapy or speech therapy), but is not considered to be a skilled nursing service.

b. Oral Medications.—The administration of oral medications by a licensed nurse is not reasonable and necessary skilled nursing care except in the specific situation in which the complexity of the beneficiary's condition, the nature of the drugs prescribed and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The medical record must document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

c. Eye Drops and Topical Ointments.--The administration of eye drops and topical ointments does not require the skills of a licensed nurse. Therefore, even if the administration of eyedrops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer them, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service. This section does not eliminate coverage for skilled nursing visits for observation and assessment of the beneficiary's condition. (See §3118.1.B.1.)

EXAMPLE 1: A physician has ordered skilled nursing visits to administer eye drops and ointments for a beneficiary with glaucoma. The administration of eye drops and ointments does not require the skills of a licensed nurse. Therefore, the skilled nursing visits cannot be covered as skilled nursing care, notwithstanding the importance of the administration of the drops as ordered.

EXAMPLE 2: A physician has ordered skilled nursing visits for a patient with a reddened area under the breast. The physician instructs the beneficiary to wash, rinse, and dry the area daily and apply A and D ointment. Skilled nursing care is not needed to provide this treatment safely and effectively.

5. Tube Feedings.--Nasogastric tube, and percutaneous tube feedings (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the beneficiary's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services.

6. Nasopharyngeal and Tracheostomy Aspiration.--Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the beneficiary's illness or injury, would be covered as skilled nursing services.

7. Catheters.--Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services which are provided at a frequency appropriate to the type of catheter in use would be considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and silicone catheters generally require skilled care once every 60-90 days and this frequency of service would be considered reasonable and necessary. However, where there are complications which require more frequent skilled care related to the catheter, such care with adequate documentation, be covered.

EXAMPLE: A beneficiary who has a Foley catheter due to loss of bladder control because of multiple sclerosis has a history of frequent plugging of the catheter and urinary tract infections. The physician has ordered skilled nursing visits once per month to change the catheter, and has left a "PRN" order for up to 3 additional visits per month for skilled observation and evaluation and/or catheter changes if the beneficiary or her family reports signs and symptoms of a urinary tract infection or a plugged catheter. During the certification period, the beneficiary's family contacts the HHA because the beneficiary has an elevated temperature, abdominal pain, and scant urine output. The skilled nurse visits the beneficiary and determines that the catheter is plugged and that there are symptoms of a urinary tract infection. The skilled nurse changes the catheter, and contacts the physician to advise him of her findings and to discuss treatment. The skilled nursing visit to change the catheter and to evaluate the beneficiary would be reasonable and necessary to the treatment of the illness or injury.

8. Wound Care.--Care of wounds, (including, but not limited to ulcers, burns, pressure sores open surgical sites, fistulas, tube sites and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency and quantity), condition and appearance of surrounding skin of wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. Coverage or denial of skilled nursing visits for wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings. Moreover, the plan of care must contain the specific instructions for the treatment of the wound. Where the physician has ordered appropriate active treatment (e.g. sterile or complex dressings, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:

a. Open wounds which are draining purulent or colored exudate or which have a foul odor present and/or for which the beneficiary is receiving antibiotic therapy,

b. Wounds with a drain or T-tube with requires shortening or movement of such drains,

c. Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze,

d. Recently debrided ulcers,

e. Pressure sores (decubitus ulcers) which present the following characteristics:

o There is partial tissue loss with signs of infection such as foul odor or purulent drainage, or

o There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

NOTE: Wounds or ulcers that show redness, edema and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.

f. Wounds with exposed internal vessels or a mass which may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva),

g. Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies.

h. Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease which has a reasonable potential to adversely affect healing (e.g., diabetes),

i. Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed.

j. Skin conditions which require application of nitrogen mustard or other chemotherapeutic medication which present a significant risk to the beneficiary.

k. Other open or complex wounds which require treatment that can only be safely and effectively provided by a licensed nurse.

EXAMPLE 1: A beneficiary has a second-degree burn with full thickness skin damage on his back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services.

EXAMPLE 2: A beneficiary experiences a decubitus ulcer where the full thickness tissue loss extends through the dermis to involve subcutaneous tissue. The wound involves necrotic tissue with a physician's order to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for a proper treatment and understanding of cellular adherence and/or exudate or tissue healing or necrosis.

NOTE: This section relates to the direct, hands on skilled nursing care provided to beneficiaries with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication (see §3118.1.B.1) or skilled teaching of wound care to the beneficiary or the beneficiary's family. (See §3118.1.B.3.)

9. Ostomy Care.--Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications.

10. Heat Treatments.--Heat treatments which have been specifically ordered by a physician as part of active treatment of an illness or injury and which require observation by a licensed nurse to adequately evaluate the patient's progress would be considered a skilled nursing service.

11. Medical Gasses.--Initial phases of a regimen involving the administration of medical gasses which are necessary to the treatment of the beneficiary's illness or injury, would require skilled nursing care for skilled observation and evaluation of the beneficiary's reaction to the gasses, and to teach the patient and family when and how to properly manage the administration of the gasses.

12. Rehabilitation Nursing.--Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs) would constitute skilled nursing services.

13. Venipuncture.--Venipuncture when the collection of the specimen is necessary to the diagnosis and treatment of the beneficiary's illness or injury and when the venipuncture cannot be performed in the course of regularly scheduled absences from the home to acquire medical treatment is a skilled nursing service. The frequency of visits for venipuncture must be reasonable within accepted standards of medical practice for treatment of the illness or injury.

For venipuncture to be reasonable and necessary:

- The physician order for the venipuncture for a laboratory test should be associated with a specific symptom or diagnosis, or the documentation should clarify the need for the test when it is not diagnosis/illness specific. In addition, the treatment must be recognized (in the Physician's Desk Reference, or other authoritative source) as being reasonable and necessary to the treatment of the illness or injury for venipunctures for monitoring the treatment to be reasonable and necessary.

- The frequency of testing should be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem or treatment regimen. Even where the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.

Examples of reasonable and necessary venipunctures for stabilized beneficiaries include, but are not limited to those described below. While these guidelines do not preclude a physician from ordering more frequent venipunctures for these laboratory tests, the HHA must present justifying documentation to support the reasonableness and necessity of more frequent testing.

a. Captopril may cause side effects such as leukopenia and agranulocytosis and it is standard medical practice to monitor the white blood cell count and differential count on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.

b. In monitoring phenytoin (e.g., Dilantin) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight and it is therefore appropriate to monitor the level on a routine basis (every 3 months) when the results are stable and the beneficiary is asymptomatic.

c. Venipuncture for fasting blood sugar (FBS)

- An unstable insulin dependent or non-insulin dependent diabetic would require FBS more frequently than once per month if ordered by the physician.
- Where there is a new diagnosis or where there has been a recent exacerbation, but the beneficiary is not unstable, monitoring once per month would be reasonable and necessary.
- A stable insulin or non-insulin dependent diabetic would require monitoring every 2-3 months.

d. Venipuncture for prothrombin

- Where the documentation shows that the dosage is being adjusted, monitoring would be reasonable and necessary as ordered by the physician.
- Where the results are stable within the therapeutic ranges, monthly monitoring would be reasonable and necessary.
- Where the results are stable within non-therapeutic ranges, there must be documentation of other factors which would indicate why continued monitoring is reasonable and necessary.

EXAMPLE: A beneficiary with coronary artery disease (CAD) was hospitalized with atrial fibrillation and was subsequently discharged to the home health agency with orders for anticoagulation therapy. Monthly venipunctures as indicated are necessary to report prothrombin (protime) levels to the physician, notwithstanding that the beneficiary's prothrombin time tests indicate essential stability.

14. Student Nurse Visits.--Visits made by a student nurse may be covered as skilled nursing care when a home health agency participates in training programs in which it utilizes student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting. To be covered, the services must be reasonable and necessary skilled nursing care, and must be performed under the general supervison of a registered or licensed nurse. The supervising nurse need not accompany the student nurse on each visit.

15. Psychiatric Evaluation and Therapy.--The evaluation and psychotherapy needed by a patient suffering from a diagnosed psychiatric disorder that necessitated active treatment in an institution requires the skills of a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing care.

Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for an R.N. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a psychiatrist. A psychiatrist may also prescribe services of non-psychiatric nursing such as intramuscular injections of behavior modifying medications.

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as home health agencies, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases.

C. Intermittent Skilled Nursing Care.--To meet the requirement for "intermittent" skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days.

Since the need for "intermittent" skilled nursing care makes the individual eligible for other covered home health services, the intermediary should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

1. The patient with an indwelling silicone catheter who generally needs a catheter change only at 90-day intervals;

2. The person who experiences a fecal impaction due to the normal aging process (i.e., loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must be manually disimpacted. Although these impactions are likely to recur, it is not possible to pinpoint a specific timeframe; or

3. The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, would be to observe and determine the need for changes in the level and type of care which have been prescribed, thus supplementing the physician's contacts with the patient. (See Coverage Issues Appendix, §HHA-1.)

Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be reimbursable. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem which would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in §3119.7) medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2-3 weeks). There may also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3-week period, the home health agency must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time; i.e., a patient who requires institutionalization, would usually not qualify for home health benefits.

3118.2 Skilled Therapy Services.--

A. General Principles Governing Reasonable and Necessary Physical Therapy, Speech Therapy, and Occupational Therapy.—

1. The service of a physical, speech or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, the skilled services must also be reasonable and necessary to the treatment of the beneficiary's illness or injury or to the restoration of maintenance of function affected by the beneficiary's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the beneficiary's overall condition, skilled management of the services provided is needed although many or all of the specific services needed to treat the illness or injury do not require the skills of a therapist.

2. The development, implementation management and evaluation of a patient care plan based on the physician's orders constitute skilled therapy services when, because of the beneficiary's condition, those activities require the involvement of a skilled therapist to meet the beneficiary's needs, promote recovery and ensure medical safety. Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, such services would be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

3. While a beneficiary's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel.

4. A service that is ordinarily considered nonskilled could be considered a skilled therapy service in cases in which there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform or supervise the service or to observe the beneficiary. However, the importance of a particular service to a beneficiary or the frequency with which it must be performed does not, by itself, make a nonskilled service into a skilled service.

5. The skilled therapy services must be reasonable and necessary to the treatment of the beneficiary's illness or injury within the context of the beneficiary's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

a. The services must be consistent with the nature and severity of the illness or injury, the beneficiary's particular medical needs, including the requirement that the amount, frequency and duration of the services must be reasonable, and

b. The services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient's condition, and

c. The services must be provided with the expectation, based on the assessment made by the physician of the beneficiary's rehabilitation potential, that:

+ The condition of the beneficiary will improve materially in a reasonable and generally predictable period of time, or

+ The services are necessary to the establishment of a safe and effective maintenance program.

Services involving activities for the general welfare of any beneficiary, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy. Those services can be performed by nonskilled individuals without the supervision of a therapist.

d. Services of skilled therapists which are for the purpose of teaching the patient or the patient's family or caregivers necessary techniques, exercises or precautions are covered to the extent that they are reasonable and necessary to treat illness or injury. However, visits made by skilled therapists to a beneficiary's home solely to train other home health agency staff (e.g., home health aides) are not billable as visits since the home health agency is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost of a skilled therapist's visit for the purpose of training home health agency staff is an administrative cost to the home health agency.

EXAMPLE: A beneficiary with a diagnosis of multiple sclerosis has recently been discharged from the hospital following an exacerbation of her condition which has left her wheelchair bound and for the first time, without any expectation of achieving ambulation again. The physician has ordered physical therapy to select the proper wheelchair for her long term use, to teach safe use of the wheelchair and safe transfer techniques to the beneficiary and the family. Physical therapy would be reasonable and necessary to evaluate the beneficiary's overall needs, to make the selection of the proper wheelchair and to teach the beneficiary and/or family safe use of the wheelchair and proper transfer techniques.

B. Application of the Principles to Physical Therapy Services.--The following discussion of skilled physical therapy services applies the principles in §3118.2A to specific physical therapy services about which questions are most frequently raised.

1. Assessment.--The skills of a physical therapist to assess and periodically reassess a beneficiary's rehabilitation needs and potential or to develop and/or implement a physical therapy program are covered when they are reasonable and necessary because of the beneficiary's condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance or functional ability.

2. Therapeutic Exercises.--Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment, due either to the type of exercise employed or to the condition of the beneficiary, constitute skilled physical therapy.

3. Gait Training.--Gait evaluation and training furnished a beneficiary whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to improve materially the beneficiary's ability to walk.

Gait evaluation and training which is furnished to a beneficiary whose ability to walk has been impaired by a condition other than a neurological, muscular or skeletal abnormality would nevertheless be covered where physical therapy is reasonable and necessary to restore the lost function.

EXAMPLE 1: A physician has ordered gait evaluation and training for a beneficiary whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the beneficiary's gait, to establish a gait training program and to provide the skilled services necessary to implement the program would be covered.

EXAMPLE 2: A beneficiary who has had a total hip replacement is ambulatory but demonstrates weakness, and is unable to climb stairs safely. Physical therapy would be reasonable and necessary to teach the beneficiary to safely climb and descend stairs.

Repetitive exercises to improve gait, or to maintain strength and endurance and assistive walking are appropriately provided by nonskilled persons and ordinarily do not require the skills of a physical therapist. Where such services are performed by a physical therapist as part of the initial design and establishment of a safe and effective maintenance program, the services would, to the extent that they are reasonable and necessary, be covered.

EXAMPLE: A beneficiary who has received gait training has reached his maximum restoration potential, and the physical therapist is teaching the beneficiary and family how to safely perform the activities which are a part of the maintenance program being established. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a therapist) would be covered since they are needed to establish the program.

4. Range of Motion.--Only a qualified physical therapist may perform range of motion tests and therefore such tests are skilled physical therapy.

Range of motion exercises constitute skilled physical therapy only if they are part of an active treatment for a specific disease state, illness, or injury, which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored). Range of motion exercises which are not related to the restoration of a specific loss of function often may be provided safely and effectively by nonskilled individuals. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by nonskilled persons do not constitute skilled physical therapy.

However, as indicated in section 3118.2A4, where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are needed to provide services which ordinarily do not need the skills of a therapist, then the services would be covered.

5. Maintenance Therapy.--Where repetitive services which are required to maintain function involve the use of complex and sophisticated procedures, the judgement and skill of a physical therapist might be required for the safe and effective rendition of such services. If the judgment and skill of a physical therapist is required to safely and effectively treat the illness or injury, the services would be covered as physical therapy services.

EXAMPLE: Where there is an unhealed, unstable fracture which requires regular exercise to maintain function until the fracture heals, the skills of a physical therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

Establishment of a maintenance program is a skilled physical therapy service where the specialized knowledge and judgement of a qualified physical therapist is required for the program to be safely carried out and the treatment aims of the physician achieved.

EXAMPLE: A Parkinson's patient or a patient with rheumatoid arthritis who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises are required for the maintenance of his present level of function. The initial evaluation of the patient's needs, the designing of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the beneficiary, family or caregivers to safely and effectively carry out the program and such reevaluations as may be required by the beneficiary's condition, would constitute skilled physical therapy.

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible (i.e., by the end of the last restorative session) the physical therapist will already have designed the maintenance program required and instructed the beneficiary or caregivers in carrying out the program.

6. Ultrasound, Shortwave, and Microwave Diathermy Treatments.--These treatments must always be performed by or under the supervision of a qualified physical therapist and are skilled therapy.

7. Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths.--Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge and judgement of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications.

C. Application of the General Principles to Speech Language Pathology Services.--The following discussion of skilled speech language pathology services applies the principles to specific speech language pathology services about which questions are most frequently raised.

1. The skills of a speech language pathologist are required for the assessment of a beneficiary's rehabilitation needs (including the causal factors and the severity of the speech and language disorders), and rehabilitation potential. Reevaluation would only be considered reasonable and necessary if the beneficiary exhibited a change in functional speech or motivation, clearing of confusion or the remission of some other medical condition that previously contraindicated speech language pathology services. Where a beneficiary is undergoing restorative speech language pathology services, routine reevaluations are considered to be a part of the therapy and could not be billed as a separate visit.

2. The services of a speech language pathologist would be covered if they are needed as a result of an illness, or injury and are directed towards specific speech/voice production.

3. Speech language pathology would be covered where the service can only be provided by a speech language pathologist and where it is reasonably expected that the service will materially improve the beneficiary's ability to independently carry out any one or combination of communicative activities of daily living in a manner that is measurably at a higher level of attainment than that prior to the initiation of the services.

4. The services of a speech language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a beneficiary toward speech-language communication goals in the plan of care would be covered speech language pathology.

5. The services of a speech language pathologist to train the beneficiary, family or other caregivers to augment the speech-language communication, treatment or to establish an effective maintenance program would be covered speech therapy.

6. The services of a speech language pathologist to assist beneficiaries with aphasia in rehabilitation of speech and language skills is covered when needed by a beneficiary.

7. The services of a speech therapist to assist individuals with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a beneficiary.

D. Application of the General Principles to Occupational Therapy.--The following discussion of skilled occupational therapy services applies the principles to specific occupational therapy services about which questions are most frequently raised.

1. Assessment.--The skills of an occupational therapist to assess and reassess a beneficiary's rehabilitation needs and potential or to develop and/or implement an occupational therapy program are covered when they are reasonable and necessary because of the beneficiary's condition.

2. Planning, Implementing and Supervision of Therapeutic Programs.--The planning, implementing and supervision of therapeutic programs including, but not limited to those listed below are skilled occupational therapy services, and if reasonable and necessary to the treatment of the beneficiary's illness or injury would be covered.

a. Selecting and teaching task oriented therapeutic activities designed to restore physical function.

EXAMPLE: Use of woodworking activities on an inclined table to restore shoulder, elbow and wrist range of motion lost as a result of burns.

b. Planning, implementing and supervising therapeutic tasks and activities designed to restore sensory-integrative function.

EXAMPLE: Providing motor and tactile activities to increase sensory output and improve response for a stroke patient with functional loss resulting in a distorted body image.

c. Planning, implementing and supervising of individualized therapeutic activity programs as part of an overall "active treatment" program for a patient with a diagnosed psychiatric illness.

EXAMPLE: Use of sewing activities which require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient.

d. Teaching compensatory techniques to improve the level of independence in the activities of daily living.

EXAMPLE: Teaching a beneficiary who has lost use of an arm how to pare potatoes and chop vegetables with one hand.

EXAMPLE: Teaching a stroke patient new techniques to enable him to perform feeding, dressing and other activities of daily living as independently as possible.

e. The designing, fabricating and fitting of orthotic and self-help devices.

EXAMPLE: Construction of a device which would enable an individual to hold a utensil and feed himself independently.

EXAMPLE: Construction of a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position.

f. Vocational and prevocational assessment and training which is directed toward the restoration of function in the activities of daily living lost due to illness or injury would be covered. Where vocational or prevocational assessment and training is related solely to specific employment opportunities, work skills or work settings, such services would not be covered because they would not be directed toward the treatment of an illness or injury.

3. Illustration of Covered Services.--

EXAMPLE 1: A physician orders occupational therapy for a patient who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting and bathing. The occupational therapist will establish goals for the beneficiary's rehabilitation (to be approved by the physician), and will undertake the teaching of the techniques necessary for the patient to reach the goals. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the beneficiary's response to treatment.

EXAMPLE 2: A physician has ordered occupational therapy for a beneficiary who is recovering from a CVA. The beneficiary has decreased range of motion, strength and sensation in both the upper and lower extremities on the right side. In addition, the beneficiary has perceptual and cognitive deficits resulting from the CVA. The beneficiary's condition has resulted in decreased function in activities of daily living (specifically bathing dressing, grooming, hygiene and toileting). The loss of function requires assistive devices to enable the beneficiary to compensate for the loss of function and to maximize safety and independence. The beneficiary also needs equipment such as himi-slings to prevent shoulder subluxation and a hand splint to prevent joint contracture and deformity in the right hand. The services of an occupational therapist would be necessary to assess the beneficiary's needs, develop goals (to be approved by the physician), to manufacture or adapt the needed equipment to the beneficiary's use, to teach compensatory techniques, to strengthen the beneficiary as necessary to permit use of compensatory techniques, to provide activities which are directed towards meeting the goals governing increased perceptual and cognitive function. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the beneficiary's response to treatment.

3119. COVERAGE OF OTHER HOME HEALTH SERVICES

3119.1 Skilled Nursing, Physical Therapy, Speech Therapy, and Occupational Therapy.--Where the beneficiary meets the qualifying criteria in 3117, Medicare covers skilled nursing services which meet the requirements of 3118.1 A and B and 3119.7, physical therapy which meets the requirements of 3118.2 A and B, speech therapy which meets the requirements of 3118.2 A and C, and occupational therapy which meets the requirements of 3118.2 A and D.

3119.2 Home Health Aide Services.--For home health aide services to be covered, the beneficiary must meet the qualifying criteria as specified in §3117, the services which are provided by the home health aide must be part-time or intermittent as discussed in §3119.7 the services must meet the definition of home health aide services of this section; and the services must be reasonable and necessary to the treatment of the beneficiary's illness or injury.

The reason for the visits by the home health aide must be to provide hands-on personal care of the beneficiary or services which are needed to maintain the beneficiary's health or to facilitate treatment of the beneficiary's illness or injury.

The physician's order should indicate the frequency of the home health aide services required by the beneficiary. These services may include but are not limited to:

a. Personal Care.--Personal care means:

o Bathing, dressing, grooming, caring for hair, nail and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the beneficiary's health, changing the bed linens of an incontinent beneficiary, shaving, deodorant application, skin care with lotions and/or powder, foot care, and ear care.

o Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed, assistance with transfers.

EXAMPLE 1: A physician has ordered home health aide visits to assist the beneficiary in personal care because the beneficiary is recovering from a stroke and continues to have significant right side weakness which causes him to be unable to bathe, dress or perform hair and oral care. The plan of care established by the home health agency nurse sets forth the specific tasks with which the beneficiary needs assistance. Home health aide visits at an appropriate frequency would be reasonable and necessary to assist in these tasks.

EXAMPLE 2: A physician ordered four home health aide visits per week for personal care for a multiple sclerosis patient who is unable to perform these functions because of increasing debilitation. The home health aide gave the beneficiary a bath twice per week and washed hair on the other two visits each week. Only two visits are reasonable and necessary since the services could have been provided in the course of two visits.

EXAMPLE 3: A physician ordered seven home health aide visits per week for personal care for a bed-bound, incontinent patient. All visits are reasonable and necessary because the patient has extensive personal care needs.

EXAMPLE 4: A beneficiary with a well established colostomy forgets to change the bag regularly and has difficulty changing it. Home health aide services at an appropriate frequency to change the bag would be considered reasonable and necessary to the treatment of the illness or injury.

Other services which may be covered when provided by home health aides include, but are not limited to:

b. Simple dressing changes which do not require the skills of a licensed nurse.

EXAMPLE 5: A beneficiary who is confined to the bed has developed a small reddened area on the buttocks. The physician has ordered home health aide visits for more frequent repositioning, bathing and the application of a topical ointment and a gauze 4x4. Home health aide visits at an appropriate frequency would be reasonable and necessary.

c. Assistance with medications which are ordinarily self-administered and which do not require the skills of a licensed nurse to be provided safely and effectively.

NOTE: Prefilling of insulin syringes is ordinarily performed by the diabetic as part of the self-administration of the insulin and, unlike the injection of the insulin, does not require the skill of a licensed nurse to be performed properly. Therefore, if the prefilling of insulin syringes is performed by home health agency staff, it is considered to be a home health aide service. However, where State law precludes the provision of this service by other than a licensed nurse or physician, Medicare will make payment for this service, when covered, as though it were a skilled nursing service. Where the beneficiary needs only prefilling of insulin syringes and does not need skilled nursing care on an intermittent basis, or physical therapy or speech therapy or have a continuing need for occupational therapy, then Medicare cannot cover any home health services to the beneficiary (even if State law requires that the insulin syringes be filled by a licensed nurse).

d. Assistance with activities which are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed such as routine maintenance exercises, and repetitive speech routines to support speech therapy.

e. Routine care of prosthetic and orthotic devices.

When a home health aide visits a patient to provide a health related service as discussed above, the home health aide may also perform some incidental services which do not meet the definition of a home health aide service (e.g., light cleaning, preparation of a meal, taking out the trash, shopping, etc.) However, the purpose of a home health aide visit may not be to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home.

EXAMPLE 1: A home health aide visits a recovering stroke patient whose right side weakness and poor endurance cause her to be able to leave the bed and chair only with extreme difficulty. The physician has ordered physical therapy and speech therapy for the beneficiary and has ordered home health aide services three or four times per week for personal care, assistance with ambulation as mobility increases, and assistance with repetitive speech exercises as her impaired speech improves. The home health aide also provides incidental household services such as preparation of meals, light cleaning and taking out the trash. The beneficiary lives with an elderly frail sister who is disabled and who cannot perform either the personal care or the incidental tasks. The home health aide visits at a frequency appropriate to the performance of the health related services would be covered, notwithstanding the incidental provision of noncovered services (i.e., the household services) in the course of the visits.

EXAMPLE 2: A physician orders home health aide visits 3 times per week. The only services provided are light housecleaning, meal preparation and trash removal. The home health aide visits cannot be covered, notwithstanding their importance to the beneficiary, because the services provided do not meet Medicare's definition of "home health aide services."

3119.3 Medical Social Services.--Medical social services which are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as home health services where the beneficiary meets the qualifying criteria specified in §3117, and:

- o The services of these professionals are necessary to resolve social or emotional problems which are or are expected to be an impediment to the effective treatment of the beneficiary's medical condition or his or her rate of recovery, and

- o The plan of care indicates how the services which are required necessitate the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker to be performed safely and effectively.

Where both of these requirements for coverage are met, services of these professionals which may be covered include, but are not limited to:

- o Assessment of the social and emotional factors related to the beneficiary's illness, need for care, response to treatment and adjustment to care,

- o Assessment of the relationship of the beneficiary's medical and nursing requirements to the individual's home situation, financial resources and availability of community resources,

- o Appropriate action to obtain available community resources to assist in resolving the beneficiary's problem (Note: Medicare does not cover the services of a medical social worker to complete or assist in the completion of an application for Medicaid because Federal regulations require the State to provide assistance in completing the application to anyone who chooses to apply for Medicaid.), and

- o Counseling services which are required by the beneficiary. Counseling of beneficiaries' families is covered only when such services are incidental to other covered medical social services being provided to the beneficiary, and when they are reasonable and necessary to treat the beneficiary's illness or injury. Visits by a medical social worker are not covered when the only reason for the visit is to counsel the beneficiary's family.

NOTE: Participating in the development of the plan of treatment, preparing clinical and progress notes, participating in discharge planning and inservice programs, and acting as a consultant to other agency personnel are appropriate administrative costs to the home health agency.

EXAMPLE 1: The physician has ordered a medical social worker assessment of a diabetic beneficiary who has recently become insulin dependent and is not yet stabilized. The skilled nurse, who is providing skilled observation and evaluation to try to restabilize the beneficiary notices during her visits that the supplies left in the home for the beneficiary's use appear to be frequently missing, and that the beneficiary is not compliant with the regimen although she refuses to discuss the matter. The assessment by a medical social worker would be reasonable and necessary to determine if there are underlying social or emotional problems which are impeding the beneficiary's treatment.

EXAMPLE 2: A physician ordered an assessment by a medical social worker for a multiple sclerosis patient who was unable to move anything but her head and who had an indwelling catheter. The beneficiary had experienced recurring urinary tract infections and multiple infected ulcers. The physician ordered medical social services after the home health agency indicated to him that the home was not well cared for, and that the beneficiary appeared to be neglected much of the time and that the relationship between the beneficiary and family was very poor. The physician and home health agency were concerned that social problems created by family caregivers were impeding the treatment of the recurring infections and ulcers. The assessment and follow-up for counseling both the beneficiary and the family by a medical social worker were reasonable and necessary.

EXAMPLE 3: A physician is aware that a beneficiary with arteriosclerosis and hypertension is not taking medications as ordered and is not adhering to dietary restrictions because he is unable to afford the medication and is unable to cook. The physician orders several visits by a medical social worker to assist in resolving these problems. The visits by the medical social worker to review the beneficiary's financial status, to discuss options and to make appropriate contacts with social services agencies or other community resources to arrange for medications and meals would be a reasonable and necessary medical social service.

EXAMPLE 4: A physician has ordered counseling by a medical social worker for a beneficiary with cirrhosis of the liver who has recently been discharged from a 28-day inpatient alcohol treatment program to her home which she shares with an alcoholic and neglectful adult child. The physician has ordered counseling several times per week to assist the beneficiary in remaining free of alcohol and in dealing with the adult child. The services of the medical social worker would be covered until the beneficiary's social situation ceased to impact on her recovery and/or treatment.

EXAMPLE 5: A physician has ordered medical social services for a beneficiary who is worried about her financial arrangements and payment for medical care. The services ordered are to arrange Medicaid if possible and resolve unpaid medical bills. There is no evidence that the beneficiary's concerns are adversely impacting recovery or treatment of her illness or injury. Medical social services cannot be covered.

EXAMPLE 6: A physician has ordered medical social services for a beneficiary of extremely limited income who has incurred large unpaid hospital and other medical bills following a significant illness. The beneficiary's recovery is adversely affected because the beneficiary is not maintaining a proper therapeutic diet, and cannot leave the home to acquire the medication necessary to treat his illness. The Medical social worker reviews the beneficiary's financial status, arranges meal service to resolve the dietary problem, arranges for home delivered medications, gathers the information necessary for application to Medicaid to acquire coverage for the medications the beneficiary needs, files the application on behalf of the beneficiary, and follows up repeatedly with the Medicaid State agency.

The medical social services which are necessary to review the financial status of the beneficiary, to arrange for meal service, to arrange for the medications to be delivered to the home, and to arrange for the Medicaid State agency to assist the beneficiary with the application for Medicaid would be covered. The services related to the assistance in filing the application for Medicaid, and the followup on the application are not covered since they must be provided by the State agency free of charge, and hence the beneficiary has no obligation to pay for such assistance.

3119.4 Medical Supplies (Except for Drugs and Biologicals) and the Use of Durable Medical Equipment.—

A. Medical Supplies.--Medical supplies are items which, due to their therapeutic or diagnostic characteristics, are essential in enabling home health agency personnel to carry out effectively the care which the physician has ordered for the treatment or diagnosis of the patient's illness or injury. Certain items which, by their very nature, are designed only to serve a medical purpose are obviously considered to be medical supplies; e.g., catheters, needles, syringes, surgical dressings and materials used for dressings such as cotton gauze and adhesive bandages, and materials used for aseptic techniques. Other medical supplies include, but are not limited to, irrigating solutions, and intravenous fluids.

Other items which are often used by persons who are not ill or injured may be considered medical supplies but only where (1) the item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation, and (2) the item is required as a part of the actual physician- prescribed treatment of a patient's existing illness or injury. For example, items which generally serve a routine hygienic purpose, such as soaps and shampoos, and items which generally serve as skin conditioners, such as baby lotion, baby oil, skin softeners, powders, lotions, etc., would not be considered medical supplies unless the particular item is recognized as serving a specific therapeutic purpose in the physician's prescribed treatment of the patient's existing skin (scalp) disease or injury.

Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and will be rendered by the patient or by family members. Such supplies as needles, syringes, and catheters which require administration by a nurse should not be left in the home between visits.

C. Drugs and Biologicals.-Drugs and biologicals are excluded from coverage as items or services administered by home health agencies, under both hospital insurance and medical insurance. They may, in certain cases, be covered under medical insurance, when administered by a physician as a part of his professional service, and are not capable of being self-administered.

D. Durable Medical Equipment.--Durable medical equipment which meets the requirements of §3113 may be covered under the home health benefit, with the beneficiary responsible for payment of a 20 percent coinsurance.

3119.5 Services of Interns and Residents.--Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program (if the agency has an affiliation with or is under common control of a hospital providing such medical services). "Approved" means approved by the Council on Medical Education of the American Medical Association, or in the case of an osteopathic hospital, the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association and, in the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association. Reimbursement is provided under Part B for other services hospital interns and residents furnish to beneficiaries receiving home health services.

The services of interns and residents-in-training in the field of podiatry under a teaching program approved by the Council on Podiatry Education of the American Podiatry Association are covered under Part A on the same basis as the services of other interns and residents-in-training in approved teaching programs.

3119.6 Outpatient Services.--Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence, or (2) which are furnished while he is at the facility to receive the services described in (1). The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers. The cost of transporting an individual to a facility cannot be reimbursed as home health services.

3119.7 Part-time or Intermittent Home Health Aide and Skilled Nursing Services.--Where a beneficiary qualifies for coverage of home health services, Medicare covers either part time or intermittent home health aide services and skilled nursing services.

A. Definition of "Part-time".--"Part-time" means any number of days per week:

- Up to and including 28 hours per week of skilled nursing and home health aide services combined for less than 8 hours per day; or

- Up to 35 hours per week of skilled nursing and home health aide services combined for less than 8 hours per day subject to review by fiscal intermediaries on a case by case basis, based upon documentation justifying the need for and reasonableness of such additional care.

B. Definition of "Intermittent".-- "Intermittent" means:

- Up to and including 28 hours per week of skilled nursing and home health aide services combined provided on a less than daily basis;

- Up to 35 hours per week of skilled nursing and home health aide services combined which are provided on a less than daily basis, subject to review by fiscal intermediaries on a case by case basis, based upon documentation justifying the need for and reasonableness of such additional care; or

- Up to and including full-time (i.e., 8 hours per day) skilled nursing and home health aide services combined which are provided and needed 7 days per week for temporary, but not indefinite, periods of time of up to 21 days with allowances for extensions in exceptional circumstances where the need for care in excess of 21 days is finite and predictable.

C. Impact on Care Provided in Excess of "Intermittent" or "Part-time" care.--Home health aide and/or skilled nursing care in excess of the amounts of care which meet these definitions of part time or intermittent may be provided to a home care beneficiary or purchased by other payers without bearing on whether the home health aide and skilled nursing care meets the Medicare definitions of part-time or intermittent.

EXAMPLE: A beneficiary needs skilled nursing care monthly for a catheter change and the home health agency also renders needed daily home health aide services 24 hours per day which will be needed for a long and indefinite period of time. The HHA bills Medicare for the skilled nursing and home health aide services which were provided before the 35th hour of service each week and bills the beneficiary (or another payer) for the remainder of the care. If the intermediary determines that the 35 hours of care are reasonable and necessary, Medicare would therefore cover the 35 hours of skilled nursing and home health aide visits.

D. Application of This Policy Revision.--A beneficiary must meet the longstanding and unchanged qualifying criteria for Medicare coverage of home health services, before this policy revision becomes applicable to skilled nursing services and/or home health aide services. The definition of "intermittent" with respect to the need for skilled nursing care where the beneficiary qualifies for coverage based on the need for "skilled nursing care on an intermittent basis" remains unchanged. Specifically:

o This policy revision always applies to home health aide services when the beneficiary qualifies for coverage;

o This policy revision applies to skilled nursing care only when the beneficiary needs physical therapy or speech therapy or continued occupational therapy, and also needs skilled nursing care; and

o If the beneficiary needs skilled nursing care but does not need physical therapy or speech therapy or occupational therapy, the beneficiary must still meet the longstanding and unchanged definition of "intermittent" skilled nursing care in order to qualify for coverage of any home health services.

(next page is 3-54.1)

Special Conditions for Coverage for Home Health Services

3122. SPECIAL CONDITIONS FOR COVERAGE OF HOME HEALTH SERVICES UNDER SUPPLMENTARY MEDICAL INSURANCE

3122.1 Non-Eligibility Under Hospital Insurance.--For home health services to be covered under supplementary medical insurance, the patient may be currently enrolled in the medical insurance plan, and, where the home health services to be provided are covered under hospital insurance, not be eligible to receive such services under hospital insurance. Where a patient is eligible for home health services which are covered under both programs, the services are chargeable under hospital insurance. When the benefits payable under hospital insurance are exhausted, he may then utilize the benefits available under the supplementary medical insurance program. Effective July 1, 1981, the 100 visit limitation is eliminated and services continue to be covered under hospital insurance (Part A). A plan covering services under the medical insurance program must be established by the physician and must be reduced to writing before the agency bills for the services.

Prior inpatient care in a hospital or skilled nursing facility is not required for coverage of home health services under the supplementary medical insurance plan.

3122.2 Change to Medical Insurance Home Health Services on Change of Residence.--A patient who changes residence before exhausting his 100 home health visits under hospital insurance can receive further home health services only under the medical insurance program if there is no further eligibility for home health services under the hospital insurance plan. This might occur, for example, in the following situations:

A. The physician in the old locality terminates the posthospital home health plan, or

B. There is no physician in the new locality who agrees to accept both the patient and the plan, e.g., the new physician wants to establish an entirely new plan.

For coverage under medical insurance in these circumstances, the new physician must establish a new plan.

See section 3121.4 for conditions under which home health services under hospital insurance may continue in the new locality.

NOTE: Effective July 1, 1981, the 100 visit limitation is eliminated.

3123. DURATION OF HOME HEALTH SERVICES

3123.1 Duration of Home Health Services Under Hospital Insurance.--Under hospital insurance prior to July 1, 1981, the patient is entitled to up to 100 visits in the 1-year period after the most recent discharge from a qualifying inpatient stay and before a new spell of illness begins (§3121.1).

If before a series of home health visits is completed, a patient receives inpatient services which start a new spell of illness, the series of visits is terminated. Both the "prior inpatient stay" (§3121.1) and "timely establishment of plan" (§3121.2) requirements must be met in the new spell of illness to provide coverage for a new series of home health visits.

If, during the same spell of illness, the home health patient returns to a hospital or extended care facility for a stay which meets the prior-stay requirement, a new 1-year priod for his Part A visits is established dating from his latest discharge. The total number of visits available before the next spell of illness begins remains unchanged.

In rare cases a home health patient may return to a hospital for a stay which satisfies the prior-stay requirement but does not begin a new spell of illness, i.e., a 3-day noncovered stay in a non-participating hospital which meets all the conditions of participation except for the utilization review and health safety requirements (§3010). In this situation a new 1-year period begins with the discharge and the number of visits remains unchanged.

The end of the year for hospital insurance purposes is determined as follows:

Count 365 days (366 when February 29 is included) beginning with the latter of the following:

a. The date of discharge after June 30, 1966, from a 3-day stay in any hospital, or

b. The date of discharge after December 31, 1966, from a skilled nursing facility stay for which posthospital extended care benefits were payable on the patient's behalf.

Effective July 1, 1981, the 100 visit limitation under Part A and Part B, and the prior inpatient stay and the spell of illness requirements under Part A are eliminated.

3123.2 Duration of Home Health Services Under Supplementary Medical Insurance.—Under supplementary medical insurance a patient is entitled to 100 visits in a calendar year. Entitlement to visits under supplementary medical insurance is related to the calendar year and is unaffected by the patient's spell(s) of illness. Effective July 1, 1981, the 100 visit limitation is eliminated. If entitled to services under both hospital insurance and supplementary medical insurance, the visit must first be charged against the hospital insurance.

The end of the year under medical insurance is December 31.

3123.3 Examples of Duration of Services Under Hospital and Medical Insurance.—

EXAMPLE: 1. Jones is hospitalized on February 10 and discharged on March 15, 1967; he has no other hospital or skilled nursing facility stay in 1967, or 1968. He has 100 home health visits beginning the latter part of March and ending on February 20, 1968. All 100 visits are paid for under hospital insurance since the 1-year period runs from March 15, 1967, the date of the hospital discharge, to March 14, 1968. Although Jones' spell of illness ended on May 13, 1967, 60 days after the hospital discharge, home health eligibility was unaffected since a new spell of illness did not begin subsequently.

EXAMPLE: 2. Robinson was an inpatient in a hospital four times during the same spell of illness; i.e., there was no period of 60 consecutive days during which he was not hospitalized. He was discharged from the hospital, which meets the requirements to qualify subsequent home health services for payment under hospital insurance, on March 15, 1967, May 13, 1967, July 12, 1967, and September 9, 1967. Each hospital stay was for at least 3 consecutive days except the last one. He had home health visits beginning with May 23, 1967, based on a plan established after his hospital discharge of May 13. The 1-year period for home health services under hospital insurance began May 13, 1967, the date of his most recent discharge (in relation to the first home health visit in the spell of illness) from a hospital after a stay of 3 days; it can end no later than July 12, 1968, 1 year after the latest discharge from a hospital stay of at least 3 consecutive days. Thus, in some situations, the "1-year period" during which an individual may have up to 100 home health visits may in fact exceed a year overall.

EXAMPLE: 3. Smith is hospitalized on February 10 and discharged on March 15. He reenters the hospital on July 4. He had 30 some health visits between March 15 and July 4. Since he had been out of the hospital for more than 60 days after his discharge on March 15, a new spell of illness began on July 4, when he reentered the hsopital. Therefore, he is not entitled to any additional home health visits under hospital insurance based on his February-March hospital stay. However, an additional 100 home health visits under hospital insurance may begin based on his hospitalization beginning July 4, if he is confined for at least 3 days. If it is for less than 3 days, he will not qualify for home health visits under hospital insurance in the new spell of illness. However, if he is enrolled in the supplementary medical insurance program he is entitled to an additional 100 visits under Part B through December 31, subject to the deductible provisions.

EXAMPLE: 4. Brown is discharged from a hospital on February 15, 1967, after a 3-day stay. He begins receiving home health visits on February 18, 1967. He has until February 14, 1968, to use his 100 visits under hospital insurance. In July, however, he receives his 100th visit, exhausting the number of visits to which he is entitled under hospital insurance. Coverage of his home health visits may continue unbroken, if he is enrolled under supplementary medical insurance. In that event, he may receive an additional 100 visits under medical insurance through December. In January 1968, he becomes entitled to an additional 100 visits under supplementary medical insurance for the calendar year of 1968.

NOTE: The Omnibus Reconciliation Act of 1980 eliminates the prior inpatient stay requirement under Part A, the visit limitation under Part A and Part B and the Part B deductible. Therefore, the above examples pertain only to home health services furnished prior to July 1, 1981.

3124. COUNTING VISITS UNDER THE HOSPITAL AND MEDICAL PLANS.

The number of visits are counted in the same manner under both the hospital plan and medical plan.

3124.1 Visit Defined.--A visit is a personal contact in the place of residence of a patient made for the purpose of providing a covered service by a health worker on the staff of the home health agency or by others under contract or arrangement with the home health agency; or a visit by a patient on an outpatient basis to a hospital, skilled nursing care facility, or rehabilitation center, or outpatient department affiliated with a medical school when arrangements have been made by the home health agency for one or more of the covered services. (See §§ 3025ff.)

3124.2 Counting Visits.--If a visit is made simultaneously by two or more persons from the home health agency to provide a single service, for which one person supervises or instructs the other, it is counted as one visit. (See example 1.) If one person visits the patient's home more than once during a day to provide services, each visit is recorded as a separate visit (see example 2). If a visit is made by two or more persons from the home health agency for the purpose of providing separate and distinct types of services, each is recorded -- i.e., two or more visits (see example 3). If the patient is taken elsewhere for the service because the service could not be furnished in his residence, one visit is counted for each service he received (see example 4).

EXAMPLES:

1. If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, one visit is counted.

2. If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, two visits are counted.

3. If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, two visits are counted.

4. If an individual is taken to a hospital to receive outpatient therapy that could not be furnished in his own home (e.g., hydrotherapy) and, while at the hospital receives speech therapy and other services, two or more visits would be charged.

5. **Many home health agencies provide home health aide services on an hourly basis (ranging from 1 to 8 hours a day).** However, in order to allocate visits properly against a patient's maximum allowable visits, home health aide services are to be counted in terms of visits. Thus, regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one "visit" is counted for each such day. If, in a rare situation, a home health aide visits a patient for an hour or two in the morning, and again for an hour or two in the afternoon, two visits are counted.

Under both hospital insurance and supplementary medical insurance, visits count toward the 100-visit maximums only if payment was made for the visits by the program or, if payment would be made if requested by the patient, and the certification requirements (§§3326ff.) were met. Visits by personnel other than those providing covered services are not counted. Salaries of personnel employed by the agency to assist in overall operation of the program (e.g., a nutritionist) may be taken into consideration in computing overhead costs of the agency when claiming reimbursement.

An important item to remember about visits under supplementary medical insurance: Visits provided a patient during the period in which he is incurring sufficient expenses to satisfy the deductible will count toward the 100-visit maximum, even though reimbursement is not possible because the deductible has not been satisfied.

NOTE: The above discussion which relates to the visit limitation and the deductible requirement for home health benefits pertains to services furnished prior to July 1, 1981.

3124.3 Evaluation Visits.--Home health agencies are required by regulations to have written policies concerning the acceptance of patients by the agency. These include consideration of the physical facilities available in the patient's place of residence, the homebound status, and the attitudes of family members for the purpose of evaluating the feasibility of meeting the patient's medical needs in the home health setting. When personnel of the agency make such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not chargeable as a visit since at this point the patient has not been accepted for care. If, however, during the course of this initial evaluation visit, the patient is determined suitable for home health care by the agency, and is also furnished the first skilled service as ordered under the physician's plan of treatment, the visit would become the first billable visit.

Cover an observation and evaluation (or reevaluation) visit made by a nurse (see § 3117.4 for a further discussion of skilled nursing observation and evaluation visits) or other appropriate personnel, ordered by the physician for the purpose of evaluating the patient's condition and his or her continuing need for skilled services, as a skilled visit.

A supervisory visit made by a nurse or other appropriate personnel (as required by the conditions of participation) to evaluate the specific personal care needs of the patient or to review the manner in which the personal care needs of the patient are being met by the aide is an administrative function, not a skilled visit.

3125. SPECIFIC EXCLUSIONS FROM COVERAGE AS HOME HEALTH SERVICES.

In addition to the general exclusions from coverage under health insurance listed in §§ 3150ff., the following are also excluded from coverage as home health services:

- Services or items which would not be paid for if provided to an inpatient of a hospital, such as a private-duty nursing service, or items of comfort which are not necessary for treatment, e.g., television;
- Meals-on-Wheels or similar food arrangements;
- Domestic or housekeeping services which are unrelated to patient care, and
- Transportation services, e.g., from place of residence to a facility to receive home health services on an outpatient basis.

3127. MEDICAL AND OTHER HEALTH SERVICES FURNISHED BY HOME HEALTH AGENCIES.

Reimbursement may be made to a home health agency which furnishes either directly or under arrangements with others the following "medical and other health services" to beneficiaries with Part B coverage.

- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations. (See § 3110.3.)
- Prosthetic devices. (See § 3110.4.) Total parenteral nutrition (TPN) systems and enteral nutrition (EN) systems are covered as prosthetic devices when the criteria in §§ 65-10 - 65-10.3 of the Coverage Issues Manual are met. When these criteria are met, the equipment and supplies which (together with nutrients) comprise the prosthetic device are not considered durable medical equipment and medical supplies, and therefore are not covered as home health services. An HHA that supplies TPN or EN systems, that meet the criteria for coverage as a prosthetic device, must bill one of the two carriers designated to process claims for TPN and EN systems. (See § 3661.)

o Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. (See § 3110.5.)

o Outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology services. (See §§ 3147ff.)

o Rental and purchase of durable medical equipment. (See §§ 3113ff. and 3119.3.) If a beneficiary meets all of the criteria for coverage of home health services and the HHA is providing home health care under the Hospital Insurance Program (Part A), any DME provided by the HHA to that patient must also be provided under Part A. Where the patient meets the criteria for coverage of home health services and the HHA is providing the home health care under the Supplementary Medical Insurance Program (Part B) because the patient is not eligible for Part A, the DME provided by the HHA may, at the beneficiary's option, be furnished under the Part B home health benefit or as a medical and other health service. Irrespective of how the DME is furnished, the beneficiary is responsible for a 20 percent coinsurance.

o Ambulance service. (See § 3114.)

NOTE: Sections 3213 and 3214 discuss the deductible and coinsurance under the supplementary medical insurance program.

3128. PHYSICIAN CERTIFICATION FOR MEDICAL AND OTHER HEALTH SERVICES FURNISHED BY HOME HEALTH AGENCY.

A physician must certify that the medical and other health services covered by medical insurance which were provided by (or under arrangements made by) the HHA were medically required. (See § 3350 for the special physician certification requirements applicable to outpatient physical therapy, occupational therapy and speech pathology services.) This certification needs to be made only once where the patient may require over a period of time the furnishing of the same item or service related to one diagnosis. There is no requirement that the certification be entered on any specific form or handled in any specific way as long as the approach adopted by the HHA permits you to determine that the certification requirement is, in fact, met. A written physician's order designating the services required would also be an acceptable certification.

(§ 3130 begins on page 3-55.5)

Coverage of Extended Care Services Under Hospital Insurance

3130. REQUIREMENTS—GENERAL

Posthospital extended care services furnished to inpatients of an SNF or a swing bed hospital (see §3130.1) are covered under the hospital insurance program. Patients having hospital insurance coverage are entitled to have payment made on their behalf for the reasonable cost of covered extended care services furnished by an SNF or swing bed facility or by others under arrangements with the SNF or swing bed hospital.

3130.1 HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

In order to address the shortage of rural SNF beds for Medicare patients, effective July 20, 1982, rural hospitals with fewer than 50 beds may be reimbursed under Medicare for furnishing post hospital extended care services to Medicare beneficiaries. Such a hospital, known as a swing bed facility, can "swing" its beds between the hospital and SNF levels of care, on an as needed basis, if it has obtained a swing bed approval from the Department of Health and Human Services. In order to obtain such an approval, the hospital must:

- o as noted above, be located in a rural area (i.e., located outside of an "urbanized area," as defined by the Census Bureau, and based on the most recent census) and have fewer than 50 beds (excluding beds for newborns and intensive care-type units);

- o have a Medicare provider agreement, as a hospital;

- o be granted any necessary certificate of need for the provision of extended care services, as required by the State;

- o be substantially in compliance with the SNF conditions of participation for patient rights, 42 CFR 405.1121(k)(2), (3), (4), (7), (8), (10), (11), (13) and (14); specialized rehabilitative services, 42 CFR 405.1126(a), (b) and (c); dental services, 42 CFR 405.1129; social services, 42 CFR 405.1130; patients activities, 42 CFR 405.1131; and discharge planning, 42 CFR 405.1137(h); (most other SNF conditions would be largely met by virtue of the facility's compliance with comparable hospital conditions);

- o not have in effect a 24-hour nursing waiver granted under 42 CFR 405.1910(c); and

- o not have had a swing bed approval terminated within the 2 years previous to application for swing bed participation.

However, the Department may grant a swing bed approval, on a demonstration basis, with hospitals meeting all of the statutory requirements except bed size and geographic location.

When a hospital has a swing bed approval from the Department, it may provide and be reimbursed by Medicare Part A for providing extended care or SNF-type services. When a swing bed hospital provides extended care services, Medicare reimbursement for those services will be at what is generally a SNF rate for comparable services. This rate is set under explicit statutory conditions and is described at 42 CFR 405.434 and 405.452.

When a hospital is providing extended care services, it will be treated as a SNF for purposes of applying coverage rules. This means that those services are subject to the same Part A coverage, deductible, coinsurance and physician certification/recertification provisions that are applicable to SNF extended care services (i.e., the coverage requirements in §§3130 through 3136 and the application of waiver of liability to some of those requirements as discussed in §3431.1; the coinsurance requirements in §§3203 and 3211, the Part A deductible provision in §3235 and the certification/recertification provisions in §§3333 through 3338).

Swing bed approvals do not cover services billed for under Part B. This means that pursuant to such an approval a hospital may be reimbursed under Part A for either SNF or hospital level services. However, if a service is to be reimbursed under Part B (due to Part A exhaustion, etc. (see §3110)), the hospital may be reimbursed for only hospital services covered under Part B.

Under §4005(b)(2) of the Omnibus Budget Reconciliation Act of 1987, effective for swing-bed agreements entered into after March 31, 1988, hospitals with more than 49 beds (but less than 100 beds) are subject to the following:

- If there is an available SNF bed in the geographic region, the extended care patient must be transferred within 5 days of the availability date (excluding weekends and holidays) unless the patient's physician certifies, within that 5-day period, that transfer of that patient to that facility is not medically appropriate on the availability date. In order to do this, hospitals need to identify all SNFs in their geographic region and enter into agreements with them for the transfer of extended care patients under which SNFs are to notify the hospitals of the availability of beds and the dates these beds will be available for extended care patients; and

- The 5 week day transfer requirement and the 15 percent payment limitation do not apply for Medicaid reimbursement purposes.

Hospitals having fewer than 50 beds and rural hospitals which entered into agreements before March 31, 1988 (i.e., those which were licensed for more than 49 beds but were operating as a 50 or less bed facility) are not subject to the 5 week day transfer requirement or the payment limitation for extended care days. (See §2230.7 of the Provider Reimbursement Manual for the explanation of the payment limitation.)

"Geographic region" is an area which includes the SNFs with which a hospital has traditionally arranged transfers and all other SNFs within the same proximity to the hospital. In the case of a hospital without existing transfer practices upon which to base a determination, the geographic region is an area which includes all the SNFs within 50 miles of the hospital unless the hospital can demonstrate that the SNFs are inaccessible to its patients. In the event of a dispute as to whether an SNF is within this region or the SNF is inaccessible to hospital patients, the HCFA regional office shall make a determination.

3131. PRIOR HOSPITALIZATION AND TRANSFER REQUIREMENTS

In order to qualify for posthospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least 3 consecutive calendar days. In addition, effective December 5, 1980, the individual must have been transferred to a participating SNF within 30 days after discharge from the hospital, unless the exception in §3131.3B applies.

3131.1 Three-Day Prior Hospitalization.--The hospital discharge must have occurred on or after the first day of the month in which the individual attained age 65 or, effective July 1, 1973, became entitled to health insurance benefits under the disability or chronic renal disease provisions of the law. The 3 consecutive calendar days requirement can be met by stays totalling 3 consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day.

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services or a condition which arose while in the SNF for treatment of a condition for which he was previously hospitalized. In addition, the qualifying hospital stay must have been medically necessary. Medical necessity will generally be presumed to exist. When the facts which come to you in your normal claims review process indicate that the hospitalization may not have been medically necessary, fully develop the case, checking with the attending physician and the hospital, as appropriate. Rule the stay unnecessary only when hospitalization for 3 days represents a substantial departure from normal medical practice.

The 3-day hospital stay need not be in a hospital with which the SNF has a transfer agreement. However, the hospital must be:

- a participating general or psychiatric hospital; or
- an institution which meets at least the conditions of participation for hospitals described in §3010E and G, i.e., an emergency services hospital.

A nonparticipating psychiatric hospital need not meet the special requirements applicable to psychiatric hospitals (§§3015 and 3016). Stays in Christian Science Sanatoriums (§3023) are excluded for the purpose of satisfying the 3-day period of hospitalization. (See §3520.3 for prohibition on use of waiver of liability days in meeting the 3-day requirement.)

NOTE: While a 3-day stay in a psychiatric hospital satisfies the prior hospital stay requirement, institutions which primarily provide psychiatric treatment cannot participate in the program as SNFs. Therefore, a patient with only a psychiatric condition who is transferred from a psychiatric hospital to a participating SNF is likely to receive only noncovered care. In the SNF, the term "noncovered care" refers to any level of care which is less intensive and skilled than the SNF level of care which is covered under the program. (See §§3132ff.)

3131.2 Three-day Prior Hospitalization—Foreign Hospital.—A stay of 3 or more days in a hospital outside the United States may satisfy the prior inpatient stay requirement for posthospital extended care services within the United States if the foreign hospital is qualified as an "emergency hospital." If a stay of 3 or more days in a hospital outside the United States is being considered to satisfy the prior inpatient stay requirement, the SNF will submit documentation to you. This evidence will be either:

A. An itemized bill or hospital form prepared by the foreign hospital showing dates of admission and discharge and a description of the illness or injury treated (obtained from the beneficiary); or

B. A medical report prepared by the foreign hospital and sent to the patient's U.S. physician showing dates of admission and discharge and a description of the illness or injury treated (obtained from the physician).

If neither type of evidence can be obtained, the SNF will secure whatever information is available. Such evidence or information will be attached to the admission notice sent to you. When you receive a notice of admission involving a prior inpatient stay in a foreign hospital, contact the regional office for a determination as to whether the prior stay requirement is met.

If the regional office states the hospital does not qualify as an "emergency hospital," advise the provider that the prior inpatient stay requirement is not met.

If the regional office states the hospital qualifies as an "emergency hospital" and documentation is submitted as outlined in either A or B which otherwise meets the prior-stay requirement, the intermediary will then process the admission notice.

3131.3 Thirty-Day Transfer.—

A. General.—Posthospital extended care services represent an extension of care for a condition for which the individual received inpatient hospital services. Extended care services are "posthospital" if initiated within 30 days after discharge from a hospital stay which included at least 3 consecutive days of medically necessary inpatient hospital services. In certain circumstances the 30-day period may be extended, as described in B below.) For SNF admissions occurring after October 29, 1972, but before December 5, 1980, see §D below.

In determining the 30-day transfer period, the day of discharge from the hospital is not counted in the 30 days. For example, a patient discharged from a hospital on August 1 and admitted to an SNF on August 31 was admitted within 30 days. The 30-day period begins on the day following actual discharge from the hospital and continues until the individual is admitted to a participating SNF, and requires and receives a covered level of care. Thus, an individual who is admitted to an SNF within 30 days after discharge from a hospital, but does not require a covered level of care until more than 30 days after such discharge, does not meet the 30-day requirement. (See B below for an exception under which such services may be covered.)

If an individual whose SNF stay was covered upon admission is thereafter determined not to require a covered level of care for a period of more than 30 days, payment could not be resumed for any extended care services he may subsequently require even though he has remained in the facility. Such services could not be deemed to be "posthospital" extended care services. (For exception, see B below.)

B. Medical Appropriateness Exception.--An elapsed period of more than 30 days is permitted for SNF admissions where the patient's condition makes it medically inappropriate to begin an active course of treatment in an SNF immediately after hospital discharge, and it is medically predictable at the time of the hospital discharge that he will require covered care within a predeterminable time period. The fact that a patient enters an SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

1. Medical Needs are Predictable.--In determining the type of case which this exception is designed to handle, it is necessary to recognize the intent of the extended care benefit itself. The extended care benefit covers relatively short-term care when a patient requires skilled nursing or skilled rehabilitation services as a continuation of treatment begun in the hospital. The requirement that covered extended care services be provided in an SNF within 30 days after hospital discharge is one of the means of assuring that the SNF care is related to the prior hospital care.

This exception to the 30-day requirement recognizes that for certain conditions, SNF care can serve as a necessary and proper continuation of treatment initiated during the hospital stay, although it would be inappropriate from a medical standpoint to begin such treatment within 30 days after hospital discharge. Since the exception is intended to apply only where the SNF care constitutes a continuation of care provided in the hospital, it will be applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame. Accordingly, to qualify for this exception it must be medically predictable at the time of hospital discharge that a covered level of SNF care will be required within a predictable period of time for the treatment of a condition for which hospital care was received and the patient must begin receiving such care within that time frame.

An example of the type of care for which this provision was designed is care for a hip fracture case. Under the established pattern of treatment of hip fractures it is known that skilled therapy services will be required subsequent to hospital care, and that they can normally begin within 4-6 weeks after hospital discharge, when weight bearing can be tolerated. Under the exception to the 30-day rule, the admission of a hip fracture patient to an SNF within 4-6 weeks after his hospital discharge for skilled care, which as a practical matter can only be provided on an inpatient basis by an SNF, would be considered a timely admission.

2. Medical Needs are Not Predictable.—When a patient's medical needs and the course of treatment are not predictable at the time of hospital discharge because the exact pattern of care which he will require and the time frame in which it will be required is dependent on the developing nature of his condition, his admission to an SNF more than 30 days after discharge from the hospital could not be justified under this exception to the 30-day rule. For example, in some situations the prognosis for a patient diagnosed as having cancer is such that it can reasonably be expected that he will require additional care at some time in the future. However, at the time of discharge from the hospital it is difficult to predict the actual services which will be required or the time frame in which the care will be needed. Similarly, it is not known in what setting any future necessary services will be required; i.e., whether he will require the life-supporting services found only in the hospital setting, the type of care covered in an SNF, the intermittent type of care which can be provided by a home health agency, or custodial care which may be provided either in a nursing home or his place of residence. In some instances such patients may require care immediately and continuously; others may not require any skilled care for much longer periods, perhaps measured in years. Therefore, since in such cases it is not medically predictable at the time of the hospital discharge that the individual will require covered SNF care within a predeterminable time frame, such cases do not fall within the 30-day exception.

3. SNF Stay Prior to Beginning of Deferred Covered Treatment.-In some cases where it is medically predictable that a patient will require a covered level of SNF care within a predeterminable time frame, the individual will also have a need for a covered level of SNF care within 30 days of hospital discharge. In such situations,

this need for covered SNF care does not negate further coverage at a future date even if there is a noncovered interval of more than 30 days between the two stays, provided all other requirements are met. (See example No. 1 below.) However, this rule applies only where part of the care required involves deferred care which was medically predictable at the time of hospital discharge. If the deferred care is not medically predictable at the time of hospital discharge, then coverage may not be extended to include SNF care following an interval of more than 30 days of noncovered care (see example No. 2). Where it is medically predictable that a patient will require a covered level of SNF care within a specific time frame, the fact that an individual enters an SNF immediately upon discharge from the hospital for noncovered care does not negate coverage at a later date, assuming the requirements of the law are met (see example No. 3).

EXAMPLE NO. 1: A patient who has had an open reduction of a fracture of the neck of the femur and has a history of diabetes mellitus and angina pectoris is discharged from the hospital on January 30, 1981 and admitted immediately to an SNF. He requires among other services careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to detect signs of deterioration in his condition or complications resulting from his restricted mobility, which necessitates skilled management of his care to ensure his safety and recovery. It is also medically predictable that when he reaches weight bearing, skilled rehabilitative services will be required. After he is in the SNF for 2 days, he becomes unhappy and at his request is released to his home in the care of a full time private duty nurse. Five weeks later when he reaches weight bearing he is readmitted to the SNF for the needed rehabilitative care. The patient would be eligible for coverage under the program for the care furnished him during both of these stays.

EXAMPLE NO. 2: An individual is admitted to an SNF for daily skilled rehabilitative care which as a practical matter can only be provided on an inpatient basis in an SNF. After 3 weeks the therapy is discontinued because the patient's condition has stabilized and daily skilled services are no longer required. Six weeks later, however, as a result of an unexpected change in the patient's condition, daily skilled services are again required. Since the second period of treatment did not constitute care which was predictable at the time of hospital discharge and could not thus be considered as care which was deferred until medically appropriate, it would not represent an exception to the 30-day exception rule. Therefore, since more than 30 days of noncovered care had elapsed between the last period of covered care and the reinstitution of skilled services, reimbursement could not be made under the extended care benefit for the latter services.

EXAMPLE NO. 3: A patient whose right leg was amputated was discharged from the hospital and admitted directly to an SNF on January 30, 1981. Although upon admission to the SNF the patient required help with meeting his activities of daily living, he did not require daily skilled care. Subsequently, however, after the stump had healed, daily skilled rehabilitative services designed to enable him to use a prosthesis were required. Since at the time of the patient's discharge from the hospital it was medically predictable that at a predeterminable time interval covered SNF care would be required, and since such care was initiated when appropriate, the patient would be entitled to extended care benefits for the period during which such care was provided.

4. Effect of Delay in Initiation of Deferred Care.—As indicated, where the required care commences within the anticipated time frame the transfer requirement would be considered met even though more than 30 days have elapsed. However, situations may occur where complications necessitate delayed initiation of the required care and treatment beyond the usual anticipated time frame (e.g., skilled rehabilitative services which will enable an amputee patient to use a prosthetic device must be deferred due to an infection in the stump). In such situations, the 30-day transfer requirement may still be met even though care is not started within the usual anticipated time frame, if the care is begun as soon as medically possible and the care at that time is still reasonable and necessary for the treatment of a condition for which the patient received inpatient hospital care.

5. Effect on Spell of Illness.—In the infrequent situation where the patient has been discharged from the hospital to his home more than 60 days before he is ready to begin a course of deferred care in an SNF, a new spell of illness begins with the day the beneficiary enters the SNF thereby regenerating another 100 days of extended care benefits. Another qualifying hospital stay would not be required, providing the care furnished is clearly related to the hospital stay in the previous spell of illness and represents care for which the need was predicated at the time of discharge from such hospital stay.

C. Readmission to an SNF.—If an individual who is receiving covered posthospital extended care leaves an SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days, the 30-day transfer requirement is considered to be met. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to an SNF. (See B.3 above for situations where a period of more than 30 days between SNF discharge and readmission, or more than 30 days of noncovered care in an SNF, is followed by later covered care.)

D. Transfer Rules for SNF Admissions Subsequent to October 29, 1972 and Prior t December 5, 1980.—

1. General.—Under the transfer rules in effect during this time frame an individual must have been admitted to a participating SNF, and have required and received a covered level of care within 14 days after discharge from a qualifying hospital stay, unless one of the exceptions in D.2 or D.3 below applies.

2. Nonavailability of Appropriate Bed Space in a Participating SNF.—Intervals of up to 28 days were permitted where transfer to a participating SNF (for this purpose a "participating SNF" includes only those facilities participating under title XVIII) was deferred under the following conditions.

a. The individual required within the 14-day period after the hospital discharge, and continued to require through admission to the SNF, a covered level of SNF care for a condition for which he received inpatient hospital care, and he met all other extended care requirements, and either b or c below applied;

b. There was no bed available in the facilities ordinarily utilized in the geographic area in which the beneficiary resided. (A private room is considered an "available bed" for this purpose, and is subject to reimbursement per sections 3101.1ff.) The geographic area in which a beneficiary resides should be defined in such a way that a patient would not be taken away from his family and transported over great distances;

c. There was an available bed in an SNF but it did not constitute appropriate bed space for the patient. In determining whether appropriate bed space was available, consideration should be given only to whether the facility in which a vacant bed was available had the capacity to meet the individual's medical needs, i.e., was capable of providing the required skilled services. Such nonmedical considerations as the individual's or his physician's preference for a particular SNF should not be considered.

Absent evidence to the contrary, the intermediary may accept the statement of the provider reflected on the billing form (see section 3620, Item 12, Qualifying and Other Prior Stay Information—SNF Bills) that delayed admission to the SNF was due to the nonavailability of an SNF bed or to the inability of an available SNF to provide the necessary services. However, where the intermediary has information available to it which raises a question as to the validity of such statements, e.g., the information available to the intermediary indicates that local SNFs were operating at less than full census, the intermediary should undertake the development necessary to establish whether or not the delayed admission was in fact due to the nonavailability of an appropriate bed.

3. Medical Appropriateness.—An elapsed period of more than 14 days was permitted for SNF admissions where the patient's condition made it medically inappropriate to begin an active course of treatment in an SNF within 14 days after hospital discharge, and it was medically predictable at the time of the hospital discharge that he would require covered care within a predeterminable time period. The fact that a patient entered an SNF immediately upon discharge from a hospital, for either covered or noncovered care, does not necessarily negate coverage at a later date, assuming the subsequent covered care was medically predictable.

4. Readmission to an SNF.--If an individual who was receiving covered posthospital extended care left an SNF and was readmitted to the same or any other participating SNF for further covered care within 14 days, the 14-day transfer requirement was considered to be met. Thus, the period of extended care services could be interrupted briefly and then resumed, if necessary, without hospitalization preceding the readmission to an SNF. (See 3 above for situations where a period of more than 14 days between SNF discharge and readmission, or more than 14 days of noncovered care in an SNF, was followed by later covered care.)

3132. SKILLED NURSING FACILITY LEVEL OF CARE - GENERAL

Care in a SNF is covered if all of the following three factors are met:

- o The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel (see §§3132.1 - 3132.3);

- o The patient requires these skilled services on a daily basis (see §3132.5); and

- o As a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in an SNF. (See §3132.6.)

If any one of these three factors is not met, a stay in an SNF, even though it might include the delivery of some skilled services, is not covered. For example, payment for an SNF level of care could not be made if a patient needs an intermittent rather than daily skilled service.

In reviewing SNF services to determine whether the level of care requirements are met, first consider whether a patient needs skilled care. If a need for a skilled service does not exist, then the "daily" and "practical matter" requirements do not have to be addressed.

In addition, the services must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of a patient's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his particular medical needs, and accepted standards of medical practice. The services must also be reasonable in terms of duration and quantity.

EXAMPLE: Even though the irrigation of a catheter may be a skilled nursing service, daily irrigations may not be "reasonable and necessary" for the treatment of a patient's illness or injury.

3132.1 Skilled Nursing and Skilled Rehabilitation Services

A. Skilled Services--Defined.—Skilled nursing and/or skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- o Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists; and

- o Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

NOTE: "General supervision" requires initial direction and periodic inspection of the actual activity. However, the supervisor need not always be physically present or on the premises when the assistant is performing services.

Assume that skilled services provided by a participating SNF are furnished by or under the general supervision of the appropriate skilled nursing or skilled rehabilitation personnel.

B. Principles for Determining Whether a Service is Skilled

o If the inherent complexity of a service prescribed for a patient is such that it can be performed safely and/or effectively only by or under the general supervision of skilled nursing or skilled rehabilitation personnel, the service is a skilled service; e.g., the administration of intravenous feedings and intramuscular injections; the insertion of catheters; and ultrasound, shortwave, and microwave therapy treatments.

o Consider the nature of the service and the skills required for safe and effective delivery of that service in deciding whether a service is a skilled service. While a patient's particular medical condition is a valid factor in deciding if skilled services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is not skilled.

EXAMPLE: Even where a patient's full or partial recovery is not possible, a skilled service still could be needed to prevent deterioration or to maintain current capabilities. A cancer patient, for instance, whose prognosis is terminal may require skilled services at various stages of his illness in connection with periodic "tapping" to relieve fluid accumulation and nursing assessment and intervention to alleviate pain or prevent deterioration. The fact that there is no potential for such a patient's recovery does not alter the character of the services and skills required for their performance.

When rehabilitation services are the primary services, the key issue is whether the skills of a therapist are needed. The deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by nonskilled personnel. (See §3132.3.A.)

o A service that is ordinarily considered nonskilled could be considered a skilled service in cases in which, because of special medical complications, skilled nursing or skilled rehabilitation personnel are required to perform or supervise it or to observe the patient. In these cases, the complications and special services involved must be documented by physicians' orders and nursing or therapy notes.

EXAMPLE: The existence of a plaster cast on an extremity generally does not indicate a need for skilled care. However, a patient with a preexisting acute skin problem, preexisting peripheral vascular disease, or a need for special traction of the injured extremity might need skilled nursing or skilled rehabilitation personnel to observe for complications or to adjust traction.

EXAMPLE: Whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required where the patient's condition is complicated by circulatory deficiency, areas of desensitization, or open wounds.

o In determining whether services rendered in an SNF constitute covered care, it is necessary to determine whether individual services are skilled, and whether, in light of the patient's total condition, skilled management of the services provided is needed even though many or all of the specific services were unskilled.

EXAMPLE: An 81-year-old woman who is aphasic and confused, suffers from hemiplegia, congestive heart failure, and atrial fibrillation, has suffered a cerebrovascular accident, is incontinent and has a Grade 1 decubitus ulcer, and is unable to communicate and make her needs known. Even though no specific service provided is skilled, the patient's condition requires daily skilled nursing involvement to manage a plan for the total care needed, to observe the patient's progress, and to evaluate the need for changes in the treatment plan.

o The importance of a particular service to an individual patient, or the frequency with which it must be performed, does not, by itself, make it a skilled service.

EXAMPLE: A primary need of a nonambulatory patient may be frequent changes of position in order to avoid development of decubitus ulcers. However, since such changing of position does not ordinarily require skilled nursing or skilled rehabilitation personnel, it would not constitute a skilled service, even though such services are obviously necessary.

The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support the need for skilled nursing or skilled rehabilitation personnel. Although the act of turning a patient normally is not a skilled service, for some patients the skills of a nurse may be necessary to assure proper body alignment in order to avoid contractures and deformities. In all such cases, the reasons why skilled nursing or skilled rehabilitation personnel are essential must be documented in the patient's record.

C. Specific Examples of Some Skilled Nursing or Skilled Rehabilitation Services

1. Management and Evaluation of a Patient Care Plan.—The development, management, and evaluation of a patient care plan, based on the physician's orders, constitute skilled nursing services when, in terms of the patient's physical or mental condition, these services require the involvement of skilled nursing personnel to meet the patient's medical needs, promote recovery, and ensure medical safety. However, the planning and management of a treatment plan that does not involve the furnishing of skilled services may not require skilled nursing personnel; e.g., a care plan for a patient with organic brain syndrome who requires only oral medication and a protective

environment. Skilled management would be required where the sum total of unskilled services which are a necessary part of the medical regimen, when considered in light of the patient's overall condition, makes the involvement of skilled nursing personnel necessary to promote the patient's recovery and medical safety.

EXAMPLE 1: An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted (but increasing) mobility. Although any of the required services could be performed by a properly instructed person, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the nature of the patient's condition, his age and his immobility create a high potential for serious complications, such an understanding is essential to assure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until the patient's treatment regimen is essentially stabilized, even though the individual services involved are supportive in nature and do not require skilled nursing personnel.

EXAMPLE 2: An aged patient is recovering from pneumonia, is lethargic, is disoriented, has residual chest congestion, is confined to bed as a result of his debilitated condition, and requires restraints at times. To decrease the chest congestion, the physician has prescribed frequent changes in position, coughing, and deep breathing. While the residual chest congestion alone would not represent a high risk factor, the patient's immobility and confusion represent complicating factors which, when coupled with the chest congestion, could create high probability of a relapse. In this situation, skilled overseeing of the nonskilled services would be reasonable and necessary, pending the elimination of the chest congestion, to assure the patient's medical safety.

Skilled planning and management activities are not always specifically identified in the patient's clinical record. Therefore, if the patient's overall condition supports a finding that recovery and safety can be assured only if the total care, skilled or not, is planned and managed by skilled nursing personnel, assume that skilled management is being provided even though it is not readily discernible from the record. Make this assumption only if the record as a whole clearly establishes that there was a likely potential for serious complications without skilled management.

2. Observation and Assessment of Patient's Condition.—Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's treatment regimen is essentially stablized.

EXAMPLE 1: A patient with arteriosclerotic heart disease with congestive heart failure requires close observation by skilled nursing personnel for signs of decompensation, abnormal fluid balance, or adverse effects resulting from prescribed medication. Skilled observation is needed to determine whether the digitalis dosage should be reviewed or whether other therapeutic measures should be considered, until the patient's treatment regimen is essentially stabilized.

EXAMPLE 2: A patient has undergone peripheral vascular disease treatment including revascularization procedures (bypass) with open or necrotic areas of skin on the involved extremity. Skilled observation and monitoring of the vascular supply of the legs is required.

EXAMPLE 3: A patient has undergone hip surgery and has been transferred to an SNF. Skilled observation and monitoring of the patient for possible adverse reaction to the operative procedure, development of phlebitis, skin breakdown, or need for the administration of subcutaneous Heparin, is both reasonable and necessary.

EXAMPLE 4: A patient has been hospitalized following a heart attack and, following treatment but before mobilization, is transferred to the SNF. Because it is unknown whether exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated, until the patient's treatment regimen is essentially stabilized.

EXAMPLE 5: A frail 85-year-old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is transferred to an SNF for monitoring of fluid and nutrient intake, assessment of the need for tube feeding and forced feeding if required. Observation and monitoring by skilled nursing personnel of the patient's oral intake is required to prevent dehydration.

If a patient was admitted for skilled observation but did not develop a further acute episode or complication, the skilled observation services still are covered so long as there was a reasonable probability for such a complication or further acute episode. "Reasonable probability" means that a potential complication or further acute episode was a likely possibility.

Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders are precluded by law from participating in Medicare.) Therefore, these cases must be carefully documented.

3. Teaching and Training Activities.—Teaching and training activities which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage his treatment regimen would constitute skilled services. Some examples are:

o Teaching self-administration of injectable medications or a complex range of medications;

o Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;

o Teaching self-administration of medical gases to a patient;

o Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;

o Teaching patients how to care for a recent colostomy or ileostomy;

o Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;

o Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;

o Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and

o Teaching patients the proper care of any specialized dressings or skin treatments.

D. Questionable Situations.—There must be specific evidence that daily skilled nursing or skilled rehabilitation services are required and received if:

o The primary service needed is oral medication; or

o The patient is capable of independent ambulation, dressing, feeding, and hygiene.

3132.2 Direct Skilled Nursing Services to Patients.—Some examples of direct skilled nursing services are:

o Intravenous, intramuscular or subcutaneous injections and hypodermoclysis or intravenous feeding (although giving an insulin injection is considered a skilled service, it is customary to teach patients to self-administer such an injection; if self-injection cannot be learned, however, insulin injection is a skilled service);

o Nasogastric tube, gastrostomy, and jejunostomy feedings;

o Naso-pharyngeal and tracheotomy aspiration;

- Insertion, sterile irrigation, and replacement of catheters; care of a suprapubic catheter and, in selected patients, urethral catheter (the mere presence of a urethral catheter, particularly one placed for convenience or the control of incontinence, does not justify a need for skilled nursing care. On the other hand, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for a urethral catheter must be justified and documented in the patient's medical record; i.e., it must be established that it is reasonable and necessary for the treatment of the patient's condition.);

- Application of dressings involving prescription medications and aseptic techniques (see §3132.4 for exception);

- Treatment of decubitus ulcers, of a severity rated at Grade 3 or worse, or a widespread skin disorder (see §3132.4 for exception);

- Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by skilled nursing personnel to adequately evaluate the patient's progress (see §3132.4 for exception);

- Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment and require the presence of skilled nursing personnel; e.g., the institution and supervision of bowel and bladder training programs;

- Initial phases of a regimen involving administration of medical gases such as bronchodilator therapy; and

- Care of a colostomy during the early postoperative period in the presence of associated complications. The need for skilled nursing care during this period must be justified and documented in the patient's medical record.

3132.3 Direct Skilled Rehabilitation Services to Patients

A. Skilled Physical Therapy

1. General.—Skilled physical therapy services must meet all of the following conditions:

- The services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a qualified physical therapist;

- The services must be of a level of complexity and sophistication, or the condition of the patient must be of a nature that requires the judgment, knowledge, and skills of a qualified physical therapist;

- The services must be provided with the expectation, based on the assessment made by the physician of the patient's restoration potential, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program;

- The services must be considered under accepted standards of medical practice to be specific and effective treatment for the patient's condition; and

- The services must be reasonable and necessary for the treatment of the patient's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

EXAMPLE 1: An 80-year-old, previously ambulatory, post-surgical patient has been bedbound for one week and, as a result, has developed muscle atrophy, orthostatic hypotension, joint stiffness and lower extremity edema. To the extent that the patient requires a brief period of daily skilled physical therapy services to restore lost functions, those services are reasonable and necessary.

EXAMPLE 2: A patient with congestive heart failure also has diabetes and previously had both legs amputated above the knees. Consequently, the patient does not have a reasonable potential to achieve ambulation, but still requires daily skilled physical therapy to learn bed mobility and transferring skills, as well as functional activities at the wheelchair level. If the patient has a reasonable potential for achieving those functions in a reasonable period of time in view of the patient's total condition, the physical therapy services are reasonable and necessary.

If the expected results are insignificant in relation to the extent and duration of physical therapy services that would be required to achieve those results, the physical therapy would not be reasonable and necessary, and thus would not be covered skilled physical therapy services.

Many SNF inpatients do not require skilled physical therapy services but do require services which are routine in nature. Those services can be performed by supportive personnel; e.g., aides or nursing personnel, without the supervision of a physical therapist. Such services, as well as services involving activities for the general good and welfare of patients (e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation) do not constitute skilled physical therapy.

2. Application of Guidelines.--Some of the more common physical therapy modalities and procedures are:

a. Assessment.--The skills of a physical therapist are required for the ongoing assessment of a patient's rehabilitation needs and potential. Skilled rehabilitation services concurrent with the management of a patient's care plan include tests and measurements of range of motion, strength, balance, coordination, endurance, and functional ability.

b. Therapeutic Exercises.--Therapeutic exercises which must be performed by or under the supervision of the qualified physical therapist, due either to the type of exercise employed or to the condition of the patient, constitute skilled physical therapy.

c. Gait Training.--Gait evaluation and training furnished a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy if they reasonably can be expected to improve significantly the patient's ability to walk.

Repetitious exercises to improve gait, or to maintain strength and endurance, and assistive walking are appropriately provided by supportive personnel, e.g., aides or nursing personnel, and do not require the skills of a physical therapist. Thus, such services are not skilled physical therapy.

d. Range of Motion.--Only the qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy. Range of motion exercises constitute skilled physical therapy only if they are part of active treatment for a specific disease state which has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored).

Range of motion exercises which are not related to the restoration of a specific loss of function often may be provided safely by supportive personnel, such as aides or nursing personnel, and may not require the skills of a physical therapist. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by aides or nursing personnel would not be considered skilled care.

e. Maintenance Therapy.--The repetitive services required to maintain function sometimes involve the use of complex and sophisticated therapy procedures and, consequently, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services. (See §3132.1.B.) The specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition, if the program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service.

EXAMPLE: A Parkinson's patient who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises are required for the maintenance of his present level of function. The initial evaluation of the patient's needs, the designing of a maintenance program which is appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician, the instruction of the patient or supportive personnel (e.g., aides or nursing personnel) in the carrying out of the program, and such infrequent reevaluations as may be required, would constitute skilled physical therapy.

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate his condition and adjust any exercise program the patient is expected to carry out himself or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible, i.e., by the end of the last restorative session, the physical therapist will have already designed the maintenance program required and instructed the patient or supportive personnel in the carrying out of the program.

f. Ultrasound, Shortwave, and Microwave Diathermy Treatments.—These modalities must always be performed by or under the supervision of a qualified physical therapist and are skilled physical therapy.

g. Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths.—Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications.

B. Speech Pathology.—See §3101.10A.

C. Occupational Therapy.—See §3101.9.

3132.4 Nonskilled Supportive or Personal Care Services.—The following services are not skilled services unless rendered under circumstances detailed in §3132.1.B:

- Administration of routine oral medications, eye drops, and ointments (the fact that a patient cannot be relied upon to take such medications himself or that State law requires all medications to be dispensed by a nurse to institutional patients would not change this service to a skilled service);

- General maintenance care of colostomy and ileostomy;

- Routine services to maintain satisfactory functioning of indwelling bladder catheters (this would include emptying containers and cleaning them, and clamping tubing);

- Changes of dressings for noninfected postoperative or chronic conditions;

- Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems;

- Routine care of the incontinent patient, including use of diapers and protective sheets;

- General maintenance care in connection with a plaster cast (skilled supervision or observation may be required where the patient has a preexisting skin or circulatory condition or needs to have traction adjusted);

- Routine care in connection with braces and similar devices;

- Use of heat as a palliative and comfort measure, such as whirlpool or steam pack;

- Routine administration of medical gases after a regimen of therapy has been established (i.e., administration of medical gases after the patient has been taught how to institute therapy);

- Assistance in dressing, eating, and going to the toilet;

- Periodic turning and positioning in bed; and

- General supervision of exercises which have been taught to the patient and the performance of repetitious exercises that do not require skilled rehabilitation personnel for their performance. (This includes the actual carrying out of maintenance programs where the performance of repetitive exercises that may be required to maintain function do not necessitate a need for the involvement and services of skilled rehabilitation personnel. It also includes the carrying out of repetitive exercises to improve gait, maintain strength or endurance; passive exercises to maintain range of motion in paralyzed extremities which are not related to a specific loss of function; and assistive walking.) (See §3101.8D.)

3132.5 Daily Skilled Services—Defined.—Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a "daily basis," i.e., on essentially a 7-day-a-week basis. However, if skilled rehabilitation services are not available on a 7-day-a-week basis, a patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the "daily basis" requirement when he needs and receives those services on at least 5 days a week. Accordingly, if a facility provides physical therapy on only 5 days a week and a patient in the facility requires and receives physical therapy on each of those days, the requirement that skilled rehabilitation services be provided on a daily basis is met. (If the services are available less than 5 days a week, though, the "daily" requirement would not be met.)

This requirement should not be applied so strictly that it would not be met merely because there is an isolated break of a day or two during which no skilled rehabilitation services are furnished and discharge from the facility would not be practical.

EXAMPLE: A patient who normally requires skilled rehabilitation services on a daily basis may exhibit extreme fatigue which results in suspending therapy sessions for a day or two. Coverage may continue for these days since discharge in such a case would not be practical.

3132.6 Services Provided on an Inpatient Basis as a "Practical Matter".—In determining whether the daily skilled care needed by an individual can, as a "practical matter," only be provided in an SNF on an inpatient basis, consider the individual's physical condition and the availability and feasibility of using more economical alternative facilities or services.

As a "practical matter," daily skilled services can be provided only in an SNF if they are not available on an outpatient basis in the area in which the individual resides or transportation to the closest facility would be:

- An excessive physical hardship;
- Less economical; or
- Less efficient or effective than an inpatient institutional setting.

The availability at home of capable and willing family or the feasibility of obtaining other assistance for the patient should be considered. Even though needed daily skilled services might be available on an outpatient or home care basis, as a practical matter, the care can be furnished only in the SNF if home care would be ineffective because the patient would have insufficient assistance at home to reside there safely.

EXAMPLE: A patient undergoing restorative physical therapy can walk only with supervision but has a reasonable potential to learn to walk independently with further training. Further daily skilled therapy is available on an outpatient or home care basis, but the patient would be at risk of further injury from falling, of dehydration or of malnutrition because insufficient supervision or assistance could be arranged for the patient in his home. In these circumstances, the physical therapy services as a practical matter can be provided effectively only in the inpatient setting.

A. The Availability of Alternative Facilities or Services.--Alternative facilities or services may be available to a patient if health care providers such as home health agencies were utilized. These alternatives are not always available in all communities and even where they exist they may not be available when needed.

EXAMPLE: Where the residents of a rural community generally utilize the outpatient facilities of a hospital located some distance from the area, the hospital outpatient department constitutes an alternative source of care that is available to the community. Roads in winter, however, may be impassable for some periods of time and in special situations institutionalization might be needed.

In determining the availability of more economical care alternatives, the coverage or noncoverage of that alternative care is not a factor to be considered. Home health care for a patient who is not homebound, for example, may be an appropriate alternative in some cases. The fact that such care cannot be covered by Medicare is irrelevant.

The issue is feasibility and not whether coverage is provided in one setting and not provided in another. For instance, an individual in need of daily skilled physical therapy might be able to receive the services needed on a more economical basis from an independently practicing physical therapist. However, the fact that Medicare reimbursement could not be made for the services because the $500 expense limitation applicable to the services of an independent physical therapist had been exceeded or because the patient was not enrolled in Part B, would not be a basis for determining that, as a practical matter, the needed care could only be provided in a SNF.

In determining the availability of alternate facilities or services, whether the patient or another resource can pay for the alternate services is not a factor to be considered.

B. Whether Available Alternatives are More Economical in the Individual Case.—If you determine that a generally more economical care alternative is available to provide the needed care, consider whether the use of the alternative actually would be more economical in the individual case.

EXAMPLE 1: If a patient's condition requires daily transportation to the alternative source of care (e.g., a hospital outpatient department) by ambulance, it might be more economical from a health care delivery viewpoint to provide the needed care in the SNF setting.

EXAMPLE 2: If needed care could be provided in the home, but the patient's residence is so isolated that daily visits would entail inordinate travel costs, care in an SNF might be a more economical alternative.

C. Whether the Patient's Physical Condition Would Permit Him to Utilize an Available, More Economical Care Alternative.—In determining the practicality of using more economical care alternatives, consider the patient's medical condition. If the use of those alternatives would adversely affect the patient's medical condition, conclude that as a practical matter the daily skilled services can only be provided by an SNF on an inpatient basis.

If the use of a care alternative involves transportation of the individual on a daily basis, consider whether daily transportation would cause excessive physical hardship. Determinations on whether a patient's condition would be adversely affected if an available, more economical care alternative were utilized should not be based solely on the fact that the patient is nonambulatory. There are individuals confined to wheelchairs who, though nonambulatory, could be transported daily by automobile from their homes to alternative care sources without any adverse impact. Conversely, there are instances where an individual's condition would be adversely affected by daily transportion to a care facility, even though he is able to ambulate to some extent.

EXAMPLE: A 75-year-old woman has suffered a cerebrovascular accident and cannot climb stairs with safety. The patient lives alone in a second-floor apartment accessible only by climbing a flight of stairs. She requires physical therapy and occupational therapy on alternate days, and they are only available in a CORF one mile away from her apartment. However, because of her inability to negotiate the stairs, the daily skilled services she requires cannot, as a practical matter, be provided to the patient outside the SNF.

The "practical matter" criterion should never be interpreted so strictly that it results in the automatic denial of coverage for patients who have been meeting all of the SNF level of care requirements, but who have occasion to be away from the SNF for a brief period of time. While most beneficiaries requiring an SNF level of care find that they are unable to leave the facility for even the briefest of time, the fact that a patient is granted an outside pass, or short leave of absence, for the purpose of attending a special religious service, holiday meal or family occasion, for going on a ride or for a trial visit home, is not by itself evidence that the individual no longer needs to be in a SNF for the receipt of his or her required skilled care. Very often special arrangements, not feasible on a daily basis, have had to be made to allow the absence from the facility. Where frequent or prolonged periods away from the SNF become possible, however, then questions as to whether the patient's care can, as a practical matter, only be furnished on an inpatient basis in an SNF may be raised. Decisions in these cases should be based on information reflecting the care needed and received by the patient while in the SNF and on the arrangements needed for the provision, if any, of this care during any absences. (See §3135.3 for counting inpatient days during a leave of absence.)

A conservative approach to retain the presumption for waiver of liability may lead a facility to notify patients that leaving the facility will result in denial of coverage. Such a notice is not appropriate. If an SNF determines that covered care is no longer needed, the situation does not change whether the patient actually leaves the facility or not. (See §3439.2, Improper Provider Coverage Decisions.)

Covered Extended Care Services

3133. COVERED EXTENDED CARE SERVICES

Patients covered under hospital insurance are entitled to have payment made on their behalf on a reasonable cost basis for covered extended care services. If a patient receives items or services in excess of, or more expensive than, those for which payment can be made, payment will be made only for the reasonable cost of the covered items or services. If the items or services were requested by the patient, the facility may charge him the difference between the amount customarily charged for the services requested and the amount customarily charged for covered services.

An inpatient is a person who has been admitted to a skilled nursing facility or swing bed hospital for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged and does not actually use a bed overnight.

NOTES: 1. Custodial care (see S 3159) is not a covered extended care service.

2. When patients requiring inpatient hospital services occupy beds in an SNF, they are considered inpatients of the SNF. In such cases, the services furnished in the SNF may not be considered inpatient hospital services, and payment may not be made under the program for such services. Such a situation may arise where the SNF is a distinct part of an institution the remainder of which is a hospital, and either there is no bed available in the hospital, or for any other reason the institution fails to place the patient in the appropriate bed. The same rule applies where the SNF is a separate institution. For the same reason, where patients who require extended care services occupy beds in a hospital, payment cannot be made on their behalf for the services furnished to them in the hospital, unless the services are extended care services furnished pursuant to a swing bed approval. (See S 3101.)

3. When patients who require SNF services are placed in a noncertified part of an institution which contains a participating "distinct part" SNF, the services may be paid under certain conditions, based on the waiver of liability provisions. (See SS3431.3 - 3431.4B.)

The following extended care services are covered under hospital insurance:

3133.1 Nursing Care Provided by or Under the Supervision of a Registered Professional Nurse.—

NOTE: The services of a private-duty nurse or other private-duty attendant are not covered. Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant. Such persons are engaged or paid by an individual patient or by someone acting on his behalf, including an SNF that initially incurs the cost and looks to the patient for reimbursement for such noncovered services.

Where the SNF acts on behalf of a patient, the services of the private-duty nurse or other attendant under such an arrangement are not extended care services regardless of the control which the SNF may exercise with respect to the services rendered by such private-duty nurse or attendant.

3133.2 Bed and Board in Semi-Private Accommodations Furnished in Connection With Nursing Care.—(See S 3101.1 for provisions relating to inpatient accommodations.)

3133.3 Physical, Speech, and Occupational Therapy Furnished by the Skilled Nursing Facility or by Others Under Arrangements with the Facility and Under Its Supervision.—

A. Physical Therapy.—See §3101.8

B. Speech Pathology.—See §3101.10A.

C. Occupational Therapy.—See §3101.9A-D.

3133.4 **Medical Social Services to Meet the Patient's Medically Related Social Needs.**—Medical social services are those social services which contribute meaningfully to the treatment of a patient's condition. Such services include, but are not limited to, (a) assessment of the social and emotional factors related to the patient's illness, his need for care, his response to treatment, and his adjustment to care in the facility; (b) appropriate action to obtain case work services to assist in resolving problems in these areas; (c) assessment of the relationship of the patient's medical and nursing requirements to his home situation, his financial resources, and the community resources available to him in making the decision regarding his discharge.

3133.5 **Drugs and Biologicals.**—Drugs and biologicals for use in the facility which are ordinarily furnished by the facility for the care and treatment of inpatients are covered. Such drugs and biologicals are not limited to those routinely stocked by the skilled nursing facility but include those obtained for the patient from an outside source, such as a pharmacy in the community. Where a facility does not bill for such drugs and biologicals or include their costs in its cost reporting forms, the intermediary should bring the matter to the attention of the regional office for referral to the State agency for consideration whether the facility is in substantial compliance with the conditions of participation. Since the provision of drugs and biologicals is considered an essential part of skilled nursing care, a facility must assure their availability to inpatients in order to be found capable of furnishing the level of care required for participation in the program. When a facility secures drugs and biologicals from an outside source, their availability is assured only if the facility assumes financial responsibility for the necessary drugs and biologicals, i.e., the supplier looks to the facility, not the patient, for payment.

The drug or biological must be either included, or approved for inclusion, in the U.S. Pharmacopoeia, the National Formulary, or the U.S. Homeopathic Pharmacopoeia; or, except for those unfavorably evaluated, in AMA Drug Evaluations (the successor publication to New Drugs) or Accepted Dental Therapeutics (the successor publication to Accepted Dental Remedies).

Use of the drug or biological must be safe and effective and otherwise reasonable and necessary as specified in section 3151. Drugs or biologicals approved for marketing by the Food and Drug Administration (FDA) are considered safe and effective for purposes of this last requirement. Therefore, you may pay for the use of an FDA-approved drug or biological, if (1) it was administered on or after the date of the FDA's approval; (2) it is reasonable and necessary for the individual patient; and (3) all other applicable coverage requirements are met. Payment may not be made for particular uses of drugs that the FDA has expressly disapproved or that are designated as not covered in the Coverage Issues Appendix.

If you have reason to question whether the FDA has approved a drug or biological for marketing, you should obtain satisfactory evidence of FDA's approval. Acceptable evidence includes a copy of the FDA's letter to the drug's manufacturer approving the new drug application (NDA); or listing of the drug or biological in the FDA's Approved Drug Products or FDA Drug and Device Product Approvals; or a copy of the manufacturer's package insert, approved by the FDA as part of the labeling of the drug, containing its recommended uses and dosage, as well as possible adverse reactions and recommended precautions in using it. When necessary, the Medicare regional office may be able to help in obtaining information.

A. Drugs Included in the Drug Compendia.—Coverage is provided only for those drugs and biologicals included, or approved for inclusion, in the latest official edition or revision of the compendia listed above.

The exclusion from coverage of drugs and biologicals unfavorably evaluated in AMA Drug Evaluations (the successor publication to New Drugs) or Accepted Dental Therapeutics (the successor publication to Accepted Dental Remedies) applies to those drugs and biologicals which have been unfavorably evaluated for all medicinal uses. If a drug or biological has been unfavorably evaluated for one or more, but not all, medicinal uses, the exclusion applies only where the drug has been unfavorably evaluated for the medicinal use to which it is being put.

Drugs and biologicals are considered "approved for inclusion" in a compendium if approved under the established procedure by the professional organization responsible for revision of the compendium.

B. Drugs Not Included in the Compendia.—Drugs not included, or approved for inclusion, in the drug compendia are nevertheless covered if such drug (1) was furnished the patient during his prior hospitalization, (2) was approved for use in the hospital by the hospital's pharmacy and drug therapeutics (or equivalent) committee, (3) is required for the continuing treatment of the patient in the skilled nursing facility, and (4) is reasonable and necessary.

C. Combination Drugs.—Combination drugs are covered if the combination itself or all the therapeutic ingredients of the combination are included, or approved for inclusion, in any of the designated drug compendia. Under the limited circumstances mentioned in B. above, a combination drug approved by a hospital pharmacy and drug therapeutics committee may also be covered as an extended care service.

D. Drugs for Use Outside the Facility.--Drugs and biologicals furnished by a facility to an inpatient for use outside the facility are, in general, not covered as extended care services. However, if the drug or biological is deemed medically necessary to permit or facilitate the patient's departure from the facility, and a supply is required until he can obtain a continuing supply, the drugs or biologicals would be covered as an extended care service. Drugs and biologicals furnished to outpatients of skilled nursing facilities are not covered.

3133.6 Supplies, Appliances, and Equipment.--Supplies, appliances, and equipment furnished for use in the facility, which are ordinarily furnished by the facility for the care and treatment of inpatients are covered extended care services. However, under certain circumstances, supplies, appliances, and equipment used during the beneficiary's stay are covered even though they leave the facility with the patient when he is discharged. There are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the patient's use of the item to the periods during which the individual is an inpatient. An example of items covered under this rule is a brace temporarily attached to the patient's body while he is receiving treatment as an inpatient and which is also necessary to permit or facilitate the patient's release from the facility.

Supplies, appliances, and equipment furnished to a patient for use only outside the facility would not, in general, be covered as extended care services. However, a temporary or disposable item provided to a patient which is medically necessary to permit or facilitate his departure from the facility and is required until such time as he can obtain a continuing supply would be covered as an extended care service.

3133.7 Medical Service of an Intern or Resident-in-Training.--
The medical services of an intern or resident-in-training under an approved teaching program of a hospital with which the facility has in effect the required transfer agreement are covered under hospital insurance.

An "approved teaching program" means a program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association. In the case of services of an intern or resident-in-training in the field of dentistry in a hospital or osteopathic hospital, the teaching program must have the approval of the Council on Dental Education of the American Dental Association.

The medical and surgical services furnished to the facility's patients by interns and residents-in-training of a hospital with which the facility has a transfer agreement are covered under medical insurance if the services are not covered under hospital insurance.

The services performed by interns and residents--including a physician acting in the capacity of an intern or resident--are reimbursable to the facility on a reasonable cost basis even though the intern or resident is a licensed physician. These services are not reimbursable on a reasonable charge basis as physicians' services.

3133.8—Other Diagnostic or Therapeutic Services Provided by a Hospital.—Extended care services also include other diagnostic or therapeutic services provided by a hospital with which the facility has a transfer agreement. While a skilled nursing facility is permitted to secure diagnostic and therapeutic services for its inpatients from the transfer hospital, the hospital itself must have the capacity to provide the services directly. If the transfer hospital does not have the capacity to provide the services directly, but provides them through an arrangement with an outside source, these services would not constitute covered extended care services.

3133.9 Other Services.—

A. General.—Other services which are necessary to the health of the patients are covered if the services are generally provided by skilled nursing facilities. The medical and other health services described in SS 3110-3110.5 are generally provided by skilled nursing facilities and are therefore extended care services. For coverage of diagnostic services and radiological therapy under Part A, the conditions described in S 3137.1 must be met.

Items or services that would not be included as inpatient hospital services if furnished to an inpatient of a hospital are also excluded from coverage as extended care services. For instance, the provision of personal laundry services by skilled nursing facilities is not a covered service under Medicare, since it would not be covered if provided to an inpatient of an acute care hospital. See SS 3101ff. for covered inpatient hospital services.

The use of an operating room and any special equipment, supplies, or services would not constitute covered extended care services except when furnished to the facility by a hospital with which the facility has a transfer agreement, since operating rooms are not generally maintained by skilled nursing facilities. However, supplies and nursing services connected with minor surgery performed in a skilled nursing facility that does not require the use of an operating room or any special equipment or supplies associated with such a room would be covered extended care services and reimbursed as part of the cost of routine services.

B. Respiratory Therapy Provided by a Hospital with which the Skilled Nursing Facility has a Transfer Agreement.—See S3101.10

Duration of Covered Extended Care Services

3135. EXTENDED CARE BENEFIT DAYS

A patient having hospital insurance coverage is entitled subject to the coinsurance requirement (S 3210) to have payment made on his behalf for up to 100 days of covered inpatient extended care services in each spell of illness. (For definition of spell of illness, see S 3035.)

3135.1 Inpatient Day Defined.—The number of days of care charged to a beneficiary for inpatient extended care services is always in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method is to be used in reporting days of care for beneficiaries, even if the facility uses a different definition for day for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, the day of discharge or death or a day on which a patient begins a leave of absence is not counted as a day. (Charges for ancillary services on the day of discharge or death or the day on which a patient begins a leave of absence are covered.) If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day. (For billing when a patient is discharged, dies, or is transferred to another facility before midnight of the day of admission, see S 3611).

3135.2 Late Discharge.—When a patient chooses to occupy his accommodations in a facility beyond the normal check-out time for personal reasons, the facility may charge the beneficiary for his continued stay. Such a stay beyond the check-out time, for the comfort or convenience of the patient, is not covered under the program and the facility's agreement to participate in the program does not preclude the facility from charging the patient. A facility may not impose late charges on a beneficiary unless he has been given reasonable notice (for example, 24 hours) of his impending discharge.

Where the patient's medical condition is the cause of the stay past the discharge hour (e.g., the patient needs further services, is bedridden and is awaiting transportation to his home, or dies in the facility), the stay beyond the discharge hour is covered under the program and the facility may not charge the patient. (See S 3620, Item 19, Accommodations.)

The imposition of a late charge by a facility does not affect the counting of days for (a) ending a spell of illness, and (b) the number of days of inpatient care available to the individual. (See §§ 3035 and 3136.) A late charge by a hospital does not affect counting of days for meeting the prior inpatient stay requirement for coverage of extended care services. (See § 3103.2)

3135.3 Leaves of Absence.--Treat the day on which the patient began a leave of absence as a day of discharge and do not count it as an inpatient day unless he returns to the facility by midnight of the same day. Treat the day the patient returns to the facility from a leave of absence as a day of admission and count it as an inpatient day if he is present at midnight of that day.

3135.4 Discharge or Death on First Day of a Skilled Nursing Facility's Participation.--Do not make program payment for accommodations on the day of discharge or death. Make payment for ancillary services (under Part A) where a patient dies or is discharged on the first day a facility becomes a participating facility and the other requirements for coverage of extended care services are met.

3136. INPATIENT EXTENDED CARE SERVICES COUNTING TOWARD MAXIMUMS.

Extended care services count toward the maximum number of benefit days payable per spell of illness only if:

o. Payment for the services is made, or

o. Payment for the services would be made if a request for payment were properly filed, the physician certified that the services were medically necessary, and the provider submitted all necessary evidence. (See § 3302.6 for patient's refusal to file, § 3333 for physician's refusal to certify, § 3600.1 for provider failure to submit evidence, and § 3610.1 for billing procedures in these situations.)

Where payment cannot be made because of the extended care coinsurance requirement, the day(s) used nevertheless count toward the beneficiary's maximum days of extended care.

Services Furnished by Skilled Nursing Facilities Covered Under Medical Insurance

3137. MEDICAL AND OTHER HEALTH SERVICES FURNISHED TO SNF PATIENTS.

The medical and other health services described in §§ 3110-3110.5 are covered under Part B when furnished by a participating SNF either directly or under arrangements to: inpatients who are not entitled to have payment made under Part A (e.g., benefits exhausted or 3-day prior-stay requirement not met); or outpatients. See § 3640.3 for information on billing for these services and § 3137.1 for the conditions under which diagnostic services and radiological therapy furnished by SNF's are covered. For coverage of total parenteral nutrition (TPN) and enteral nutrition (EN) as a prosthetic device, see §§ 3110.4 and 3111, and the Coverage Issues Manual §§ 65-10 - 65-10.3. See § 3661 for information on billing for TPN and EN services.

Rental or purchase of durable medical equipment from SNFs for use in the patient's home is covered under Part B in accordance with the provisions of § 3113. For coverage of outpatient physical therapy, occupational therapy, and speech pathology services furnished by SNFs, see §§ 3147- 3148.4. For coverage of provider ambulance services, see § 3114.

Drugs, biologicals, and blood are not covered under Part B when furnished by an SNF.

3137.1 Diagnostic Services and Radiological Therapy.--Diagnostic X-ray and radiological therapy may be provided directly by an SNF if, as part of its compliance with the conditions of participation, the SNF has a radiological department which meets the same standards required of a hospital furnishing such services under the program, or if the SNF meets the portable X-ray supplier standards. Portable X-ray services provided by an SNF under arrangements are covered only if furnished by an approved supplier.

When an SNF furnishes laboratory services directly, its laboratory must meet the same conditions required when laboratory services are furnished by participating hospitals. These services may be furnished under arrangements with another participating SNF whose laboratory meets the hospital conditions for laboratories or with either an approved independent laboratory, the laboratory of a participating hospital, or the laboratory of an "emergency" hospital which meets the hospital conditions for laboratories.

3138. AMBULANCE SERVICE.

For requirements relating to provider ambulance service, see § 3114.

Coverage of Hospice Services Under Hospital Insurance

3140. REQUIREMENTS - GENERAL.

Effective November 1, 1983, hospice care is a benefit under the hospital insurance program. In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is six months or less.

The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures and maintain the certification statements:

A. For the first 90-day period of hospice coverage, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification statements signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician (if the individual has an attending physician). The attending physician is a physician who is a doctor of medicine or osteopathy and is identified by the individual, at the time he or she elects to receive hospice care, as having the most significiant role in the determination and delivery of the individual's medical care.

B. For the subsequent 90-day or 30-day period, the hospice must obtain, no later than two calendar days after the beginning of that period, a written certification statement prepared by the medical director of the hospice or the physician member of the hospice's interdisciplinary group. The certification must include the statement that the individual's medical prognosis is that his or her life expectancy is six months or less and the signature(s) of the physician(s).

3141. ELECTION PROCEDURES.

An individual may elect to receive Medicare coverage of three election periods of hospice care. The periods consist of two 90-day periods and one 30-day period. If an individual elects to receive hospice care, he or she must file an election statement with a particular hospice. An election may also be filed by a representative acting pursuant to State law. The two 90-day election periods must be used before the 30-day period. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual remains in the care of the hospice and does not revoke the election. An individual may designate an effective date for the election period that begins with the first day of hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

An individual must waive all rights to Medicare payments for the duration of the election of hospice care for the following services:

o Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice); and

o Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services-

— Provided (either directly or under arrangement) by the designated hospice;

— Provided by another hospice under arrangements made by the designated hospice; and

— Provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

3141.1 Election, Revocation and Change of Hospice.—Each hospice will design and print its election statement. The election statement must include the following items of information:

o Identification of the particular hospice that will provide care to the individual.

o The individual's or representative's (as applicable) acknowledgement that he or she has been given a full understanding of hospice care.

o The individual's or representative's (as applicable) acknowledgement that he or she understands that certain Medicare services are waived by the election.

o The effective date of the election.

o The signature of the individual or representative.

An individual or representative may revoke the election of hospice care at any time. To revoke the election of hospice care, the individual must file a document with the hospice that includes a signed statement that the individual revokes the election for Medicare coverage of hospice care for the remainder of that election period and the date that the revocation is to be effective. An individual may not designate an effective date earlier than the date that the revocation is made.

Upon revoking the election of Medicare coverage of hospice care for a particular election period, an individual resumes Medicare coverage of the benefits waived when hospice care was elected. An individual may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

An individual may change, once in each election period, the designation of the particular hospice from which he or she elects to receive hospice care. The change of the designated hospice is not considered a revocation of the election. To change the designation of hospice programs, the individual must file, with the hospice from which he or she has received care and with the newly designated hospice, a signed statement that includes the following information: the name of the hospice from which the individual has received care, the name of the hospice from which he or she plans to receive care and the date the change is to be effective. (A change of ownership of a hospice is not considered a change in the patient's designation of a hospice, and requires no action on the patient's part.)

3142. COINSURANCE

An individual who has elected hospice care is liable for the following coinsurance payments. Hospices may charge individuals for the applicable coinsurance amounts.

A. Drugs and biologicals.—An individual is liable for a coinsurance payment for each palliative drug and biological prescription furnished by the hospice while the individual is not an inpatient. The amount of coinsurance for each prescription approximates five percent of the cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed $5.00. The cost of the drug or biological may not exceed what a prudent buyer would pay in similar circumstances. The drugs copayment schedule must be reviewed for reasonableness and approved by the intermediary before it is used.

B. Respite care.—The amount of coinsurance for each respite care day is equal to five percent of the payment made by HCFA for a respite care day. The amount of the individual's coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.

The individual hospice coinsurance period begins on the first day an election is in effect for the beneficiary and ends with the close of the first period of 14 consecutive days on each of which an election is not in effect for the beneficiary.

Thus, if a beneficiary elects to use all three of his election periods consecutively (without a two week break), he or she would be subject to a maximum coinsurance for respite care equal to the hospital inpatient deductible. Similarly, if a break between election periods exceeds 14 days, the maximum coinsurance for respite care would double or triple (depending on the number of election periods used and the timing of subsequent elections).

EXAMPLE: Mr. Brown elected an initial 90 day period of hospice care. Five days after the initial period of hospice care ended, Mr. Brown began another period of hospice care under a subsequent election.

Immediately after the period ended, he began a third period of hospice care under a final election period. Mr. Brown received inpatient respite care during all three periods of hospice care. Since these election periods were not separated by 14 consecutive days, they constitute a single hospice coinsurance period. Therefore, a maximum coinsurance for respite care during all three periods of hospice care may not exceed the amount of the inpatient hospital deductible for the year which the first period began.

3143. REQUIREMENTS FOR COVERAGE

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care in accordance with § 3141 and a plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. A certification that the individual is terminally ill must be completed as set forth in § 3140.

3143.1 Covered Services.—All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

A. Nursing care provided by or under the supervision of a registered nurse.

B. Medical social services provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

C. Physicians' services performed by a physician (as defined in regulation § 405.232a) except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

D. Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other care-giver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

E. Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital, SNF, or ICF that additionally meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management. Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home.

F. Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in § 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. Appliances may include covered durable medical equipment as described in § 42 CFR 405.231(g) as well as other self-help and personal comfort items related to the palliation or management of the patient's terminal illness. Equipment is provided by the hospice for use in the patient's home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.

G. Home health aide services furnished by qualified aides and homemaker services. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing the bed or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment and services to enable the individual to carry out the plan of care.

H. Physical therapy, occupational therapy and speech-language pathology services provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

3143.2 Special Coverage Requirements.—

A. Periods of crisis.—Nursing care may be covered on a continuous basis for as much as 24-hours per day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms.

B. Respite care.—Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time, except that any hospice that began operation before January 1, 1975 may be granted a waiver of the limitation on the frequency and number of respite care days. A hospice must be approved to receive this waiver. Applications should be sent to:

Health Care Financing Administration
Office of Coverage Policy, BERC
409 East High Rise
6325 Security Boulevard
Baltimore, Maryland 21207

C. Bereavement counseling.—Bereavement counseling consists of counseling services provided to the individual's family after the individual's death. Bereavement counseling is a required hospice service but it is not reimbursable.

3145. PROVIDER-BASED PHYSICIAN'S SERVICES.

The services of provider-based physicians (e.g., those on a salary, or percentage arrangement, lessors of departments, etc., whether or not they bill patients directly) include two distinct elements, the professional component, and the provider component. The services of interns and residents, however, are reimbursable to the provider on a reasonable cost basis even though the intern or resident is a licensed physician.

A. The Professional Component.--The professional component of provider-based physicians' services includes those services directly related to the medical care of the individual patient. (No Part B charge can be recognized for autopsy services.) Services to individual patients must be specially billed by the physician or, with his authorization, by the provider, or by a partnership, corporation, or other organization of physicians. When such services are performed by a faculty member of a medical, osteopathic, or dental school, billing by the school with the physician's authorization is an additional alternative. (See § 3604 for billing by the provider for these services.)

B. The Provider Component.--Provider-based physicians often perform professional services other than those directly related to the medical care of individual patients. These may involve teaching, administrative, and autopsy services, and other services that benefit the provider's patients as a group. Such physician services, not directly related to an individual patient, if compensated, must be considered in computing reimbursable provider costs. Reimbursement for such costs is made under Part A where they relate to inpatient services and under Part B where they relate to outpatient services and inpatient ancillary services where Part A coverage has been exhausted. (See § 3910 on distinguishing between professional and provider components for reimbursement purposes.)

C. The Roles of the Fiscal Intermediary and Carrier.--The provider's Part A intermediary will obtain from the provider the information that it and the Part B carrier need to make payment determinations where the services of provider-based physicians are involved. The Part A intermediary has the responsibility for reviewing and approving the reasonableness of the agreement between provider and physician on the allocation of physician compensation (received from or through the provider) between (1) the portion attributable to provider services, i.e., services to the institution and (2) the portion attributable to physician services, i.e., identifiable services rendered by the physician to individual patients. If the provider and physician fail to agree or if their agreement appears unreasonable, the Part A intermediary and the Part B carrier will jointly assist in resolving the issue. (§ 3912.1A) The Part B carrier is responsible for review and approval, in accordance with the applicable principles, of the basis for Part B charges for services of provider-based physicians, i.e., the schedule of such charges if the item-by-item method of determination is used, the uniform percentage if the optional method of determination is used, or the unit charge if the per diem or per visit method is used.

3145.1 Health Care Prepayment Plans (HCPPs), Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs).--Reimbursement of Professional Component.--An HCPP, HMO or CMP may make a written agreement with a hospital, or with physicians in a hospital, to reimburse the professional component of the hospital-based physician's charge for services to plan members entitled to Part B.

The hospital or physician agrees to provide services in return for a reasonable payment based on a stipulated amount. Billing is made directly to the plan. If the hospital bills, it may use any formal billing form normally used for this purpose. If the physician bills, he may use his personal billing form, or if he prefers, the Medicare billing form. The plan will arrange the billing method with the hospital and physicians and will verify that the physicians have authorized the hospital to bill for them. The plan will make reimbursement directly to the hospital or the physician based upon the stipulated amount.

Where a hospital has an arrangement with a group practice prepayment plan to provide services to the plan's members, and bills the plan, it will not submit a bill to the intermediary for the professional component for in-hospital or outpatient services provided by its salaried physicians.

Plans which have or propose to make these arrangements have been instructed to work closely with the hospital's intermediary to assure proper processing and payment of bills.

These arrangements do not alter existing instructions for determining provider costs of hospital-based physician services.

This procedure will not be used by HMOs and CMPs that have a risk contract with HCFA. All Part B nonprovider bills must be processed by the risk HMO/CMP except in the case where the enrolled member has selected the Hospice option.

3145.2 Preadmission Diagnostic Services Furnished at Hospital to Which Patient is Admitted.--(Effective only for otherwise covered services furnished after December 4, 1980, and before July 19, 1984.) Reimbursement is made under Part B for the full reasonable charge for otherwise covered physicians' services that are preadmission diagnostic services furnished on an outpatient basis in a qualified hospital, if the patient is admitted to that same hospital within 7 days and the physician agrees to accept assignment for all preadmission diagnostic services that he furnishes. This means that 100 percent reimbursement is made for the reasonable charges for such services, not subject to the coinsurance, regardless of whether inpatient benefits are payable. (These services remain subject, however, to the Part B deductible.)

NOTE: A qualified hospital, including a tuberculosis or psychiatric hospital, is a hospital that meets all of the conditions of participation. All participating hospitals are considered qualified hospitals. Assume that a nonparticipating hospital is not a qualified hospital unless there is evidence to the contrary, in which event request verification of the status of the institution from the appropriate RO.

A. Covered Services.--Physicians' services may be paid in full subject to the conditions described in the following paragraphs.

B. Reasonableness and Necessity.--The services must be reasonable and necessary as specified in § 3151. Also see Coverage Issues Appendix 50-28.

C. Inpatient Status.--Since preadmission diagnostic services may be paid in full only if the patient is admitted as an inpatient within 7 days, the usual requirements to establish inpatient status apply. See §§ 3101 and 3112.3D.

D. Conditions of Payment.--Preadmission diagnostic services must be:

1. Essential to the administration and interpretation of a diagnostic test, study or procedure;

2. Furnished within 7 calendar days prior to the date of the patient's admission to the hospital as an inpatient; and

3. Services which would have had to be performed after the admission if they had not been performed prior to the admission.

Additionally, the results of the testing must be available at the time of the patient's admission.

Such services as taking patients' histories or performing routine physical examinations are not "preadmission diagnostic services." Consultations by physician specialists to interpret test results and to decide whether or not additional tests are needed may fall within the definition of "preadmission diagnostic services," however.

These conditions are intended to permit payment for otherwise covered preadmission diagnostic services in connection with admissions for both medical and surgical treatment, as well as when the patient is admitted for diagnostic study.

If services are found not to meet the criteria for preadmission diagnostic services, but are reasonable and necessary, they may be paid at the usual 80 percent rate, and waiver of liability does not apply, as explained in F, below.

E. Reimbursement.--Use the regular reasonable charge process to determine the amount payable to physicians for preadmission diagnostic services, including existing guidelines to deal with special situations such as those involving medical complications and rare and unusual procedures.

F. Waiver of Liability.--Waiver of liability does not apply to a finding that services are not preadmission diagnostic services. That is, if payment of 80 percent of the reasonable charge is allowed, waiver does not apply.

3145.3 Agreement to Accept Assignment.--Carriers were previously instructed to notify physicians of the preadmission diagnostic services provision. In addition, they were instructed to advise physicians to furnish certain specific items of information with claims for services that could possibly meet the requirements of this provision and be reopened for full payment at a later date. Thus, for services which meet the requirements of § 3145.2 for full payment (or would meet those requirements if all or part of the deductible were not applicable), each claim which is reopened for full payment must include the following elements:

1. The place of services (hospital outpatient department) and the name and address of the hospital where the services were performed;

2. The date of the patient's admission to that hospital;

3. The date of each service performed on an outpatient basis in that hospital;

4. A notation on the claim form as follows: "preadmission diagnostic services;" and

5. An indication of agreement by the physician (or by a hospital, medical group or other entity when authorized to bill and receive payment for the services in its name—see §§ 3604.1ff.) to accept assignment for the preadmission diagnostic services on that particular claim and for all such services for which payment under the preadmission diagnostic services provision is claimed.

3146 RADIOLOGICAL AND PATHOLOGICAL SERVICES FURNISHED TO HOSPITAL INPATIENTS

Prior to the Omnibus Reconciliation Act of 1980 (P.L. 96-499), the Medicare Part B program in all cases paid 100 percent of the reasonable charges (no deductible and coinsurance) for physicians' radiological and pathological services covered under Part B, furnished to an inpatient of a qualified hospital by a physician in the field of radiology or pathology. Under the Omnibus Reconciliation Act, the Medicare Part B program pays 100 percent of the reasonable charges for such services only if the physician has in effect an agreement to accept Medicare Part B assignment for all such services he furnishes to hospital inpatients. If he does not have such an agreement in effect, the program pays 80 percent of the reasonable charges after the application of any unmet deductible.

The amendment is effective for services furnished after June 30, 1981. Radiological or pathological services furnished prior to July 1, 1981, to inpatients of qualified hospitals by physicians in the field of radiology or pathology will be reimbursed at the 100 percent rate in all cases even though the claim is filed after that date.

Expenses for which 100 percent of the reasonable charges are payable are not creditable to the Part B deductible, whether those expenses are incurred before July 1, or after June 30, 1981.

The definitions of such terms as "qualified hospital," "inpatient," radiological services," "pathological services," "field of radiology," and "field of pathology" are the same in applying the provisions in effect before July 1, and after June 30, 1981.

A qualified hospital is a hospital that meets all of the conditions of participation. All participating hospitals are considered qualified hospitals. Intermediaries and carriers may assume that a nonparticipating hospital is not a qualified hospital, unless they have information that raises a question as to the validity of that assumption. In the latter event, verification of the status of the institution should be requested from the appropriate regional office. The meaning of the other terms is explained below.

A. Inpatient Status, For 100 percent reimbursement to be made for services furnished by physicians in the field of radiology or pathology, the beneficiary must be an inpatient of a qualified hospital at the time the services are rendered. An inpatient is a person who has been admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or transferred to another hospital and does not actually use a bed overnight.

The beneficiary's relationship to the facility in which the physician furnishes the services does not affect the 100 percent reimbursement provision. For example, where an inpatient of a qualified hospital which is not equipped to provide radiation therapy is transported temporarily to another facility and returns the same day, the inpatient status is maintained.

In the case of services furnished before July 1, 1981, the method of billing does not affect the 100 percent reimbursement provision. The controlling factor is the inpatient status of the beneficiary. For example, in the case of a non-hospital-based radiologist who furnished radiology services to an inpatient of a qualified hospital, Part B reimbursement for services furnished before July 1, 1981, is at 100 percent whether the hospital or physician bills the program or the beneficiary. For 100 percent reimbursement to be made for physician radiology or pathology services to hospital inpatients after June 30, 1981, the person or entity doing the billing must enter into an agreement to accept assignment for all such services for which he or it is authorized to bill. See §§3146.1 - 3.46.2.

B. Billing for Radiological and Pathological Services Provided to Hospital Inpatients.--Subject to the requirements of §§3604.1ff and to the assignment agreement requirement that applies after June 30, 1981, a hospital and a physician are free to decide whether the charges for the physician's services are to be billed by the hospital or by the physician, as well as to determine the additional elements of the parties' financial arrangements with each other.

1. Where the physician has authorized the hospital to combine bill on his behalf, it will not be necessary, in most cases, to break down the bill into professional and hospital components on a patient-by-patient basis. The exceptions are situations in which:

a. the Part A expenses are less than the Part A deductible;
b. the patient is not enrolled under Part B; or
c. Part B, rather than Part A, benefits are involved.

Reimbursement for the combined charge will be made on an interim basis by the Part A intermediary from the Part A funds. Adjustments between the Part A and Part B trust funds will be made at the end of the hospital's fiscal year. Where the combined billing method is used, it must be used for the services of all radiologists or pathologists in the department. (See §3604.6)

2. Where a separate claim (HCFA-1554 or HCFA-1500) is filed by the hospital for the physician's services, reimbursement for the professional component is made from Part B funds by the carrier and is subject to adjustment as provided by §2108.7 of the Provider Reimbursement Manual. Reimbursement for the Part A component of these services is made by the intermediary.

3. A hospital-based physician in the field of radiology or pathology may, if he chooses, accept an assignment and submit a bill to the program, or may bill the beneficiary for the services furnished to the inpatient of a qualified provider. In the case of services furnished after June 30, 1981, one hundred percent reimbursement may be made, however, only where the physician has in effect the required agreement to accept assignments.

In some cases, the radiologist or pathologist may own or lease the equipment and bear some or all of the direct expenses of operating a hospital department. Where, under such an arrangement, the physician rather than the hospital bills patients and insurers, no allocation between Part A and Part B services is required, and the services are covered under Part B on a reasonable charge basis for 100 percent reimbursement for inpatients (subject after June 30, 1981, to the requirement for an agreement to accept assignments) and 80 percent (after the deductible) for outpatients and nonprovider patients. However, where the same conditions exist and the hospital bills for the physician services, Part A - Part B allocation must be made. The component representing physician compensation is reimbursed under Part B (at 80 or 100 percent depending on the status of the patient and, after June 30, 1981, on whether the hospital entered into the required agreement to accept assignments.) That is, program reimbursement is based on a determination of actual departmental costs rather than the physician's charges. (However, in this situation as indicated in 1 above, where the hospital uses the inpatient combined billing method, the Part A and Part B allocation would not be made on a claim by claim basis.)

C. Definition of Radiological and Pathological Services.—The term "radiological services" means services in which X-rays or rays from radioactive substances are used for diagnostic or therapeutic purposes. Such services include but are not limited to radium therapy, the use of radioisotopes for diagnostic or therapeutic purposes (as in nuclear medicine), and diagnostic tests such as angiograms, aortograms, pyelograms, myelograms, arteriograms, and ventriculograms, and ultrasonic diagnostic procedures performed before January 1, 1975. Effective with procedures performed after December 31, 1974, ultrasonic diagnostic procedures are not considered radiological services, i.e., the physician's charge for his professional service is subject to the applicable Part B deductible and coinsurance.

The term "pathological services" refers to services performed in both clinical and anatomical pathology. Included are microbiological, serological, chemical, hematological, biophysical, cytological, immunohematological, and pathological examinations performed on materials derived from the human body, to provide information for the diagnosis, prevention, or treatment of a disease or assessment of a medical condition.

Such tests as basal metabolism rate tests, electroencephalograms, and electrocardiograms are considered to be neither radiological nor pathological services. Therefore, reimbursement for such tests can be made only at the 80 percent rate after recognition of the deductible, and the combined billing method may not be used for such services rendered to hospital inpatients.

D. Field of Radiology or Pathology.—Reimbursement can be made at the 100 percent rate for only those radiological and pathological services performed by physicians in the fields of radiology and pathology. A physician in the "field of radiology or pathology" includes not only a specialist in one of those fields, i.e., a radiologist or a pathologist, but also a physican who normally performs or supervises the radiological or pathological services for all of the patients of a particular hospital, even though the physician does not otherwise specialize in radiology or pathology. An example of this situation is a small hospital which has no radiologist but designates a physician to handle or supervise the hospital's radiological procedures. The full reasonable charge for the radiological services of this physician rendered in such a capacity could be covered. (In addition, it is not always necessary that a physician perform the full range of radiological services for the 100 percent reimbursement provision to be applicable. A physician can be considered in the field of radiology if he normally performs one or more types of covered radiological services for the inpatients of a particular hospital. For example, where a neurosurgeon possesses equipment with which he performs a particular covered diagnostic radiological service for all the patients of a hospital who require the service, the neurosurgeon would be considered a physician in the field of radiology.) On the other hand, the reading of an X-ray film as part of his usual services for his own patients by, for example, an attending physician or a surgeon would normally be covered only as regular physician's services; i.e., the basis for reimbursement would be 80 percent of the reasonable charge, subject to the deductible.

E. Status of Independent Laboratory.—An independent laboratory is by definition independent of a physician's office or a hospital. It is not considered "a physician in the field of radiology or pathology" even where it is physician-directed and provides services requiring performance by a physician. (A radiological facility is not considered an "independent laboratory" for program purposes.) Where an independent laboratory provides diagnostic laboratory services to patients (including hospital inpatients) and bills the patient or program directly, the services are reimbursable at 80 percent of the reasonable charge, subject to the deductible.

A provider, however, may purchase the services of an independent laboratory for its patients "under arrangements," in which case the program reimburses on the basis of reasonable provider costs. For example, where a hospital obtains such services for its inpatients, the services are covered under Part A (regardless of whether the laboratory is physician-directed) and are reimbursable at 100 percent of the reasonable cost. (A hospital may not purchase services "under arrangements" from a leased laboratory on its premises.) In the case of services obtained by a hospital from a noncertified independent laboratory, see § 3101.5C.

3146.1 Who Must Execute the Agreement—The agreement to accept assignment (as required after June 30, 1981) for all radiological or pathological services furnished by a physician to hospital inpatients must be filed by:

A. The physician, with respect to those services for which he bills and receives payment in his own name.

B. The hospital, medical group, or other entity, with respect to those services for which it is authorized to bill and receive payment in its name.

3146.2 Scope of the Agreement.—

A. Physician Bills in His Own Name.—For full payment to be made directly to a physician in the field of radiology for his covered physician radiological services furnished to inpatients of qualified hospitals, he must agree to accept assignment for all such services for which he bills and receives payment in his own name.

For full payment to be made directly to a physician in the field of pathology for his covered physician pathological services furnished to inpatients of qualified hospitals, he must agree to accept assignment for all such services for which he bills and receives payment in his own name.

B. Hospital, Medical Group, or Other Entity Bills for Physician Services.—For full payment to be made to a hospital, medical group, or other entity for covered physician radiological services furnished to inpatients of qualified hospitals by physicians in the field of radiology, the entity must agree to accept assignment for all such services for which the entity is authorized to bill and receive payment in its name.

For full payment to be made to a hospital, medical group, or other entity for covered physician pathological services furnished to inpatients of qualified hospitals by physicians in the field of pathology, the entity must agree to accept assignment for all such services for which the entity is authorized to bill and receive payment in its name.

A hospital may not use the combined billing procedure for either radiological or pathological services unless it has in effect the agreement described in this subsection with respect to services in that field.

C. Examples of the Rules in A and B.—

EXAMPLE 1: A radiologist provides radiological and other services in Hospital A and Hospital B. He bills in his own name for his services in Hospital A and has entered into a contractual arrangement with Hospital B giving it the right to bill and receive payment for his radiological services in that hospital. He files an agreement to accept assignment in all cases for the radiological services for which he bills in his own name. Hospital B does not file such an agreement with respect to the physician radiological services for which it has the right to bill and receive payment. Medicare Part B pays the physician 100 percent of the reasonable charges for his covered radiological services to inpatients of Hospital A but all Medicare payments for the physician's services to inpatients in Hospital B are subject to deductible and coinsurance.

EXAMPLE 2: Same facts as in EXAMPLE 1 but Hospital B files the agreement to accept assignment from all inpatients for the physician radiological services for which it has the right to bill and receive payment but the physician does not file such an agreement with respect to the radiological services - in Hospital A - for which he bills and receives payment. Medicare Part B pays Hospital B 100 percent of the reasonable charges for the physician's covered radiological services to inpatients of Hospital B but the Medicare Part B payments for the physician's services to inpatients of Hospital A are subject to deductible and coinsurance.

EXAMPLE 3: A physician who engages in general practice in two small rural hospitals A and B also undertakes to provide the pathological services in those hospitals. He bills for his services in the field of general practice in his own name while Hospital A and Hospital B have the contractual right to bill and receive the payments for his pathological services in the respective hospitals. Hospital A, but not Hospital B, files an agreement to accept assignment in all cases with respect to physician pathological services that are furnished to hospital inpatients and for which it has the right to bill and receive payment. Medicare Part B pays Hospital A 100 percent of the reasonable charges for the covered physician pathological services furnished by the physician to inpatients of that hospital while all payments for such services in Hospital B are subject to deductible and coinsurance.

D. Requirements for Payment to an Entity for Physician Services.—The requirements for payment to a hospital, medical group, or other entity for a physician's services are stated in §§3604.1ff. Among other requirements, the contractual arrangement between the entity and the physician must apply to all or a well-defined category of his services. That category must be consistent with proper determination of Part B reimbursement and may not be based on whether the patient has Medicare or the entity accepts assignment.

3146.3 Language of the Agreement.—

A. Physician Bills in His Own Name. The following language must be used for the agreement to accept assignments, if the physician bills in his own name:

Name of Physician Identification Number

> As a condition for receiving direct payment from the Medicare Part B program of 100 percent of Medicare approved charges for covered physician (radiological or pathological) services which I furnish to inpatients of qualified hospitals and for which I bill and receive payment in my own name, I agree to accept Medicare Part B assignment with respect to all such services for which I bill and receive payment in my own name. Under the terms of an assignment, the Medicare approved charge is the full charge for the service. The agreement shall be effective with services furnished on or after . (The physician shows here the date he desires, subject to the condition that such date be no earlier than the day the agreement is mailed or handed over to a Medicare carrier having jurisdiction of claims for services included in the agreement and no later than the 90th day thereafter.) I agree to submit no claims for services included in the agreement to a carrier until the carrier has acknowledged in writing that it has received the agreement and accepted the specified effective date. The agreement shall cease to be effective with services furnished more than 15 days after a carrier having jurisdiction of claims included in the agreement receives my written request for revocation of the agreement.

(Signature) (Date)

Address:

Separate agreements should be entered into for radiology and pathology in the rare event the physician practices in both fields.

B. Hospital, Medical Group, or Other Entity Accepts Assignment on a General Basis for Inpatient Services by Radiologists or Pathologists.—The following language must be used for the agreement if a hospital, medical group, or other entity wishes to enter into an agreement to accept assignments for services which are furnished to hospital inpatients by physicians practicing in the field of radiology or pathology and for which the entity is authorized to bill and receive payment:

Name of Entity Identification Number

As a condition for receiving direct payment from the Medicare Part B program of 100 percent of Medicare approved charges for covered physicians' (radiological or pathological) services which are furnished to inpatients of qualified hospitals by physicians in the field of (radiology or pathology) and for which (name of entity), hereafter called "the entity," is authorized to bill and receive payment in its name, the entity agrees to accept Medicare Part B assignment with respect to all such services for which the entity is authorized to bill and receive payment in its name. Under an assignment, the Medicare approved charge is the full charge for the service. This agreement shall be effective with services furnished on or after . (The entity shows here the date it desires, subject to the condition that such date be no earlier than the day the agreement is mailed or handed over to a Medicare carrier or intermediary having jurisdiction of claims for services included in the agreement and no later than the 90th day thereafter.) The entity agrees to submit no claims for services included in the agreement to a carrier or intermediary until the carrier or intermediary has acknowledged in writing that it has received the agreement and accepted the specified effective date. The agreement shall cease to be effective with services furnished more than 15 days after a carrier or intermediary having jurisdiction of claims included in the agreement receives the entity's written request for revocation of the agreement.

____
(Signature of authorized official of entity)

____
(Date)

____
(Title)

Address of entity:

Separate agreements should be entered into for radiology and pathology.

3146.4 Where Agreement Should Be Filed.--The agreement to accept assignments for physician radiological or pathological services to hospital inpatients must be filed with a Medicare contractor (carrier or intermediary) having jurisdiction of claims for which 100 percent payment may be made under the agreement. (The term "Medicare contractor" includes HCFA's Office of Direct Reimbursement or Group Health Plans Operations Staff where that Office or Staff has jurisdiction.)

A hospital should file the agreement with its intermediary with respect to those services for which it uses the combined billing procedure and with the carrier with respect to those services for which it bills on HCFA-1554 or HCFA-1500 (and on HCFA-1490 as long as claims are filed on this form). A physician, medical group, or other carrier dealing entity should file its agreement with its area carrier. (See §3146.8B for the agreement requirements for carrier and direct dealing group practice prepayment plans (GPPPs) and Health Maintenance Organizations (HMOs)). In all cases, the person or entity filing the agreement should address it to the contractor, Attention: Medicare Program Section 943 Agreement. If a physician (or carrier dealing entity) submits claims to more than one area carrrier (e.g., because he has offices in more than one carrier's jurisdiction), he should file the agreement with the carrier to which he expects to submit the most claims for full payment and note on the agreement the other area carrier(s) to which he expects to submit such claims and the addresses of his offices in the other carrier jurisdiction(s).

3146.5 Effective Date of the Agreement and Contractor Action on Receiving It.--The agreement to accept assignments shall be effective with services furnished on or after the date the physician, or the entity entitled to bill and receive payment for physician services, specifies in the agreement, subject to the following conditions:

1. The date specified may be no earlier than the day on which the physician or entity mails or hands the agreement over to a carrier or intermediary having jurisdiction of claims included in the agreement and no later than the 90th day after that day; and

2. The physician or entity agrees to submit no claims to a carrier or intermediary for services included in the agreement until that carrier or intermediary has acknowledged in writing that it has received the agreement and accepted the specified effective date.

These requirements will enable physicians and entities to make their agreements effective immediately but preclude the submission of claims until the contractors have had the opportunity to reflect the filing of the agreements in their systems.

The Medicare contractor that receives the agreement must ordinarily immediately annotate it, preferably by stamp, with the following statement, which should be initialed:

Received by (name of contractor) (date)

Effective (date specified in the agreement)

Where an agreement with an acceptable effective date is filed with the area carrier, that carrier will immediately send a photocopy of the annotated agreement to any other area carrier noted in the agreement and to the Travelers Insurance Company, Railroad Retirement Board Claims Office for the region(s) in which the physician's or entity's office(s) are located. In Oklahoma, the area carrier, Aetna Life and Casualty, will also send a copy to the Oklahoma Department of Public Welfare. When a contractor sends a copy of the agreement to another contractor, it should address the copy to the contractor: Medicare Program Section 943 Agreement.

Each contractor receiving a copy of the annotated agreement from another contractor should also annotate it in the same manner as the original contractor. (Each annotation will show a different contractor but the same effective date.)

After a contractor that received a copy of the agreement either directly or indirectly from a physician or entity has processed the agreement into its system (see §3146.9A), it should send a photocopy of the annotated agreement back to the physician or entity that submitted the agreement. Thus, the physician or entity will receive an annotated copy of the agreement from each contractor having jurisdiction of his or its claims.

3146.6 Termination of Agreement.—A physician, hospital, medical group or other entity may revoke its agreement to accept assignments by filing a written revocation request with the contractor having jurisdiction of claims for which full payment may be made under the agreement (the intermediary in the case of a hospital doing combined billing for the services, the area carrier in other cases). The revocation is ordinarily effective for services furnished more than 15 days after the request is received by the contractor. However, the physician or entity revoking the agreement and the carrier or intermediary may establish a later effective date for the termination, by mutual consent.

The physician or entity should address the request for revocation to the contractor, Attention: Medicare Program Section 943 Agreement. A physician (or carrier dealing entity) filing a revocation request should note thereon any other area carrier(s) to which he submits claims for full payment, giving the address of his office(s) in the other carrier jurisdiction(s).

The Medicare contractor that receives the revocation request must immediately annotate it, preferably by stamp, with the following statement, which should be initialed:

> "Received by (name of contractor) (date)
>
> Effective date (16th day after date of receipt)."

The contractor should then immediately send a photocopy of the annotated revocation request back to the physician or entity that submitted the agreement.

The area carrier with which a revocation request is filed will also send a photocopy of the annotated revocation request to the other carriers noted on the revocation or in its files as being area carriers to which the physician or entity submits claims for full payment and to the Travelers Insurance Company, Railroad Retirement Board Claim

Office for the region(s) in which the physician's or entity's office(s) are located. In Oklahoma, the area carrier, Aetna Life and Casualty, will also send a copy to the Oklahoma Department of Public Welfare. When a contactor sends a copy of the revocation request to another contractor, it should address the copy to the other contractor, Attention: Medicare Program Section 943 Agreement.

3146.7 Physician or Entity Moves.—An agreement to accept assignments remains in effect if a physician (or entity) changes contractor jurisdiction. If there is such a change, the physician (entity) should furnish the new contractor with a copy of his annotated agreement before submitting any claims to that contractor.

3146.8 Submission of Claims Under Agreement.—

A. General.-The agreement to accept assignments does not change the procedures for submitting claims or the information to be shown on claims. Moreover, even though a physician (or entity) has entered into an agreement to accept assignments for certain services on a continuing basis, he should still indicate acceptance of assignment on the individual claims where this is called for by the claim form.

B. Group Practice Prepayment Plans (GPPPs) and Health Maintenance Organizations (HMOs).—Most GPPPs and HMOs permit physician radiological and pathological services that are furnished on an inpatient hospital basis to plan members who are Part B enrollees to be billed by the physician or medical group to the member or the carrier, or by the hospital to the intermediary or carrier, rather than to the GPPP or HMO. Only those GPPPs and HMOs that provide for those services to be billed to the GPPP or HMO must enter into an agreement under these instructions, in order for the GPPP or HMO to obtain the 100 percent reimbursement. The agreement should be filed by a carrier dealing GPPP with its carrier and by a direct dealing GPPP or HMO with the Group Health Plans Operation Staff, HCFA.

3146.9 Carrier and Intermediary Action.—

A. Payment controls.—Carriers and intermediaries must "flag" their systems with the necessary information to insure proper payment action on claims under their jurisdiction for radiological and pathological services furnished to hospital inpatients. This information would include the identification of the physician or entity which executed the agreement, whether radiology or pathology is involved, the effective date of the agreement, and, if the agreement has been terminated, its termination date.

B. Recordkeeping.—Each carrier and intermediary should maintain a file on each physician and entity under its jurisdiction which has entered into the agreement(s) required for the contractor to make full payment to that physician or entity for radiological and/or pathological services. That file should include the agreement(s), revocation requests and any related correspondence.

Outpatient Physical Therapy, Occupational Therapy, and Speech Pathology Services

3147. COVERAGE OF OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES.

Coverage of outpatient physical therapy, occupational therapy, and outpatient speech pathology services under Part B includes such services furnished by or under arrangements made by a participating provider of services. For the purpose of this coverage, the term "provider of services" includes approved clinics, rehabilitation agencies, and public health agencies as well as participating hospitals, SNFs, and HHAs. Reimbursement for these outpatient services is made to the provider on a reasonable cost basis. The patient is responsible only for the regular Part B deductible and coinsurance amounts (i.e., the annual deductible and 20 percent coinsurance).

NOTE: Although coverage is available for a limited amount of physical or occupational therapy services furnished a patient by a physical or occupational therapist as an independent practitioner, no similar coverage exists for speech pathology services furnished by a speech pathologist as an independent practitioner.

3147.1 Services Furnished Under Arrangements With Providers.--A provider may make arrangements with others to furnish covered outpatient physical therapy, occupational therapy, or speech pathology services. When such arrangements are made, receipt of payment by the provider for the arranged services must (as with services provided directly) relieve the beneficiary or any other person of further liability to pay for the services. (See § 3007.)

See § 3149 for the special provisions relating to arrangements for outpatient physical therapy services that may be made by public health agencies and hospitals in rural communities.

3148. CONDITIONS FOR COVERAGE OF OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, OR SPEECH PATHOLOGY SERVICES.

To be reimbursable under the Medicare program, outpatient physical therapy, occupational therapy, or speech pathology services furnished a beneficiary by a participating provider must meet all of the conditions set forth in § 3101.8 A, B, and C, 3101.9 A, B, and C, or 3101.10A and the following requirements:

3148.1 Physician's Certification and Recertification.--(See §§ 3322 and 3350.)

3148.2 Outpatient Must be Under the Care of a Physician.--Outpatient physical therapy, occupational therapy, or speech pathology services must be furnished to an individual who is under the care of a physician. There must be evidence in the clinical record of the patient that he has been seen by a physician at least every 30 days. If the patient has not been seen by the physician within a 30-day period, the provider is responsible for contacting the physician. This physician may be the patient's private physician, or a physician on the staff of the provider, or a physician associated with an institution which is the patient's residence, or a physician associated with a medical facility in which the patient is an inpatient. The attending physician establishes or

best copy available

reviews the plan of treatment and also makes the necessary certifications. A plan of treatment may be established by either the physician or the qualified physical therapist, occupational therapist, or speech pathologist who will be providing such services. However, the physician still must make the necessary certifications (see §§ 3148.3 and 3148.4).

3148.3 Outpatient Physical Therapy, Occupational Therapy or Speech Pathology Services Furnished Under a Plan.--Outpatient physical therapy, outpatient occupational therapy, or outpatient speech pathology services must be furnished under a written plan of treatment established by:

- a physician after any necessary consultation with the physical therapist, occupational therapist, or speech pathologist, as appropriate;
- the physical therapist who will provide the physical therapy services;
- the occupational therapist who will provide the occupational therapy services; or
- the speech pathologist who will provide the speech pathology services.

The plan must be established (that is, reduced to writing either by the person who established the plan or by the provider when it makes a written record of that person's oral orders) before treatment is begun. The plan should be promptly signed by the ordering physician, therapist, or pathologist and incorporated into the provider's permanent record for the patient.

The plan must relate the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech pathology services that are to be furnished the patient and indicate the diagnosis and anticipated goals. Any changes to this plan must be made in writing and signed by the physician, therapist, or pathologist. Changes to the plan may also be made pursuant to oral orders given by the attending physician to a qualified physical therapist (in the case of physical therapy services), a qualified occupational therapist (in the case of occupational therapy services), a qualified speech pathologist (in the case of speech pathology services), a registered professional nurse, or a physician on the staff of the provider.

Changes to such plans also may be made pursuant to oral orders given by the pathologist to another qualified speech pathologist, by the occupational therapist to another qualified occupational therapist, or by the physical therapist to another qualified physical therapist, or by the therapist or pathologist to a registered professional nurse on the staff of the provider. Such changes must be immediately recorded in the patient's records and signed by the individual receiving the orders. While the physician may change a plan of treatment established by the pathologist or therapist providing such services, the therapist or pathologist may not alter a plan of treatment established by a physician.

The plan must be reviewed by the attending physician, in consultation with the physical therapist(s), occupational therapist(s), or speech pathologist(s) of the provider, at such intervals as the severity of the patient's condition requires, but at least every 30 days. Each review of the plan should contain the initials of the physician and the date performed. The patient's plan normally need not be forwarded to the intermediary for review but will be retained in the provider's file. The provider must certify on the billing form that the plan is on file (see §§ 3120.3, 3640.8-Item 22, and 3640.9).

3148.4 Requirement That Services be Furnished on an Outpatient Basis.--Outpatient physical therapy, occupational therapy, and speech pathology services are covered when furnished by a provider to its outpatients, i.e., to patients in their homes, to patients who come to the facility's outpatient department, or to inpatients of other institutions. In addition, coverage includes physical therapy, occupational therapy, and speech pathology services furnished by participating hospitals and SNFs to those of their inpatients who have exhausted their Part A inpatient benefits or who are otherwise not eligible for Part A benefits. Providers of outpatient physical therapy, occupational therapy, and speech pathology services that have inpatient facilities, other than participating hospitals and SNFs, may not furnish covered outpatient physical therapy, occupational therapy, or speech pathology services to their own inpatients.

However, since the inpatients of one institution may be considered the outpatients of another institution, all providers of outpatient physical therapy, occupational therapy, and speech pathology services may furnish such services to inpatients of another health facility. It should be noted that the certified distinct part of an institution is considered to be a separate institution from a nonparticipating remainder. Consequently, when only part of an institution is certified as a participating provider of services, that certified distinct part may render covered outpatient physical therapy, occupational therapy, or speech pathology services to the inpatients of the noncertified remainder. The certified part must bill the program under Part B for outpatient physical therapy, occupational therapy, and speech pathology services it furnishes to inpatients of the noncertified part.

While outpatient physical therapy, occupational therapy and speech pathology are covered when furnished in the home, when added expense is caused by a visit to the home, a question must be raised as to whether the rendition of the service in the home is reasonable and necessary. Where the patient is not confined to his home, such added expense cannot be considered as reasonable and necessary for the treatment of an illness or injury since the home visit is substantially more costly than the medically appropriate and realistically feasible alternative pattern of care; e.g., in the facility's outpatient department. Consequently, these additional expenses incurred by providers due to travel to a person who is not homebound are not covered.

Under the Medicare law, there is no authority to require a provider to furnish a type of service. Therefore, a hospital or SNF may furnish physical therapy, occupational therapy, or speech pathology to its inpatients without having to set up facilities and procedures for furnishing those services to its outpatients. However, if the provider chooses to furnish a particular service, it is bound by its agreement not to charge any individual or other person for items or services for which the individual is entitled to have payment made under the program. Thus, whenever a hospital or SNF furnishes outpatient physical therapy, occupational therapy, or speech pathology to a Medicare beneficiary (either directly or under arrangements with others) it must bill the program under Part B and may only charge the patient for the applicable deductible and coinsurance.

3149. OUTPATIENT PHYSICAL THERAPY SERVICES FURNISHED IN THE OFFICE OF AN INDEPENDENTLY PRACTICING PHYSICAL THERAPIST UNDER ARRANGEMENTS MADE BY A PUBLIC HEALTH AGENCY OR HOSPITAL IN RURAL COMMUNITIES.

Where the provider is a public health agency or a hospital in a rural community, it may enter into arrangements to have outpatient physical therapy services furnished in the private office of a qualified physical therapist if the agency or hospital does not have the capacity to provide on its premises all of the modalities of treatment, tests, and measurements that are included in an adequate outpatient physical therapy program and the services and modalities which the public health agency or hospital cannot provide on its premises are not available on an outpatient basis in another accessible certified provider.

General Exclusions From Coverage

3150. GENERAL EXCLUSIONS.

No payment can be made under either the hospital insurance or supplementary medical insurance program for certain items and services.

A. Not reasonable and necessary (S 3151);

B. No legal obligation to pay for or provide (S 3152);

C. Paid for by a governmental entity (S 3153);

D. Not provided within United States (S 3154);

E. Resulting from war (S 3155);

F. Personal comfort (S 3156);

G. Routine services and appliances (S 3157);

H. Excluded foot care services and supportive devices for feet (S 3158);

I. Custodial care (S 3159);

J. Cosmetic surgery (S 3160);

K. Charges by immediate relatives or members of household (S 3161).

L. Dental services (S 3162)

M. Paid or expected to be paid under workers' compensation (S 3163).

N. Nonphysician services provided to a hospital inpatient which were not provided directly or arranged for by the hospital (S 3164).

3151. SERVICES NOT REASONABLE AND NECESSARY.

Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member are not covered.

3151.1 Devices Not Approved by FDA.--Medical devices which have not been approved for marketing by the Food and Drug Administration (FDA) are considered investigational by Medicare and are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures or services performed using devices which have not been approved for marketing by FDA.

3152. NO LEGAL OBLIGATION TO PAY FOR OR PROVIDE SERVICES.

Program payment may not be made for items or services which neither the beneficiary nor any other person or organization has a legal obligation to pay for or provide. This exclusion applies where items and services are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, such as free X-rays or immunizations provided by health organizations. However, Medicare reimbursement is not precluded merely because a provider, physician, or supplier waives the charge in the case of a particular patient or group or class of patients, as the waiver of charges for some patients does not impair the right to charge others, including Medicare patients. The determinative factor in applying this exclusion is the reason the particular individual is not charged.

The following sections illustrate the applicability of this exclusion to various situations involving services other than those paid for directly or indirectly by a governmental entity. (For a discussion of the latter, see § 3153.)

A. Indigency.--This exclusion does not apply where items and services are furnished an indigent individual without charge because of his inability to pay, if the provider, physician, or supplier bills other patients to the extent that they are able to pay.

B. Provider, Physician, or Supplier Bills Only Insured Patients.--Some providers, physicians, and suppliers waive their charges for individuals of limited means, but they also expect to be paid where the patient has insurance which covers the items or services they furnish. In such a situation, because it is clear that a patient would be charged if insured, a legal obligation to pay exists and benefits are payable for services rendered to patients with medical insurance if the provider, physician, or supplier customarily bills all insured patients--not just Medicare patients--even though non-insured patients are not charged.

Individuals with conditions which are the subject of a research project may receive treatment financed by a private research foundation. The foundation may establish its own clinic to study certain diseases or it may make grants to various other organizations. In most cases, the patient is not expected to pay for his treatment out-of-pocket, but if he has insurance, the parties expect that the insurer will pay for the services. In this situation, a legal obligation is considered to exist in the case of a Medicare patient even though other patients may not have insurance and are not charged.

C. Medicare Patient Has Other Health Coverage.--Except as provided in §§ 3419ff., 3490ff. and 3491ff., payment is not precluded under Medicare even though the patient is covered by another health insurance plan or program which is obligated to provide or pay for the same services. This plan may be the type which pays money toward the cost of the services, such as a health insurance policy, or it may be the type which organizes and maintains its own facilities and professional staff. Examples of this latter type are employer and union sponsored plans which furnish services to special groups of employees or retirees or to union members, and group practice prepayment plans.

The exceptions to this rule are services covered by automobile medical or no-fault insurance (§§ 3419ff.), services rendered during a specified period of up to 12 months to individuals entitled solely on the basis of end stage renal disease who are insured under an employer group health plan (§§ 3490ff.) and services rendered employed individuals age 65 or over and spouses age 65 or over of employed individuals of any age who are insured under an employer group health plan (§§ 3491ff.) and services covered by workers' compensation. (See §§ 3407ff.) In these cases, the other plan pays primary benefits and if the other plan does not pay the entire bill, secondary Medicare benefits may be payable. Medicare is also secondary to the extent that services have been paid for by a liability insurer. (See §§ 3419ff.)

D. Items Covered Under Warranty.—When a defective medical device such as a cardiac pacemaker is replaced under a warranty, hospital or other provider services rendered by parties other than the warrantor are covered despite the warrantor's liability. However, consider recovering Medicare payment for such services under the liability insurance provisions in §§3419ff.

With respect to payment for the device itself, under cost reimbursement the following rules apply: If the device is replaced free of charge by the warrantor, no program payment may be made, since there was no charge involved. If, however, a replacement device from another manufacturer had to be substituted because the replacement device offered under the warranty was not acceptable to the beneficiary or his physician, payment may be made for the replaced device. Also, if the warrantor supplied the replaced device, but some charge or pro rata payment was imposed, program payment may be made for the partial payment imposed for the device furnished by the warrantor.

If a hospital could have obtained an acceptable device free of charge under a warranty but chose to purchase one instead, payment cannot be made for the purchased device under the prudent buyer rules. (See Provider Reimbursement Manual, Part 1, §2103.) Also, if an acceptable device could have been purchased at a reduced price under a warranty but the hospital did not take advantage of the warranty (i.e., it paid the full price to the original manufacturer or purchased the replacement device from a different manufacturer), the most the hospital can receive as reimbursement for the purchased device is the amount it would have had to pay if it had pursued the warranty.

While payments to a hospital for inpatient services under the prospective payment system (PPS) are not reduced to reflect collections by the provider under warranty provisions for medical devices, cost-based reimbursed hospitals and exempt units are subject to the prudent buyer rules.

E. Members of Religious Orders.--A legal obligation to pay exists where a religious order either pays for or furnishes services to members of the order. Although medical services furnished in such a setting would not ordinarily be expressed in terms of a legal obligation, the order has an obligation to care for its members who have rendered life-long services, similar to that existing under an employer's prepayment plan. Thus, payment may be made for such services whether they are furnished by the order itself or by independent sources that customarily charge for their services.

3153. ITEMS AND SERVICES FURNISHED, PAID FOR OR AUTHORIZED BY GOVERNMENTAL ENTITIES--FEDERAL, STATE OR LOCAL GOVERNMENTS.

The law contains three separate exclusions applicable to items and services furnished, paid for or authorized by governmental entities. In general payment may not be made for items and services: (1) furnished by a provider (Governmental or nongovernmental) or other person at public expense pursuant to an authorization issued by a Federal agency (§3153.1); (2) furnished by a provider of services or agency of the Federal government (§3153.2); and (3) paid for directly or indirectly by a Federal, State, or local governmental entity (§3153.3). Apply each of these exclusions separately, i.e., benefits are excluded where any one of the exclusions applies.

3153.1 Items and Services Which a Non-Federal Provider Furnishes Pursuant to an Authorization Issued by a Federal Agency.--

A. VA Authorized Services.—Medicare does not pay for any item or service rendered by a non-Federal provider pursuant to an authorization issued by a Federal agency, under the terms of which the Federal government agrees to pay for the services.

The VA may authorize non-Federal providers to render services at Federal expense. For example, the VA may pay for treatment of veterans in non-VA hospitals for service-connected disabilities and, in certain circumstances, for nonservice-connected disabilities, provided the VA has given prior authorization for the services. The VA may also agree to pay for emergency services furnished a veteran who appears at a hospital without prior authorization, provided a notification of the veteran's admission and a request for authorization to provide care at VA expense is submitted to the VA within 72 hours after the admission.

The VA may authorize up to 6 months of care in non-VA SNFs for veterans requiring such care after transfer from a VA hospital. Services furnished pursuant to a VA authorization do not count against the 100 days of extended care benefits available in a spell of illness. Where a veteran remains in an SNF until his VA benefits are exhausted, extended care benefits could begin under Medicare. Such benefits begin with the first day after the VA benefits are exhausted, provided a physician certifies that the individual still requires skilled nursing care on a continuing basis for a condition for which he received inpatient hospital services or which arose while he was still being treated in the facility for such a condition. The 3-day qualifying hospital stay and 30-day transfer requirements of the law must be met as of the time he entered the facility.

Where an authorization from the VA was not given to the party rendering the services, Medicare payment is not precluded even though the individual might have been entitled to have payment made by the VA had he requested the authorization. Also, Medicare secondary benefits may be payable where the VA authorizes fewer days than the total number of covered days in the stay. (See subsection C.)

Generally it is advantageous for Medicare beneficiaries who are veterans to have items and services paid for by the VA where possible, since in most cases (see subsection E for exception) the VA has no deductible or coinsurance requirements. Also, services paid for in full by the VA do not count against the individual's maximum number of benefit days or visits available in a benefit period.

B. Services Authorized by Indian Health Service.--The Division of Indian Health of the United States Public Health Service authorizes private physicians and privately owned hospitals and nursing homes to provide treatment to Indians and their dependents under contractual arrangements with the Division of Indian Health. In the case of such contract health services to Indians and their dependents entitled under the Indian Health Service (IHS) program and Medicare, Medicare is the primary payer and the IHS the secondary payer.

C. Medicare Secondary Payment Where VA Authorizes Fewer Days Than Total Number of Covered Days In the Stay.--The Medicare secondary payment is the lower of:

o The gross amount payable by Medicare for all covered days in the stay (without regard to deductible or coinsurance) minus the amount paid by the VA for Medicare covered services, or

o The gross amount payable by Medicare (without regard to deductible or coinsurance) minus any applicable Medicare deductible or coinsurance.

EXAMPLE: The VA authorizes payment for 4 days of a 7-day stay. Charges for the 4 days total $2,350. The VA reimburses the hospital that amount. The gross amount payable by Medicare (unreduced by deductible and coinsurance) for the 7-day stay is $3,350. The beneficiary's Part A deductible has not been met. The Medicare secondary payment is determined by subtracting the VA payment from the gross amount payable by Medicare: $3,350 - $2,350 = $1,000.

Medicare pays $1,000, which is less than the gross amount payable by Medicare minus the Medicare deductible ($3,350 - $540 = $2,810). The beneficiary's Part A deductible is met by the VA payment.

D. Effect of VA Payments on Medicare Deductible and Utilization.--Where an authorization issued by the VA binds the VA to pay in full for the items and services, no payment may be made under Medicare. When the VA pays in full, the services do not count against benefit maximums, e.g., the 90 days of inpatient hospital services or the 60-day lifetime reserve. Charges which would be reimbursable by Medicare except for the fact that the VA paid in full for authorized services may be credited to the Medicare deductibles.

When the VA authorizes fewer days than the total number of covered days in the stay, Medicare utilization is determined as follows:

o Divide the actual Medicare payment (as determined in subsection C) by the amount Medicare would have paid for covered charges as primary payer (i.e., the gross amount payable by Medicare for all covered days in the stay reduced by applicable Medicare deductible and coinsurance).

- o Multiply this percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day, but is charged as a full day if it is .5 or more of a day.

EXAMPLE: Same facts as presented in example in subsection C. The amount Medicare would pay as a primary payer is $2,810 ($3,350 - $540 deductible). Utilization is determined as follows: $1,000 ÷ $2,810 = .35 X 7 days = 2.45, rounded to 2 days.

When the VA pays an amount for Medicare covered services that is equal to, or less than, the deductible and coinsurance that would apply if Medicare was the primary payer, utilization is not reduced.

E. VA Copayments.—The VA charges veterans copayments for treatment of nonservice-connected conditions if a veteran's income exceeds a specified amount (38 CFR Part 17). The copayment amount is always paid by the veteran directly to the VA, i.e., the VA does not reduce its payments to providers. If a beneficiary is charged a copayment by the VA for authorized services, a Medicare secondary benefit may be payable. As a general rule, the VA does not authorize inpatient services at non-VA facilities for treatment of nonservice connected conditions. Accordingly, you should receive few, if any, requests for reimbursement for a VA copayment for treatment in a non-VA provider. If a beneficiary requests that you reimburse him for the amount of the VA copayment, he must submit to you, VA Form 10-9014, Statement of Charges for Medical Care, along with his request. These requests will be handled on an ad hoc basis. For further guidance contact:

HCFA, Bureau of Program Operations
Office of Program Operations Procedures
Division of Provider Procedures
1-H-3 Meadows East Building
6300 Security Boulevard
Baltimore, Maryland 21207

3153.2 Items and Services Furnished by Federal Provider of Services or Federal Agency.--Generally, Federal providers are excluded from participation in the Medicare program. However, Federal hospitals, like other nonparticipating hospitals, may be paid for emergency inpatient and outpatient hospital services. A provider or other facility acquired by the Department of Housing and Urban Development (DHUD) in the administration of an FHA mortgage insurance program is not considered to be a Federal provider or agency and this exclusion is not applicable to services furnished by such facilities. The law provides exceptions to this exclusion which permit the following categories of Federal providers to participate in Medicare:

- o A Federal provider which is determined to be providing services to the public generally as a community institution or agency. VA hospitals which have sharing agreements with non-VA participating hospitals, under which the VA hospitals furnish end-stage renal disease services to nonveterans, may be considered community hospitals with respect to any otherwise covered service rendered end-stage renal disease beneficiaries. This exception does not apply to Federal clinics or other Federal health facilities which are not "providers of services" as defined in the Medicare law, i.e., which are not hospitals, SNFs, HHAs or comprehensive outpatient rehabilitation facilities. HCFA, OMB is responsible for processing claims for services furnished directly by Federal providers. If you receive a request for Medicare reimbursement of such services forward the request to:

HCFA
Office of Management and Budget
Division of Accounting
P.O. Box 17255
Baltimore, Maryland 21203-7255

NOTE: The VA copayment provisions mentioned in §3153.1 also apply to inpatient services furnished in a VA hospital. If you receive a request for Medicare reimbursement of VA copayment amounts for emergency services furnished by VA hospitals, refer the request to HCFA, OMB.

- Hospitals and SNFs of Indian Health Service.

3153.3 Items or Services Paid For by Governmental Entity.—Medicare payment may not be made for items or services paid for directly or indirectly by a Federal, State or local governmental entity. However, the law specifies that this exclusion does not prohibit payment for: (1) items or services furnished under a health benefits or insurance plan established for employees of the governmental entity; (2) items or services furnished under one of the titles of the Social Security Act (such as medical assistance under title XIX); or (3) rural health clinic services.

A. Application of Exclusion to State and Local Government Providers.-- Except for the two categories of facilities referred to below, payment may not be made for items and services which a State or local government facility furnishes free of charge; i.e., without expectation of payment from any source and without regard to the individuals' ability to pay. A facility which reduces or waives its charges for patients unable to pay, or charges patients only to the extent of their Medicare and other health insurance coverage, is not viewed as furnishing free services and may therefore receive program payment.

Medicare regulations permit payment to the following two categories of governmental providers even though they furnish services free of charge:

1. Payment may be made for items and services furnished in or by a participating State or local Government hospital, including a psychiatric or tuberculosis hospital, which serves the general community. A psychiatric hospital to which patients convicted of crimes are committed involuntarily is considered to be serving the general community if State law provides for voluntary commitment to the institution. However, payment may not be made for services furnished in or by State or local hospitals which serve only a special category of the population, but do not serve the general community, e.g., prison hospitals.

2. Payment may be made for items and services paid for by a State or local governmental entity and furnished an individual as a means of controlling infectious diseases or because the individual is medically indigent.

B. Application of Exclusion to Nongovernmental Providers.—Payment may not be made for items or services furnished by a nongovernmental provider if the charges have been paid for by a government program other than Medicare, or if the provider intends to look to another government program for payment, unless the payment by the other program is limited to the Medicare deductible and coinsurance amounts, as it is for certain individuals covered under CHAMPUS/CHAMPVA. (See §3153.3D.).

The mere fact that a nongovernmental provider receives government financing does not mean that the items and services it furnishes are considered paid for by a governmental entity. However, if a clinic receives government financing earmarked for particular services to patients (e.g., in the form of a research grant), Medicare may not pay for the same services.

If an individual has the option of receiving care free of charge at a government provider or care which is not free at a nongovernment provider, and he chooses the latter, Medicare payment may be made for the care at the nongovernment provider. However, items and services authorized by a Federal agency (for example, by the VA at a nongovernmental hospital) are excluded. (See § 3153.1.)

C. Examples of Application of Government Entity Exclusion.--The following paragraphs explain the application of the governmental entity exclusion to various situations involving services rendered by governmental and nongovernmental facilities:

1. State Veterans Homes.--Many State governments operate veterans homes and hospitals. These institutions are generally open only to veterans and certain dependents of veterans, and include domiciliary, hospital, infirmary, and/or nursing home type facilities. These institutions are financed primarily from State funds; in addition, most receive nominal per diem payments from the VA for domiciliary care, hospital care, or nursing home type care for each veteran who would also qualify for admission to a VA hospital or domiciliary.

When such a participating institution charges its residents and patients to the extent of their ability to pay, or seeks payment from available sources other than Medicare, benefits are payable for covered items and services furnished to Medicare beneficiaries. However, if it is the policy of the institution to admit and treat a veteran without charge simply because he is a veteran, or because he has a service-connected condition, payment would be precluded under title XVIII.

Per diem amounts paid by the VA to State veterans homes on behalf of those patients who are otherwise eligible for care in a VA facility may be credited towards any deductible, coinsurance, or noncovered amounts required to be paid by the patient. However, if a State veterans home collects amounts from the VA in excess of the applicable deductible and coinsurance, reduce the Medicare payment to the extent of such payments.

2. State and Local Psychiatric Hospitals.--In general, payment may be made under Medicare for covered services furnished without charge by State or local psychiatric hospitals which serve the general community. (See §3153.3A(1).) However, payment may not be made for services furnished without charge to individuals who have been committed under a penal statute (e.g., defective delinquents, persons found not guilty by reason of insanity, and persons incompetent to stand trial). For Medicare purposes such individuals are "prisoners," as defined in subsection 3, and may have services paid by Medicare only under the exceptional circumstances described there.

A psychiatric hospital to which patients convicted of crimes are committed is considered to be serving the general community if State law also provides for voluntary admissions to the institution.

3. Prisoners.--Generally, no payment is made for services rendered to prisoners, since the State (or other government component which operates the prison) is responsible for their medical and other needs. (For this purpose, the term "prisoner" means a person who is in the custody of the police, penal authorities, or other agency of a governmental entity.) This is a rebuttable presumption that may be overcome only at the initiative of the government entity. However, the entity must establish to your satisfaction, in consultation with the RO, that:

- State or local law requires that individuals in custody repay the cost of the services.

- The State or local government entity enforces the requirement to pay by billing and seeking collection from all individuals in custody with the same legal status (e.g., not guilty by reason of insanity), whether insured or uninsured, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts. This includes collection of any Medicare deductible and coinsurance amounts and the cost of items and services not covered by Medicare.

NOTE: Require evidence that routine collection efforts include the filing of lawsuits to obtain liens against individuals' assets outside the prison and income derived from nonprison sources.

- The State or local entity documents its case with copies of regulations, manual instructions, directives, etc., spelling out the rules and procedures for billing and collecting amounts paid for prisoners' medical expenses. As a rule, inspect a representative sample of cases in which prisoners have been billed and payment pursued, randomly selected from both Medicare and non-Medicare eligibles. The existence of cases in which the State or local entity did not actually pursue collection, even though there is no indication that the effort would have been unproductive, indicates that the requirement to pay is not enforced.

D. CHAMPUS (Civilian Health and Medical Program of Uniformed Services) and CHAMPVA (Civilian Health and Medical Program of Veterans Administration.--

1. General.-- CHAMPUS and CHAMPVA are similar programs administered by the Department of Defense, except that the Veterans Administration determines the eligibility of persons seeking to establish entitlement to CHAMPVA coverage. CHAMPUS provides benefits for health care services furnished by civilian providers, physicians, and suppliers to retired members of the Uniformed Services and to spouses and children of active duty, retired, and deceased members. The term "Uniformed Services" includes the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the U.S. Public Health Service and of the National Oceanic and Atmospheric Administration. CHAMPVA provides similar benefits for spouses and children of veterans who are entitled to VA permanent and total disability benefits and to widows and children of veterans who died of service-connected disabilities.

The governmental entity exclusion does not preclude Medicare payment for items or services furnished to a beneficiary who is also eligible for CHAMPUS/CHAMPVA benefit payments for the same services. Medicare is the primary payer for such items and services, and CHAMPUS/CHAMPVA is a supplementary payer. (See subsection D3.)

2. Effect of Medicare Eligibility on CHAMPUS/CHAMPVA Entitlement.-- CHAMPUS/CHAMPVA beneficiaries, other than dependents of active duty members, lose their entitlement to CHAMPUS/CHAMPVA if they qualify for Medicare Part A on any basis except the premium-HI provisions. (See §3001.4.) Individuals who are eligible for Medicare Part B benefits only, do not lose their entitlement to CHAMPUS/CHAMPVA benefits. If a Medicare beneficiary who has lost entitlement to CHAMPVA upon becoming entitled to Part A of Medicare, thereafter exhausts any Part A benefits, the individual can again be entitled to CHAMPVA. Once the individual reattains CHAMPVA benefits, he or she will not lose them by virtue of later again becoming eligible for Medicare Part A benefits. There is no similar provision for CHAMPUS which enables an individual to reattain CHAMPUS eligibility after exhausting Medicare Part A benefits. Direct questions concerning this provision to the CHAMPVA Center.

3. Medicare-CHAMPUS/CHAMPVA Relationship.--If a CHAMPUS/CHAMPVA beneficiary also has Medicare coverage, CHAMPUS/CHAMPVA reduces its liability in all cases by the amount payable by Medicare, i.e., Medicare is the primary payer and CHAMPUS/CHAMPVA supplements Medicare by paying the Medicare deductible and coinsurance amounts and portions of the bill not covered by Medicare. Thus, dually entitled individuals may be reimbursed up to 100 percent of expenses for items and services covered by both programs.

CHAMPUS/CHAMPVA has established policies and procedures which provide for (a) the identification of claimants who have coverage under both CHAMPUS/CHAMPVA and Medicare and (b) the detection of duplicate payments under both programs. If CHAMPUS/CHAMPVA inadvertently pays amounts which duplicate Medicare payments for the same items or services, CHAMPUS/CHAMPVA will take steps to recover the incorrect CHAMPUS/CHAMPVA payments.

E. Active Duty Members of Uniformed Services.-- In limited circumstances, active duty members of the Uniformed Services may have care in civilian facilities paid for by the Army, Navy, Air Force, Marine Corps, or other appropriate uniformed service. Except for emergency services, prior approval is generally required before such payment can be made. Services furnished pursuant to such approval and services paid for or expected to be paid for by the Uniformed Services are not reimbursable under Medicare.

3154. SERVICES NOT PROVIDED WITHIN UNITED STATES

Items and services furnished outside the U.S. are excluded from coverage except for the following Canadian and Mexican services:

- Emergency inpatient hospital services where the emergency occurred:
  - While the beneficiary was physically present in the U.S. (§3698.4).
  - In Canada while the beneficiary was traveling without unreasonable delay by the most direct route, between Alaska and another State. (See §3698.4.)
- Emergency or nonemergency inpatient hospital services furnished in a Canadian or Mexican hospital closer to, or substantially more accessible from the beneficiary's U.S. residence than the nearest participating U.S. hospital which was adequately equipped to deal with and available to provide treatment of the illness or injury. (See §§3698.5 and 3698.13.)
- Physician and ambulance services furnished in connection with, and during a period of, covered foreign hospitalization. Program payment may not be made for any other Part B medical and other health services, including outpatient services furnished outside the U.S. (See §3698.6.)
- Christian Science services furnished under specified conditions in a Christian Science sanatorium. (See §3698.8.)

Under the Railroad Retirement Act, payment is made to QRRBs by the RRB for covered hospital services furnished in Canadian hospitals as well as in the U.S. Physician and ambulance services are not covered by the Railroad Retirement Act; however, under an agreement between HCFA and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- Whether the requirements in §§3698B and 3698.6 are met in regard to the inpatient services; and
- Whether the physician and/or ambulance services were furnished in connection with the services.

Payment may not be made for any item provided or delivered to the beneficiary outside the United States, even though the beneficiary may have contracted to purchase the item while he was within the United States or purchased the item from an American firm. See §3113.7B for rules on rental and periodic purchase payments for DME used outside the United States.

3155. SERVICES RESULTING FROM WAR

Items and services which are required as a result of war, or of an act of war, occurring after the effective date of the patient's current coverage are not covered.

3156. PERSONAL COMFORT ITEMS

Items which do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.

Charges for special items requested by the patient such as radio, television, telephone, and air conditioner, and beauty and barber services are excluded from coverage. The patient may be charged for such a service if he has requested it with knowledge that he will be charged. To avoid misunderstanding and disputes, the provider will inform the individual when he requests such an item or service that there will be a specified charge (not exceeding the customary charge). Thereafter, the provider may not charge the patient more for the item or service than the charge specified. A provider may not require a beneficiary to request noncovered items or services as a condition of admission or of continued stay.

Basic personal services such as simple barber and beautician services (e.g., shaves, haircuts, shampoos and simple hair sets) which patients need and cannot perform for themselves may be viewed as ordinary patient care when furnished by a long-stay institution. Such services are covered costs reimbursable under Part A when included in the flat rate charge and provided routinely without charge to the patient by an SNF or by a general psychiatric or tuberculosis hospital. The services are maintenance of at least a minimum level of personal hygiene, decency, and presentability essential to the well-being of the patient himself and of other patients who must associate with him. However, under the personal comfort exclusion, more elaborate services, such as professional manicures, hair styling, etc., are excluded even when furnished routinely and without special charge.

3157. ROUTINE SERVICES AND APPLIANCES.

Routine physical checkups; eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed; hearing aids and examinations for hearing aids; and immunizations are not covered.

The routine physical checkup exclusion applies to (a) examinations performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury; and (b) examinations required by third parties such as insurance companies, business establishments, or Government agencies.

(If the claim is for a diagnostic test or examination performed solely for the purpose of establishing a claim under title IV of Public Law 91-173, "Black Lung Benefits," the service is not covered under Medicare and the claimant should be advised to contact his local social security office regarding the filing of a claim for reimbursement under the "Black Lung" program.)

The exclusions apply to eyeglasses or contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses for refractive errors. The exclusions do not apply to physicians' services (and services incident to a physicians' service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to postsurgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. Such prosthetic lens is a replacement for an internal body organ--the lens of the eye. (See § 3110.4.)

Expenses for all refractive procedures, whether performed by an ophthalmologist (or any other physician) or an optometrist and without regard to the reason for performance of the refraction, are excluded from coverage.

A. Vaccinations or inoculations—Vaccinations or inoculations are excluded as "immunizations" unless they are directly related to the treatment of an injury or direct exposure such as antirabies treatment, tetanus antitoxin, or booster vaccine, botulin antitoxin, antivenin or immune globulin.

1. Pneumococcal Pneumonia Vaccinations.—With the enactment of P.L. 96-611, effective July 1, 1981, Part B of Medicare pays 100 percent of the reasonable charges for pneumococcal pneumonia vaccine and its administration to a patient if it is ordered by a physician who is a doctor of medicine or osteopathy. When furnished by a provider of services, payment is on a reasonable cost basis.

Cross Refer: §§3112.4B, 3213 and 3214.

2. Hepatitis B Vaccine.—With the enactment of P.L. 98-369, coverage under Part B is extended to hepatitis B vaccine and its administration, furnished to a Medicare beneficiary who is at high or intermediate risk of contracting hepatitis B. This coverage is effective for services furnished on or after September 1, 1984.

High-risk groups currently identified include:

End-Stage Renal Disease (ESRD) patients;
Hemophiliacs who receive Factor VIII or IX concentrates;
Clients of institutions for the mentally retarded;
Persons who live in the same household as an Hepatitis B Virus (HBV) carrier;
Homosexual men;
Illicit injectable drug abusers.

Intermediate risk groups currently identified include:

Staff in institutions for the mentally retarded;
Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

Exception:

> Persons in the above-listed groups would not be considered at high or intermediate risk of contractng hepatitis B, however, if there is laboratory evidence positive for antibodies to hepatitis B. (ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy.)

For Medicare program purposes, the vaccine may be administered—upon the order of a doctor of medicine or osteopathy—by home health agencies, skilled nursing facilities, ESRD facilities, hospital outpatient departments, persons recognized under the "incident to physicians' services" provision of the law, and, of course, doctors of medicine and osteopathy.

A charge separate from the ESRD composite rate will be recognized and paid for administration of the vaccine to ESRD patients.

For reimbursement, see Section 2745 of the Provider Reimbursement Manual, Part I.
Cross Refer: CIA 50-17 & §§3112.4B and 3174.3.

B. Antigens.— Prior to the Omnibus Reconciliation Act of 1980, a physician who prepared an antigen for a patient could not be reimbursed for that service unless the physician also administered the antigen to the patient. Effective January 1, 1981, payment may be made for a reasonable supply of antigens that have been prepared for a particular patient even though they have not been administered to the patient by the same physician who prepared them if: (1) the antigens are prepared by a physician who is a doctor of medicine or osteopathy, and (2) the physician who prepared the antigens has examined the patient and has determined a plan of treatment and a dosage regimen. The associations of allergists that we consulted advised us that a reasonable supply of antigens is considered to be not more than a 12-week supply of antigens that has been prepared for a particular patient at any one time. The purpose of the reasonable supply limitation is to assure that the antigens retain their potency and effectiveness over the period in which they are to be administered to the patient. Cross Refer: §3112.4B.

Exclusion of Foot Care and Supportive Devices for the Feet

3158. EXCLUDED FOOT CARE SERVICES.

Effective January 1, 1968, the scope of covered foot care services under both Part A and B was limited by excluding the following types of services:

A. Treatment of Flat Foot.-- The term "flat foot" as defined as a condition in which one or more arches in the foot have flattened out. Services directed toward the care or correction of such condition are not covered. (See § 3158.2 for supportive devices; see also § 3158.1 for situations where the initial diagnostic service will be covered.)

B. Treatment of Subluxations of the Foot.-- Subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles of the foot.

Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis and treatment (except by the use of orthopedic shoes or other supportive devices for the foot) of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures are covered services. Surgical correction of a subluxated foot structure that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

This exclusion does not apply to the ankle joint (talo-crural joint).

C. Routine Foot Care.-- Routine foot care includes the cutting or removal of corns, or calluses, the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients, and any services performed in the absence of localized illness, injury or symptoms involving the foot. For example, foot care such as routine soaking and application of topical medication on the physician's order between required visits to the physician is not covered. In addition, any treatment of a fungal (mycotic) infection of the toenail is considered routine and not covered in the absence of (1) clinical evidence of mycosis of the toenail, and (2) compelling medical evidence documenting that the patient either (A) has a marked limitation of ambulation requiring active treatment of the foot, or (B) in the case of a nonambulatory patient has a condition that is likely to result in significant medical complications in the absence of such treatment.

NOTE: Effective July 1, 1981, the treatment of warts (including plantar warts) is no longer considered routine foot care. As a result, services provided for the treatment of warts on the foot are covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

Certain foot care procedures that are generally considered to be routine foot care--e.g., cutting or removal of corns, calluses, or nails--may pose a hazard when performed by a nonprofessional person on patients with a systemic condition that has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Although not intended as a comprehensive list, the following metabolic, neurological, and peripheral vascular diseases (with synonyms in parenthesis) most commonly represent the underlying conditions contemplated:

*Diabetes mellitus

Arteriosclerosis obliterans (A.S.O. arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)

Buerger's disease (thromboangiitis obliterans)

*Chronic thrombophlebitis

Peripheral neuropathies involving the feet

- *Associated with malnutrition and vitamin deficiency
  - malnutrition (general, pellagra)
  - alcoholism
  - malabsorption (celiac disease, tropical sprue)
  - pernicious anemia
- *Associated with carcinoma
- *Associated with diabetes mellitus
- *Associated with drugs and toxins
- *Associated with multiple sclerosis
- *Associated with uremia (chronic renal disease)
- Associated with traumatic injury
- Associated with leprosy or neurosyphilis
- Associated with hereditary disorders
  - hereditary sensory radicular neuropathy
  - angiokeratoma corporis diffusum (Fabry's)
  - amyloid neuropathy

Where the patient's condition is one of these designated by an asterisk (*), routine procedures can be reimbursable but only if the patient is under the active care of a doctor of medicine or osteopathy for such a condition.

In evaluating whether the routine services can be reimbursed, a presumption of coverage may be made where the evidence available discloses certain physical and/or clinical findings consistent with the diagnosis and indicative of severe peripheral involvement. For purposes of applying this presumption the following findings are pertinent:

Class A Findings

- Nontraumatic amputation of foot or integral skeletal portion thereof

Class B Findings

- Absent posterior tibial pulse
- Advanced trophic changes as: (Three required.) hair growth (decrease or absence) nail changes (thickening) pigmentary changes (discoloration) skin texture (thin, shiny) skin color (rubor or redness)
- Absent dorsalis pedis pulse

Class C Findings

- Claudication
- Temperature changes (e.g., cold feet)
- Edema
- Paresthesias (abnormal spontaneous sensations in the feet)
- Burning

The presumption of coverage may be applied when the physician rendering the routine foot care has identified: (1) a Class A finding; (2) two of the Class B findings; or (3) one Class B and two Class C findings. Cases evidencing findings falling short of these alternatives may involve podiatric treatment that may constitute covered care and should be reviewed by the intermediary's medical staff and developed as necessary.

For purposes of applying the coverage presumption where the routine services have been rendered by a podiatrist, the intermediary may deem the active care requirement met if the claim or other evidence available discloses that the patient has seen an M.D. or D.O. for treatment and/or evaluation of the complicating disease process during the 6-month period prior to the rendition of the routine-type services. The intermediary may also accept the podiatrist's statement that the diagnosing and treating M.D. or D.O. also concurs with his findings as to the severity of the peripheral involvement indicated.

Services ordinarily considered routine may also be covered if they are performed as a necessary and integral part of otherwise covered services, such as diagnosis and treatment of diabetic ulcers, wounds, and infections.

3158.1 Application of Foot Care Exclusions to Provider Services.-- Charges for provider services furnished in connection with noncovered foot care which are normally separately identified by the provider must be shown as noncovered charges and excluded from reimbursement. However, the provider will not be expected to identify services in connection with noncovered foot care where it is neither the normal practice to separately identify the services nor administratively feasible to establish a separate charge for such services, or where such services are performed as a necessary and integral part of otherwise covered services. In addition, where services or procedures are performed in connection with the diagnosis of specific symptoms or complaints which suggest the need for covered services, the initial diagnostic services will be considered covered services regardless of the resulting diagnosis.

Where a patient who is receiving covered hospital services in connection with treatment of an illness or injury also receives hospital services in connection with noncovered foot care (e.g., routine hygienic foot care included as a regular part of the nursing care) and a separate charge is not made for such services, it would not be necessary to compute and exclude that portion of the hospital's charge which is attributable to the noncovered foot care. If, however, a patient receives inpatient or outpatient hospital services for the purpose of noncovered foot care all of the hospital services received by the patient can be attributed to noncovered services and hence must be excluded from coverage.

An exception to this latter rule may be made where a doctor of medicine or osteopathy certifies that hospitalization is required for proper medical management of a systemic disease during noncovered foot treatment. In such cases, the inpatient hospital services, including all ancillaries, may be covered even though no payment may be made for the professional services performed by the podiatrist or other physician in connection with the foot care. (Development of such claims by the intermediary should follow the same guidelines outlined in Part A Intermediary Manual, § 3101.7, with respect to claims for hospitalization for a noncovered dental procedure where a nondental impairment exists which requires medical management.)

It is expected that the foot care exclusions will have greater application to outpatient hospital services than to inpatient services. For example, in the outpatient department it is more likely that the total services received on an occasion can be attributed to noncovered foot care and hence excluded. In an outpatient situation it is also more likely that separate itemization of charges for noncovered foot care not integrally related to a covered procedure may be the usual practice, thereby permitting exclusion of such charges (as in the case of a separate excludable charge for routine foot care furnished as a hospital service as part of followup visits to a diabetic clinic).

3158.2 Supportive Devices for Feet.--Orthopedic shoes or other supportive devices for the feet are not covered. The exclusion of orthopedic shoes does not apply to such a shoe if it is an integral part of a leg brace.

3159. CUSTODIAL CARE

Custodial care is excluded from coverage. Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, consider the level of care and medical supervision required and furnished. Do not base the decision on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

Institutional care that is below the level of care covered in a SNF is custodial care. (See §3132.) Some examples of custodial care in hospitals and SNFs are:

- A stroke patient who is ambulatory, has no bladder or bowel involvement, no serious associated or secondary illnesses and does not require medical or paramedical care but requires only the assistance of an aide in feeding, dressing, and bathing;
- A cardiac patient who is stable and compensated and has reasonable cardiac reserve and no associated illnesses, but who because of advanced age has difficulty in managing alone in the home, and requires assistance in meeting the activities of daily living; and
- A senile patient who has diabetes which remains stabilized as long as someone sees to it that the patient takes oral medication and sticks to a prescribed diet.

Even if a patient's stay in a hospital or SNF is determined to be custodial, some individual services may still be covered under Part B if they are reasonable and necessary. (See §§3110 and 3137.)

3159.1 Custodial Care Under A Hospice Program.--Care furnished to an individual who has elected the hospice care option is custodial only if it is not reasonable and necessary for the palliation or management of the terminal illness or related conditions. (See §3143.)

(§3160 begins on page 3-64.9)

3160. COSMETIC SURGERY

Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

3161. CHARGES IMPOSED BY IMMEDIATE RELATIVES OF THE PATIENT OR MEMBERS OF HIS HOUSEHOLD

A. General.--Payment may not be made for expenses which constitute charges by immediate relatives of the beneficiary or by members of his household. The intent of this exclusion is to bar Medicare payment for personal services of physicians or suppliers which would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. Payment may be made, however, for reasonable charges imposed on such individuals by a physician or supplier to recover out-of-pocket expenses he has incurred in furnishing covered items or supplies, e.g., expenses for covered drugs and biologicals, prosthetic devices, etc. In such cases, the charge may not exceed the physician's or supplier's actual out-of-pocket costs.

B. Services of Providers and Provider-Based Physicians.--This exclusion applies only to services reimbursed on a charge basis and does not apply to provider services and to the services of group practice prepayment plans which are reimbursed for their costs rather than charges. Thus, reimbursement may be made for covered services furnished by a provider to an owner of the institution or to an immediate relative of an owner, or a member of an owner's household.

Reimbursement may not be made, however, for the professional component of services of provider-based physicians furnished to an immediate relative of the physician or to a member of the physician's household. Since the personal services of provider-based physicians are billed on a charge basis, they would be subject to this exclusion whether the bill is submitted by the physician or. with his authorization, by the provider.

C. Immediate Relative.--The following degrees of relationship are included within the definition of "immediate relative": (1) husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) stepparent, stepchild, stepbrother, and stepsister; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; (6) grandparent and grandchild.

NOTE: A brother-in-law or sister-in-law relationship does not exist between a physician (or supplier) and the spouse of his wife's (husband's) brother or sister.

A father-in-law or mother-in-law relationship does not exist between a physician and his spouse's stepfather or stepmother.

A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties. Thus, for example, if a physician treats his stepfather after the death of his natural mother or after the stepfather and natural mother are divorced, or if he treats his father-in-law or mother-in-law after the death of his wife, the services would be considered to have been furnished to an immediate relative and, therefore, excluded from coverage.

D. Members of the Patient's Household.--These are persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

E. Charges by Professional Corporation or Business Organization Such as Supplier and Clinic.--Charges imposed by a medical group, clinic, or supplier which is not a corporation are, in effect, imposed by the owner or owners of the business. Thus, this exclusion applies where such a firm is owned by a sole proprietor who bears one of the excluded relationships to the patient. In the case of a partnership, the exclusion applies only where all of the partners bear one of the excluded relationships to the patient. Charges imposed by a corporation are not subject to this exclusion except in the case of charges imposed by a professional corporation for items or services furnished (1) by an owner who bears one of the excluded relationships to the patient or (2) by an employee under the supervision of a related owner. "Professional corporation" means a corporation that is operated solely for the purpose of conducting the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic. Only members of the profession can own stock in a professional corporation. Any physician or group of physicians which is incorporated constitutes a professional corporation. (Generally, physicians who are incorporated identify themselves by adding letters such as P.C. or P.A. after their title.)

The exclusion does not apply to charges imposed by a corporation other than a professional corporation, regardless of the patient's relationship to any of the stockholders of the corporation or to the person who furnished the service.

3162. DENTAL SERVICES EXCLUSION.

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. "Structures directly supporting the teeth" means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process. However, payment may be made for certain other services of a dentist. (See S3030.2 and Coverage Issues Manual S50-26.)

When an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered. Similarly, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service; e.g., the preparation of the mouth for dentures. In like manner, the removal of the torus palatinus (a bony protuberance of the hard palate) could be a covered service. However, with rare exception, this surgery is performed in connection with an excluded service; i.e., the preparation of the mouth for dentures. Under such circumstances, reimbursement should not be made for this purpose.

The extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered. This is an exception to the requirement that to be covered, a noncovered procedure or service performed by a dentist must be an incident to and an integral part of a covered procedure or service performed by him. Ordinarily, the dentist extracts the patient's teeth, but another physician; e.g., a radiologist, administers the radiation treatments.

Whether or not such services as the administration of anesthesia, diagnostic X-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an X-ray taken in connection with the reduction of a fracture of the jaw or facial bone would be covered. However, a single X-ray or X-ray survey taken in connection with the care or treatment of teeth or the periodontium would not be covered.

See also SS3101.7 and 3030.2 for additional information on dental services.

3163. ITEMS AND SERVICES UNDER A WORKERS' COMPENSATION LAW.

Items and services to the extent that payment has been made, or can reasonably be expected to be made under a workers' compensation law or plan of the United States or State may not be paid for by the program. Payments for items and services under the health insurance program are subject to repayment to the appropriate trust fund if notice or information is received that payment is available for the items and services under a workers' compensation plan. (See SS3407ff.)

3164. INPATIENT HOSPITAL SERVICES NOT DELIVERED DIRECTLY OR UNDER ARRANGEMENT BY THE HOSPITAL.

Unless a hospital has been granted a waiver as described in SS3110 and 3618C, any nonphysician service provided to an inpatient of a hospital which is not provided directly by the hospital or under arrangement is excluded from coverage under Medicare. (See S3007.)

3165. INTRODUCTION

End-stage renal disease (ESRD) or "chronic kidney failure" is that stage of renal impairment that requires either a regular course of dialysis or kidney transplantation. ESRD occurs from the destruction of normal kidney tissues over a long period of time. Often there are no symptoms until the kidney has lost more than half its function. The loss of kidney function in ESRD is usually irreversible and permanent.

3166. COMPOSITE RATE REIMBURSEMENT FOR OUTPATIENT MAINTENANCE DIALYSIS

The composite rate reimbursement system is a prospective, incentive system for the payment of outpatient maintenance dialysis services furnished to Medicare beneficiaries. All maintenance dialysis treatments furnished to Medicare beneficiaries in an approved ESRD facility are covered by this system. Further, the composite rate system is one of two methods by which Medicare pays for maintenance dialysis performed in a beneficiary's home. (For a description of the other method see §3169.)

The facility's composite rate is a comprehensive payment for all modes of infacility and home dialysis. It is payment for the complete dialysis treatment except for physicians' professional services, separately billable laboratory services and separately billable drugs. This payment is subject to the normal Part B deductible and coinsurance requirements.

Under composite rate reimbursement, an ESRD facility must furnish all of the necessary dialysis services, equipment and supplies. If it fails to furnish (either directly or under arrangements or under an agreement with another approved ESRD facility) any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that the facility does furnish.

3166.1 Definitions.—Some services are listed in the definitions shown below. These services are covered by Medicare unless otherwise noted.

A. Dialysis.—A process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. There are two types of renal dialysis procedures in common clinical usage: hemodialysis and peritoneal dialysis. Both hemodialysis and peritoneal dialysis are acceptable modes of treatment for end-stage renal disease under Medicare.

1. Hemodialysis.—Blood passes through an artificial kidney machine and the waste products diffuse across a manmade membrane into a bath solution known as dialysate after which the cleansed blood is returned to the patient's body. Hemodialysis is accomplished usually in 4-5 hours, 3 times a week.

2. Peritoneal

a. Continuous Ambulatory Peritoneal Dialysis (CAPD).—CAPD is a continuous dialysis process using the patient's peritoneal membrane as a dialyzer. For more information, see §3171.

b. Continuous Cycling Peritoneal Dialysis (CCPD).—CCPD is a treatment modality which combines the advantages of the long dwell, continuous steady state dialysis of CAPD, with the advantages of automation inherent in intermittent peritoneal dialysis (IPD). The major difference between CCPD and CAPD is that the solution exchanges which are performed manually during the day by the patient on CAPD are moved to the nighttime with CCPD and are performed automatically with a peritoneal dialysis cycler. The long nighttime dwell of CAPD is moved to the daytime with CCPD.

At night, the patient connects a surgically implanted catheter to the cycler system, which has 4 two-liter containers of dialysate suspended. The cycler automatically empties the patient's peritoneal cavity of the all-day dwell. The cycler then cycles the noctural exchanges automatically while the patient sleeps. The number of nocturnal exchanges with CCPD are prescribed by the physician; generally there are 3 nocturnal exchanges occurring at intervals of 2 1/2 to 3 hours, with the fourth exchange being instilled in the morning upon awakening. The patient then disconnects from the cycler and leaves the last 2-liter fill inside the peritoneum to continue the daytime long dwell dialysis.

c. Intermittent Peritoneal Dialysis (IPD).—Waste products pass from the patient's body through the peritoneal membrane into the peritoneal cavity where the dialysate is introduced and removed periodically by machine. Peritoneal dialysis generally is required for approximately 30 hours a week, either as 3-ten hour sessions or less frequent, but longer, sessions.

B. ESRD Facility.—A facility which is approved to furnish at least one specific ESRD service. Such facilities are:

1. Renal Transplantation Center.—A hospital unit which is approved to furnish transplantation and other medical and surgical specialty services required for the care of the ESRD transplant patients, including inpatient dialysis furnished directly or under arrangement. A renal transplantation center may also be a renal dialysis center.

2. Renal Dialysis Center.—A hospital unit which is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of ESRD dialysis patients (including inpatient dialysis furnished directly or under arrangement). A hospital need not provide renal transplantation to qualify as a renal dialysis center.

3. Renal Dialysis Facility.—A unit which is approved to furnish dialysis service(s) directly to ESRD patients.

4. Self-Dialysis Unit.—A unit that is part of an approved renal transplantation center, renal dialysis center, or renal dialysis facility, and furnishes self-dialysis services.

5. Special Purpose Renal Dialysis Facility.—A renal dialysis facility which is approved to furnish dialysis at special locations on a short-term basis to a group of dialysis patients otherwise unable to obtain treatment in the geographical area. The special locations must be either special rehabilitative (including vacation) locations serving ESRD patients temporarily residing there, or locations in need of ESRD facilities under emergency circumstances.

C. ESRD Service.—The type of care or services furnished to an ESRD patient. Such types of care are:

1. Transplantation service.—A process by which (a) a kidney is excised from a live or cadaveric donor, (b) a kidney is implanted in an ESRD patient, and (c) supportive care is furnished to the living donor and to the recipient following implantation.

2. Dialysis Service:

a. Acute Dialysis.—Dialysis given to patients who are not ESRD patients, but who require dialysis because of temporary kidney failure due to a sudden trauma; e.g., traffic accident or ingestion of certain drugs.

b. Back-Up Dialysis.—Dialysis given to patients under special circumstances. Examples are dialysis of a home dialysis patient in a dialysis facility when his equipment fails; inpatient dialysis when a patient's illness requires more comprehensive care on an inpatient basis; and pre- and postoperative dialysis provided to transplant patients.

c. Institutional Dialysis Services.—Institutional dialysis services include all services, supplies, items, and equipment and ESRD related laboratory tests covered under the composite rate necessary to perform dialysis in an approved renal dialysis facility or center.

d. Inpatient Dialysis.—Dialysis which, because of medical necessity, is furnished to an ESRD patient on a temporary inpatient basis in a hospital.

e. Outpatient Dialysis.—Dialysis furnished on an outpatient basis at a renal dialysis center or facility. Outpatient dialysis includes:

(1) Staff-assisted Dialysis.—Dialysis performed by the staff of the center or facility.

(2) Self-Dialysis.—Dialysis performed by an ESRD patient who has completed an appropriate course of training with little or no professional assistance .

(3) Home Dialysis.—Dialysis performed by an appropriately trained patient at home.

(4) Self-Dialysis and Home Dialysis Training. A program that trains ESRD patients to perform self-dialysis or home dialysis with little or no professional

assistance, and trains other individuals to assist patients in performing self-dialysis or home dialysis.

3. Hemofiltration.—Hemofiltration is a safe and effective technique for the treatment of ESRD patients and an alternative to peritoneal dialysis and hemodialysis. Hemofiltration (which is also known as diafiltration) removes fluid, electrolytes and other low molecular weight toxic substances from the blood by filtration through hollow artificial membranes and may be routinely performed in 3 weekly sessions. (See §3174.)

D. Hemoperfusion.—Hemoperfusion is a process which removes substances from the blood through the dialysis membrane by using a charcoal or resin artificial kidney. When used in the treatment of life threatening drug overdose, hemoperfusion is a covered service for patients with or without renal dialysis. Hemoperfusion is also covered when used in conjunction with DFO to treat aluminum toxicity. (See §3175.) However, hemoperfusion is not covered when used to improve the results of hemodialysis nor when used in conjunction with deferoxamine (DFO) to remove iron overload.

E. Home Dialysis—Supplies, Equipment and Support Services

1. Home Dialysis Equipment.—Home dialysis equipment includes all of the medically necessary home dialysis equipment prescribed by the attending physician, including (but not limited to) artifical kidney and automated peritoneal dialysis machines, and support equipment. Home dialysis supplies and equipment may be covered if used by an ESRD beneficiary in a nursing home.

2. Installation.—Installation includes (but is not limited to): the identification of any minor plumbing and electrical changes required to accommodate the equipment; the ordering and performing of these changes; delivery of the equipment and its actual installation (i.e., hooking-up), as well as any necessary testing to assure proper installation and function.

Minor plumbing and electrical changes include those parts and labor required to connect the dialysis equipment to plumbing and electrical lines that already exist in the room where the patient will dialyze. Medicare does not cover wiring or rewiring of the patient's home, or installing any plumbing to the patient's home or to the room of the home where the patient will dialyze.

3. Maintenance.—Maintenance includes (but is not limited to): travel to the patient's home, or if needed, transportation of the equipment to a repair site; the actual performance of the maintenance or repair; and all necessary parts. Water purification equipment maintenance includes replacing the filter on a reverse osmosis device, regenerating the resin tanks on a deionization device, and the chemicals used in a water softener, and periodic water testing to assure proper performance. Routine maintenance tasks customarily performed by a patient are not covered services except for the cost of parts involved in this maintenance furnished by the facility to a patient.

4. Supplies.—Supplies include all durable and disposable items and medical supplies necessary for the effective performance of a patient's dialysis. Supplies include (but are not limited to): dialyzers, forceps, sphygmomanometer with cuff and stethoscope, scales, scissors, syringes, alcohol wipes, sterile drapes, needles, topical anesthetics, and rubber gloves.

5. Support Services.—Support services include (but are not limited to): 1) periodic monitoring of a patient's adaptation to home dialysis and performance of dialysis; 2) visits by trained technical personnel made in accordance with a plan prepared and periodically reviewed by a professional team which includes the physician; 3) individual's unscheduled visits made on an as-needed basis; e.g., assistance with difficult access situations; 4) ESRD related laboratory tests covered under the composite rate; and 5) providing, installing, repairing, testing, and maintaining home dialysis equipment, including appropriate water testing and treatment. (See §3171.3 for CAPD support services.)

6. Support Equipment.—Support equipment is equipment used in conjunction with the basic dialysate delivery system. Such equipment includes (but is not limited to) pumps, such as blood and heparin pumps, alarms, such as bubble detectors, water purification equipment used to improve the quality of the water used for dialysis, and adjustable dialysis chairs.

F. Hospital-based ESRD Facility.—An ESRD facility is hospital-based if it is an integral and subordinate part of a hospital and is operated with other departments of the hospital under common licensure, governance and professional supervision, with all services of the hospital and facility fully integrated. Specifically, the facility would be hospital-based only if all the following conditions are met:

o The facility and hospital are subject to the bylaws and operating decisions of a common governing board. All authority in management flows from this administrative body which approves all personnel actions, appoints medical staff and carries out similar management functions.

o The ESRD facility's director or administrator is under the supervision of the hospital's chief executive officer and reports through him to the governing board.

o The facility personnel policies and practices conform to those of the hospital.

o The administrative functions of the facility (that is, records, billing, laundry, housekeeping, and purchasing) are integrated with those of the hospital.

o The dialysis unit and hospital are financially integrated, as evidenced by the cost report, which must reflect allocation of hospital overhead to the facility through the required step-down methodology.

The existence of an agreement or an arrangement between a facility and a hospital with respect to the referral of patients, a shared service arrangement between a facility and a hospital (a common practice recognized by both Medicare and Medicaid), or the physical location of a dialysis unit on the premises of a hospital, does not mean that a facility is hospital-based. Any facility that does not meet all of the above criteria would be considered an independent facility.

G. Therapeutic Pheresis (Apheresis).—Apheresis is a medical procedure utilizing specialized equipment to remove selected blood constitutents (plasma or cells) from whole blood and return the remaining constitutents to the person from whom the blood was taken. Apheresis has been used for both pre and post transplant services. When used for these purposes, it is considered an experimental procedure and is not a covered service under the Medicare program.

H. Ultrafiltration.—A process of removing excess fluid from the blood through a dialysis membrane by exerting pressure. It is not a substitute for dialysis. Occasionally, medical complications may occur which require that ultrafiltration be performed separately from the dialysis treatment.

3166.2 Frequency of Dialysis Sessions.—Hemodialysis and peritoneal dialysis are covered under the composite rate:

A. Hemodialysis

The usual pattern of hemodialysis consists of three sessions weekly, and these may be covered routinely. If the ESRD facility bills for any sessions in excess of this frequency, the bills must be accompanied by medical justification acceptable to the intermediary.

B. Peritoneal Dialysis

Peritoneal dialysis sessions are covered routinely at the same frequency as hemodialysis described above. However, the pattern of peritoneal dialysis may vary, in which case an equivalence is established between peritoneal and hemodialysis as described in §3644. If the facility bills for any sessions in excess of this frequency, the bills must be accompanied by medical justification acceptable to the intermediary.

3167. OUTPATIENT MAINTENANCE DIALYSIS —COVERAGE

Maintenance dialysis treatments are covered by Medicare when they are provided to end-stage renal disease (ESRD) patients by an approved ESRD hospital-based renal dialysis facility, including a renal dialysis center, an independent renal dialysis facility, or a special purpose renal dialysis facility. Dialysis treatments are covered in various settings: hospital inpatient, hospital outpatient, independent renal dialysis facility, or the patient's home. Dialysis treatments at renal dialysis facilities differ according to the types of patients being treated, the types of equipment and supplies used, the preferences of the treating physician, and the capability and makeup of the support staff. Although all facilities do not provide an identical range of services, the most common elements of a dialysis treatment are overhead costs, personnel services, administrative services (registered nurse, licensed practical nurse, technician, social worker, dietitian), equipment and supplies—dialysis machine and its maintenance, ESRD related laboratory tests, certain injectable drugs (such as heparin and its antidote) and biologicals.

Facilities with self-dialysis units must meet certain health and safety requirements specific to self-dialysis, and certain standards applicable to staff-assisted dialysis have been adjusted for self-dialysis units in consideration of the differences in the two modalities. Before participating in self-dialysis, patients must have completed an appropriate training program in emergency procedures, and have a safe storage area for their supplies. Access to the self-dialysis unit is limited to patients for whom the facility maintains patient care plans, in order to exclude transient patients who might not be familiar with the facility's equipment or emergency procedures. The self-dialysis unit need not be physically separate from the rest of the facility nor operate on a separate shift.

3167.1 Laboratory Services Included Under the Composite Rate.--The costs of certain ESRD laboratory services performed by either the facility's staff or an independent laboratory were included in the composite rate calculations. Therefore, payment for all of the tests is included in the facility's composite rate and the tests may not be billed separately to the Medicare program. Laboratory tests are either performed by the facility, in which case reimbursement is included in the composite rate, or by an outside laboratory for the facility, in which case the laboratory would bill the facility and be reimbursed only under the rate. (See §3644.) These laboratory tests are listed in §§3167.3 and 3171.2A. (See §2710 of the Provider Reimbursement Manual for reimbursement instructions.)

3167.3 Laboratory Tests for Hemodialysis, Intermittent Peritoneal Dialysis (IPD), Continuous Cycling Peritoneal Dialysis (CCPD) and Hemofiltration.--The tests listed below are usually performed for dialysis patients and are routinely covered, at the frequency specified in the absence of indications to the contrary, i.e., no documentation of medical necessity is required other than knowledge of the patient's status as an ESRD beneficiary. When any of these tests are performed at a frequency greater than that specified, the additional tests are separately billable and will be covered only if they are medically justified by accompanying documentation. A diagnosis of ESRD alone is not sufficient medical evidence to warrant coverage of the additional tests. The nature of the illness or injury (diagnosis, complaint or symptom) requiring the performance of the test(s) must be present on the claim. Such information must be furnished using the ICD-9-CM coding system.

Per Treatment

All hematocrit and clotting time tests furnished incident to dialysis treatments.

Weekly

Prothrombin time for patients on anticoagulant therapy
Serum Creatinine
BUN

Monthly

Serum Calcium
Serum Potassium
Serum Chloride
CBC
Serum Bicarbonate
Serum Phosphorous
Total Protein
Serum Albumin
Alkaline Phosphatase
SGOT
LDH

Automated Battery of Tests.--If an automated battery of tests, such as the SMA-12, is performed and contains most of the tests listed in one of the weekly or monthly categories, it is not necessary to separately identify any tests in the battery that are not listed.

The following list identifies certain separately billable laboratory tests that are covered routinely, i.e., without documentation of medical necessity other than knowledge of the patient's status as an ESRD beneficiary, when furnished at the specified frequencies. If they are performed at a frequency greater than that specified, they are covered only if accompanied by medical documentation. A diagnosis of ESRD alone is not sufficient documentation. In order to document the medical necessity of the test(s), the nature of the illness or injury (diagnosis, complaint or symptom) requiring the performance of the test(s) must be present on the claim. Such information must be furnished using the ICD-9-CM coding system.

Guidelines for Separately Billable Tests for Hemodialysis, IPD, CCPD and Hemofiltration

Shown below is the recommended schedule for the administration of the hepatitis B vaccine. However, the actual frequency is determined by the physician based on medical necessity. (See §3157A2.)

Hepatitis B vaccine - 3 (two ml doses) doses

First dose
Second dose - 1 month after the first dose
Third dose - 6 months after the first dose

All vaccinees should be tested for antibody (hepatitis B surface antibody) to hepatitis B surface antigen no sooner than 1 month after the third dose of vaccine is administered to determine whether they have responded to the vaccine. Thereafter, individuals who have responded to the vaccine by showing evidence of surface antibody need only be tested annually for hepatitis B surface antibody to confirm continued immunity.

For Seronegative Patients -- (including patients who have received hepatitis B vaccine but did not have a positive response to the vaccine) Hepatitis B Surface Antigen (HB_sAg)--one a month.

Bone Survey (either the roentgenographic method or the photon absorptiometric procedure for bone mineral analysis) - one a year

Chest X-ray - one every 6 months

EKG - one every 3 months

Hepatitis B Surface Antibody or Hepatitis B Core Antibody - one, but not both, once a year

Nerve Conductor Velocity Test (Peroneal NCV) - one every 3 months

Serum aluminum - one every 3 months

Serum ferritin - one every 3 months

(See §3171.2A for laboratory tests rendered to CAPD patients.)

EKGs and X-rays.--EKGs and X-rays are covered. When furnished by an independent facility, these tests should be billed on the HCFA-1450. However, if the physician incurs a cost for these tests, he must bill the Medicare carrier on the HCFA-1500.

3168. DRUGS AND BIOLOGICALS

Parenteral items that are dialysis related and are furnished by ESRD facilities are covered as described in paragraphs A and B, below.

Blood furnished by a hospital-based or an independent dialysis facility is covered by Medicare.

Drugs and biologicals, such as blood, are generally not covered in the home dialysis setting unless they are provided under the direct personal supervision of a physician. When this condition is met, the physician must bill the carrier.

Certain drugs and biologicals, however, can be considered home dialysis supplies, and can be covered as such. This exception is limited to heparin, the heparin antidote, local anesthetics such as xylocaine and antibiotics for peritoneal dialysis patients when used to treat infections of the catheter site, or peritonitis.

Other drugs and biologicals generally are covered only if all of the following requirements are met: (a) they meet the definition of "drugs" or "biologicals"; (b) they are of the type that cannot be self-administered (see below); (c) they are not excluded as immunizations; (d) they are reasonable and necessary for the diagnosis or treatment of the illness or injury for which they are administered according to accepted standards of medical practice; and (e) they meet all the general requirements for coverage of items as "incident-to" a physician's service.

Whether a drug or biological is of a type which cannot be self-administered is based on the usual method of administration of the form of that drug or biological as furnished by the physician. Thus, where a physician gives a patient pills or other oral medication, these are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a physician gives a patient an injection which is usually self-injected (for example, insulin), the drug is excluded from coverage, unless administered to the patient in an emergency situation (for example, diabetic coma). Where, however, a physician injects a drug which is not usually self-injected, this drug is not subject to the self-administrable drug exclusion (regardless of whether the drug may also be available in oral form) since it is not self-administrable in the form in which it was furnished to the patient. (See §3112.4B.)

A. Drugs Covered Under the Composite Rate.--Certain parenteral items used in the dialysis procedure are covered under the facility's composite rate and may not be billed separately. Drugs that are used as a substitute for any of these items, or are used to accomplish the same effect, are also covered under the composite rate. For home patients choosing Method II payments (See S3169.), these items may be covered without documentation for medical necessity and may be billed by an ESRD facility regardless of where they are furnished.

Following is a list of these items:

heparin
protamine
mannitol
saline
pressor drugs
glucose
dextrose
antihistamines
antiarrythmics
antihypertensives

The administration of these items (both the staff time and the supplies) is covered under the composite rate and may not be billed separately.

Nonparenteral items are not covered under the Medicare program.

B. Separately Billable Drugs.--There are other parenteral items that are not covered under the composite rate, but that may be medically necessary for some patients receiving dialysis. When furnished to infacility dialysis patients, these items must be billed separately and be accompanied by medical justification either through information on the claims form or as requested by the intermediary. They include:

antibiotics
hematinics
anabolics
muscle relaxants
analgesics
sedatives
tranquilizers

These separately billable parenteral items may only be billed by an ESRD facility if they are actually administered in the facility by the facility staff. Staff time used to administer separately billable parenteral items is covered under the composite rate and may not be billed separately. However, the supplies used to administer these parenteral items may be billed in addition to the composite rate. (See S3644.)

NOTE: Albumin may be reasonable and medically necessary for the treatment of certain medical complications in renal dialysis patients. In such cases facilities must document medical need to the satisfaction of the intermediary's medical staff. If the intermediary approves, then separate payment in addition to the facility's composite rate may be made. However, if albumin is used as a substitute for any parenteral item covered under the composite rate or used to accomplish the same effect, for example, as a volume expander, then payment for it must be included in the facility's composite rate payment for maintenance dialysis.

3169. COMPOSITE RATE REIMBURSEMENT FOR PATIENTS DIALYZING AT HOME

Medicare beneficiaries dialyzing at home can choose between two methods of payment. This choice is recorded on the Beneficiary Selection Form, HCFA-382. (See §3169.2.)

Method I - The Composite Rate

If the Medicare home dialysis patient choses Method I, the dialysis facility with which the patient is associated must assume responsibility for providing all home dialysis equipment and supplies, and home support services. For these services, the facility receives the same Medicare dialysis payment rate as it would receive for an infacility patient under the composite rate system. (See Provider Reimbursement Manual §§2702-2717.) Under this arrangement, the beneficiary is responsible for paying the Part B deductible and the 20 percent coinsurance on the Medicare rate to the facility.

Method II - Dealing Direct

If the beneficiary elects to deal directly with the Medicare program and make arrangements for securing the necessary supplies and equipment to dialyze at home, the beneficiary deals with the various suppliers. The beneficiary or a supplier other than a facility bills the Part B carrier if assignment is taken. If the beneficiary obtains supplies and equipment from a facility, see §2740.1 of the Provider Reimbursement Manual. The beneficiary is also responsible to the suppliers for any unmet Part B deductible and the 20 percent Medicare coinsurance requirement. The dialysis facility will not receive a regular per treatment payment for a patient who chooses this option. However, if the facility provides any home dialysis equipment, supplies or support services to a beneficiary who selects this option, the facility is reimbursed for these items or services.

3169.1 Items and Services Included Under the Composite Rate for Home Dialysis.—All items and services are covered and included under the composite rate and must be furnished by the facility, either directly or under arrangements, to all of its dialysis patients who elect this method of reimbursement. If it fails to furnish (either directly or under arrangements) any part of the items and services covered under the rate, then the facility cannot be paid any amount for the part of the items and services that the facility does furnish. These items and services include:

- o Medically necessary home dialysis equipment;

- o Home dialysis support services, which include the delivery, installation, maintenance, repair and testing of home dialysis equipment and support equipment;

- o Purchase and delivery of all necessary home dialysis supplies;

- ESRD related laboratory tests listed as covered under the composite rate; and
- All dialysis services furnished by the facility's staff.

Some examples (but not an all-inclusive list) of items and services that are covered and included in the composite rate and may not be billed separately when furnished by a dialysis facility are:

- Staff time used to administer blood;
- Declotting of shunts and any supplies used to declot shunts;
- Oxygen and the administration of oxygen; and
- Staff time used to administer separately billable parenteral items.

3169.2 Beneficiary Selection Form (HCFA-382) for Home Dialysis Patients

Each Medicare home dialysis beneficiary must choose the method by which he wants Medicare to pay for his dialysis services. To do this, each beneficiary must complete the Beneficiary Selection Form HCFA-382, sign it and return it to the facility that supervises his care. See §2740.2 of the Provider Reimbursement Manual, Part I.

3169.3 Coverage of Infacility Dialysis Sessions Furnished to Home Patients Who Are Traveling.— Patients who are normally home dialysis patients may be dialyzed by a facility on an infacility basis when traveling away from home. (See §2713 of the Provider Reimbursement Manual.)

3170. HOME DIALYSIS EQUIPMENT—GENERAL

Home dialysis equipment and other medically necessary items for home dialysis prescribed by a physician are covered under Part B.

There are two methods by which a patient can be reimbursed for his dialysis equipment—the composite rate method and the direct dealing method. Under the composite rate method, the facility with which the patient is associated assumes responsibility for providing all home dialysis equipment and supplies. Under the direct dealing method the beneficiary deals directly with the Medicare program and makes his own arrangements for securing the necessary supplies and equipment to dialyze at home. (See §3169.)

The direct dealing patient has the choice of buying or renting (leasing) the equipment. With the exception of purchased items costing $120 or less, which may be reimbursed in a single payment, Medicare pays for both rented and purchased equipment in monthly installments. Installment payments are made regardless of whether the patient pays for purchased equipment in a lump sum or in installments. Medicare makes monthly payments at a rate which approximates the reasonable monthly rental charge for similar equipment until either its share of the reasonable purchase price is paid, or until the equipment is no longer medically necessary, whichever comes first. Likewise, when covered home dialysis equipment is rented or leased, Medicare will pay 80 percent of the reasonable rental (lease) charge as long as the equipment is medically necessary.

When payments stop because the beneficiary's condition has changed and the equipment is no longer necessary, the beneficiary is responsible for the remaining charges. Similarly, when payments stop because the beneficiary dies, his estate is responsible for the remaining charges. A beneficiary may sell or otherwise dispose of purchased equipment for which he has no further use. If, after disposal of such equipment, there is again medical need for similar equipment, Medicare can pay for the rental or purchase of that equipment. Under Part B, payment can also be made for the installation, delivery, repair, maintenance, or replacement of home dialysis equipment. This payment also includes the costs of necessary supply items needed to effectively perform the dialysis. These items are covered only under the specified conditions discussed in the following sections. When covered, these items are reimbursed in a lump sum.

A variety of contractual agreements may be entered into by the patient for the leasing or purchase of home dialysis equipment and supplies:

o Manufacturers or suppliers may deal directly with a paying patient;

o Facilities may furnish equipment and supplies on a sale or rental basis to a patient. (See §3644.)

o Equipment or supplies may be furnished to a patient by a manufacturer or supplier through a facility (i.e., items may be shipped directly to a patient but billed to a facility).

3170.1 Installation and Delivery of Home Dialysis Equipment.--Medicare will cover all reasonable and necessary expenses incurred in the original installation of home dialysis equipment. This coverage is not extended to expenses attributable to home improvement (e.g., plumbing or electrical work beyond that necessary to tie in with existing plumbing and power lines). Testing and assurance of equipment performance which may be billed for as part of the basic delivery charge are also covered. Medicare does not cover maintenance contracts on equipment, since Medicare pays only for costs which are actually incurred. The delivery and installation charge should be itemized, either on the face of the bill or on an attached invoice.

3170.2 Current Use of Equipment.--Monthly rental or installment payments for purchased items may be made only if the item was actually used during the month for which payment is claimed. Exceptions are allowed only under the circumstances outlined below and apply only to items of dialysis equipment necessary for home dialysis. Monthly rental charges or payments for purchased items may be continued for a period of up to three months after the month the equipment is last used because high installation charges could be paid a number of times for the same equipment if it is removed for temporary periods of non-use. Non-use is covered under the following circumstances:

- o Beneficiary requires infacility treatment either for restabilization or as a result of some acute condition, but is expected to return to home dialysis;
- o Beneficiary is temporarily without a suitable home dialysis assistant;
- o Beneficiary is temporarily away from home but expects to return; (However, when a beneficiary consistently spends periods exceeding three months away from his home, this section does not apply).
- o Beneficiary is a transplant candidate and is taken off home dialysis preparatory to transplant. (If the transplant cannot occur, or if the transplant is not successful, the patient will probably resume home dialysis and an evaluation can be made whether it will be within the immediate or forseeable future.)

3170.3 Other Requirements For Coverage of Home Dialysis Equipment.--

In addition to meeting the specific requirements of home dialysis equipment, the equipment must also meet the requirements outlined in S3113ff:

- o The device is required because the patient has ESRD; and
- o The equipment is appropriate for home use and is of the type prescribed by recognized specialists at approved home dialysis training centers.

Payment can also be made under the home dialysis equipment provision for supportive equipment which is used in conjunction with the basic dialysate delivery system. This includes blood and heparin pumps, air bubble detectors, blood leak detectors, unipuncture devices, water purification systems, and adjustable dialysis chairs.

Adjustable chairs, such as recliners, are covered when required as a component of a home hemodialysis delivery station. These chairs serve to preserve patients' health by allowing rapid manipulation in body position when medical circumstances warrant such changes during dialysis (e.g., when acute hypotension occurs and the patient is in danger of going into shock). Reasonable costs of recliner chairs may not include a premium for style or for the capacity to rock, swivel, heat, or vibrate. Claims for recliner chairs will be reviewed to ensure that payment is consistent with what is reasonable and medically necessary to serve the intended therapeutic purpose. Since the adjustable chair is desirable in the absence of illness or injury, instructions in S60-1 (Coverage Issues Manual) should be followed closely when replacement is claimed.

3170.4 Home Dialysis Equipment Provided To Home Hemodialysis and Peritoneal Dialysis Patients.—Coverage of any item of home dialysis equipment used for home dialysis depends on its medical necessity. Medical necessity is established by the physician's prescription, and by the equipment meeting Medicare guidelines which define home dialysis equipment. The beneficiary has the option of having the facility provide the equipment under the composite rate, or of renting or purchasing such equipment directly from a supplier. Reimbursement for the equipment is affected by the manner in which it is supplied (i.e., sold, rented or leased), whether the supplier is reimbursed based on charges or costs, and the relationship of the supplier with the equipment manufacturer or equipment owner.

3170.5 Coverage of Home Dialysis Supplies.—Supplies necessary to perform all modalities of home dialysis are covered, including such items as alcohol wipes, sterile drapes, gloves, telfa pads, bandages, etc.

Instruments and nonmedical supplies, such as scales, stopwatches, and blood pressure apparatus, are covered, regardless of whether provided separately or as part of a start-up kit. However, these items may not be provided separately on a rental basis. They must either be purchased or be provided as part of the dialysis equipment and included in the charge for the equipment. These items do not qualify as dialysis equipment.

3170.6 Coverage of Home Dialysis Support Services.—If a beneficiary chooses Method II (direct dealing) all home dialysis supplies and support services required to perform dialysis at home are covered.

Some home dialysis support services must be furnished by a dialysis facility which is approved under Subpart U to furnish home dialysis services. Under the composite rate, ESRD facilities are required by rules of Method I to furnish items A through G either directly or under arrangements. Under Method II a facility may also furnish them under an agreement. Covered support services include:

- Periodic monitoring of the patient's home adaptation (including visits to the home, in accordance with a written plan prepared and periodically reviewed by a team that includes the patient's physician and other professionals familiar with the patient's condition);
- Emergency visits by qualified ESRD facility personnel;
- Providing and arranging for supplies (If Method II, supplier can provide.);
- Installation and maintenance of dialysis equipment (If Method II, supplier can provide.);

- ESRD related laboratory tests included under the composite rate and listed in §3167.3 and §3171.2A, (If Method II, either a facility, a doctor or an independent laboratory can furnish);

- Testing and appropriate treatment of water; and

- Monitoring the functioning of the dialysis equipment (If Method II, supplier can provide.).

Some covered support services may involve indirect patient contact. The patient, for example, may need to consult with a nurse regarding dietary restrictions or with a social worker if he is having problems adjusting. The consultations may be by phone.

3171. CONTINUOUS AMBULATORY PERITONEAL DIALYSIS

Continuous ambulatory peritoneal dialysis (CAPD) is a variation of peritoneal dialysis that was developed as an alternative mode of dialysis for home dialysis patients. In CAPD the patient's peritoneal membrane is used as a dialyzer. The patient connects a 2 liter plastic bag of dialysate to a surgically implanted indwelling catheter and allows the dialysate to pour into his peritoneal cavity.

Four to six hours later the patient drains the fluid out into the same bag, and replaces the old bag with a new bag of fresh dialysate. This is done three to five times a day, with the first exchange being made when the patient wakes up in the morning, and the last exchange being made at bed time. Because no machine is used, CAPD frees patients from the confinement of a machine, and because it is continuous, CAPD frees patients from the dietary restrictions associated with intermittent hemodialysis or intermittent peritoneal dialysis.

3171.1 Certification of Facilities Furnishing CAPD Services.—In order to furnish covered CAPD services, a facility must be a Medicare approved ESRD facility, and must meet additional standards established by the Health Care Financing Administration (HCFA).

3171.2 Institutional Dialysis Services Furnished to CAPD Patients.—Institutional dialysis services that are specifically CAPD services are training services and include associated services that are furnished in the facility during training. (Once the patient is trained, CAPD is primarily a home service, as the patient performs CAPD 24 hours per day.) Persons who are primarily treated by CAPD may also require infacility dialysis, either intermittent peritoneal dialysis (IPD) or hemodialysis, from time to time.

A. Laboratory Tests.--The following laboratory tests are covered routinely at the frequencies specified below if furnished to a CAPD patient in a certified setting. Any test furnished in excess of this frequency, or any test furnished that is not listed here is covered only if there is documentation of its medical necessity. A diagnosis of ESRD alone is not sufficient medical documentation. The nature of the illness or injury (diagnosis, complaint or symptom) requiring the test(s) must be present on the claims form. Such information must be furnished using the ICD-9-CM coding system. The nature of the illness or injury (diagnosis, complaint or symptom) requiring the performance of any test not listed here must also be present on the form.

1. Laboratory Tests for CAPD Covered Routinely and Included Under the Composite Rate

Monthly

BUN
Creatinine
Sodium
Potassium
CO2
Calcium
Magnesium
Phosphate
Total Protein
Albumin
Alkaline Phosphatase
LDH
SGOT
HCT
Hgb
Dialysate Protein

2. Laboratory Tests for CAPD Covered Routinely and Separately Billable

Every 3 Months

WBC
RBC
Platelet count

3. Every 6 Months

Residual renal function
24 hour urine volume
Chest X-ray
Bone mineral density
MNCV
EKG

(See S3167.3 for laboratory tests rendered to hemodialysis, intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemofiltration patients.)

B. Equipment and Water Testing.--CAPD does not require the use of any equipment or testing of water because the dialysate is prepared and delivered by the manufacturer. Therefore, neither a dialysis machine nor water testing or water treatment are covered for CAPD patients. Patients changing from another form of home dialysis to CAPD may have their claims for rental or lease-purchase of home dialysis equipment reimbursed up to 3 months after completing the CAPD training course, in accordance with the coverage tolerance rule in S3170.2.

3171.3 Support Services and Supplies Furnished to Home CAPD Patients.--CAPD certification requires facilities furnishing CAPD services to provide directly, or via an agreement or arrangement with another renal dialysis facility (approved to furnish staff-assisted peritoneal dialysis or peritoneal self-dialysis training) the provision of home dialysis services required to support home patients. Home dialysis support services may be furnished in the home or in the facility. Support services may be provided directly or via an agreement or arrangement with another approved renal dialysis facility (approved to furnish staff-assisted peritoneal dialysis or peritoneal self-dialysis training), or by a physician's direct personal supervision.

A. Home Dialysis Support Services.--The full range of home dialysis support services required by home CAPD patients is covered. In addition to the general support services furnished to home hemodialysis patients, support services specifically applicable to CAPD patients include but are not limited to: (1) changing the connecting tube (also referred to as an administration set), (2) watching the patient perform CAPD and assuring that it is done correctly, and reviewing for the patient any aspects of the technique he may have forgotten, or informing the patient of modifications in apparatus or technique, (3) documenting whether the patient has or has had peritonitis that requires physician intervention or hospitalization (unless there is evidence of peritonitis, a culture for peritonitis is not necessary), and (4) inspection of the catheter site.

The CAPD support services must be furnished periodically (not less than once every 90 days) either directly by the sponsoring CAPD facility or through agreement or arrangement with a facility approved to furnish training in peritoneal self-dialysis or peritoneal staff assisted dialysis. These services will usually be furnished during a periodic follow-up visit, but they may be furnished at separate times. They may be furnished in the facility or in the home.

Normally, the changing of the connecting tube is performed in the facility, and all of the other CAPD support services can be performed at the same time. However, sometimes a member of the facility's staff may go to the patient's home to observe the patient's CAPD technique, take blood samples, etc. In any case, each of the CAPD support services may be covered routinely at a frequency of once per month.

Because these services must be furnished periodically, any claims under Method II for additional support services furnished more frequently than monthly (whether by the sponsoring CAPD facility or under an agreement or arrangement) must be documented for medical necessity.

B. Supplies.--All supplies required to perform CAPD are covered. These include start-up durable supplies (whether or not they are part of a start-up kit) such as weight scales, sphygmomanometer, I.V. stand, and dialysate heaters; and consumable and disposable supplies such as dialysate, tubing and gauze pads.

3172. TRAINING

3172.1 Hemodialysis Training.--The average training time for hemodialysis patients is approximtately 3 months, based upon 5 hour sessions given 3 times per week. In some dialysis programs, the dialysis partner is trained to perform the dialysis treatment in its entirety. The patient plays a secondary role. In other programs, the patient performs most of the treatment and is only aided by a helper.

Hemodialysis training services and supplies include personnel services, dialysis supplies parenteral items used in dialysis, written training manuals and materials, and laboratory tests covered under the composite rate. See S3167.3 for these laboratory tests which are covered during training.

3172.2 Intermittent Peritoneal Dialysis Training (IPD).—IPD patients can be trained in approximately 4 weeks. IPD is usually accomplished in sessions of 10-12 hours. It is sometimes accomplished in fewer sessions of longer duration. (See S3112.6D for other types of IPD training programs.) In the IPD program, the patient's partner is usually trained to carry out the dialytic care. The patient plays a secondary or very minimal role as most are unable to perform self-care dialysis. IPD patients are usually unable to perform self-care dialysis because of other debilitating conditions. Training services and supplies include personnel services, dialysis supplies, parenteral items routinely used in dialysis, written manuals and materials, and laboratory tests covered under the composite rate. These laboratory tests are covered during training (See S3167.3).

3172.3 Continuous Ambulatory Peritoneal Dialysis (CAPD) Training.—CAPD training is furnished in sessions that can last up to 8 hours (one session per day) 5-6 days per week. Typically, 6-8 CAPD exchanges can be performed per day for the purpose of teaching the patient the CAPD technique; however, no specific number of exchanges is required. Normally patients are trained within 2 weeks (5-6 training sessions per week); however, up to 15 sessions (i.e., 15 training days) may be covered routinely. Additional CAPD training sessions are covered only when documented for medical necessity. Extra training sessions raise questions about either the adequacy of CAPD for the patient or the patient's capacity to learn or perform the CAPD technique. The patient's physician should address these questions in his explanation of the need for extra training sessions. The intermediary will make a determination whether or not to permit training sessions in excess of 15.

CAPD training services and supplies include personnel services, dialysis supplies, parenteral items routinely used in dialysis, training manuals and materials, and CAPD laboratory tests included under the composite rate.

CAPD laboratory tests included under the composite rate are those monthly tests listed in S3171.2A and they are covered during training. The coverage frequency screens for these laboratory tests do not apply during training, as these tests are commonly given during each training session. All of these tests are included in the training screen, regardless of how frequently they are given, and may not be billed separately. However, separately billable laboratory tests must be documented for medical necessity.

A. CAPD Training Furnished to Inpatients.—Normally, CAPD training is covered only on an outpatient basis. While CAPD training itself does not justify inpatient status, CAPD training is covered under Part A when furnished during a medically necessary inpatient stay. If Part A payment is not made for the stay, the CAPD training sessions would be reimbursed under Part B and be subject to the normal Part B deductible and coinsurance requirements.

B. CAPD Training for Patients Already Trained in Another Mode of Self-Dialysis.—Services furnished in training a patient who is already trained in some other form of self-dialysis are covered. Fewer sessions should be required because of the transferability of certain basic skills.

C. Supplemental Dialysis During CAPD Training.—It may be necessary to supplement the patient's dialysis during CAPD training with intermittent peritoneal dialysis because the CAPD technique has not yet been mastered by the patient. Generally, no more then three supplemental intermittent peritoneal dialysis sessions are required during the course of CAPD training, and these may be covered routinely. If more than three sessions are billed during training, the claims must be documented for medical necessity. Under certain circumstances, the form of supplemental dialysis may be hemodialysis.

3172.4 Continuous Cycling Peritoneal Dialysis (CCPD) Training.—Continuous cycling peritoneal dialysis training is furnished in sessions of 8 hours per day 5 days per week. Typically, 5 exchanges can be performed per day to teach the patient the technique; however, no specific number of exchanges is required. Most patients are trained within 2 weeks; however, up to 15 sessions may be covered routinely. The intermediary will determine whether or not training sessions over 15 are medically necessary.

All training services and supplies are covered. These include personnel services, dialysis supplies, parenteral items routinely used in dialysis, training manuals and materials, and CCPD laboratory tests covered under the composite rate and listed in S3167.3.

3172.5 Physician's Services During Self-Dialysis Training.—

A. Initial Training.—All physician's services required to create the capacity for self-dialysis are covered as shown below:

- o Direction of and participation in, training of dialysis patients.
- o Review of family, home status, and environment, and counseling and training of family members.
- o Review of training progress.

B. Subsequent Training.—Occasionally, it is necessary to furnish additional training to an ESRD self-dialysis beneficiary after the initial training course is completed; e.g., because of a change from hemodialysis to peritoneal dialysis, or a change in equipment. The amount of additional training required depends upon the transferability of the skills the patient has already learned; subsequent training would normally be very limited.

Physicians' training services furnished during subsequent training of an ESRD beneficiary are covered and reimbursed in addition to the initial training fee. The payment for subsequent training sessions should be based on the amount of $20 per training session. The total payment for a course of subsequent training may not be based on an amount that exceeds $500.

Subsequent training sessions that are reimbursable under this rule must be distinguished from the ongoing services for which the original training fee is considered payment in full; e.g., answering the patient's questions arising after home dialysis has begun about the machine the patient has already been trained to use. No additional payment is made after the initial training course unless the subsequent training is required because of a change from the patient's treatment machine to a machine that he had not been trained to use in the initial training course, a change in the type of dialysis, or a change in setting or dialysis partner.

3173. INPATIENT HOSPITAL DIALYSIS

3173.1 Inpatient Dialysis in Hospitals Certified to Provide ESRD Services.—Dialysis services are covered when furnished to an ESRD patient by a hospital that meets the Conditions for Coverage of Suppliers of End-Stage Renal Disease Services (Subpart U). In many cases, patients who require inpatient care are experiencing complications that affect the nature of the dialysis services. Payment for medically necessary inpatient dialysis is not subject to the composite rate.

3173.2 Inpatient Dialysis in Hospitals Certified to Provide Medicare Services.—In special situations, dialysis services are covered when furnished to an ESRD patient by a hospital that meets the Conditions of Participation for Hospitals (Subpart J), but is not certified under the ESRD Conditions (Subpart U). For example, dialysis services provided by any participating Medicare hospital are covered if the inpatient stay is medically necessary and the primary reason for the admission is not maintenance dialysis. To illustrate, if an ESRD patient needs surgery unrelated to his kidney condition, and the surgeon has operating privileges only at a participating Medicare, but non-ESRD certified hospital, the inpatient dialysis he receives while being treated for the unrelated condition is covered.

In addition, services may be covered in back-up dialysis situations when significant travel distances, severe weather, or other conditions preclude patients from dialyzing at their usual facility.

A Subpart J hospital may decide not to provide dialysis services directly. In this situation, the hospital must make arrangements with an ESRD certified facility to provide the dialysis services.

Inpatient dialysis services are also covered if an ESRD emergency occurs. However, when the emergency is over, inpatient dialysis must be performed in an ESRD certified facility or coverage will be denied. All claims for inpatient dialysis services in hospitals that are not certified under the ESRD Conditions for Coverage should be examined by the intermediary to assure that one or more of these special situations existed.

3173.3 Inpatient Dialysis in Nonparticipating Hospitals.—Emergency inpatient dialysis services provided by a nonparticipating U.S. hospital are covered if the Health Care Financing Administration's Regional Office determines that the requirements in §3173.2 are met.

3173.4 Extended Intermittent Peritoneal Dialysis.—Extended intermittent peritoneal dialysis (EIPD) is performed once a week, usually for 30 hours or more, and is provided in the hospital due to the duration of treatment. Although the services are provided in the hospital, they are billed as outpatient maintenance dialysis services and reimbursed under Part B as long as the patient is not admitted as an inpatient for another reason. EIPD is an acceptable, but not optimal, mode of treatment, appropriate only when the patient cannot attend a facility two or three times a week, for geographic or other reasons, and is not suited for home dialysis. (See S3112.6.)

3173.5 Services Provided Under An Agreement.—An approved ESRD facility may make a written agreement with a second facility under which the second facility furnishes certain covered outpatient dialysis items or services to patients. When services are provided under an agreement, the first facility is discharged from professional responsibility for the services furnished. The second facility is responsible for obtaining reimbursement directly from the Medicare program and the beneficiary, but may not bill the beneficiary for amounts in excess of the normal coinsurance and any applicable deductible.

3173.6 Services Provided Under An Arrangement.—An approved ESRD facility may make written arrangements with a second facility to provide certain covered outpatient dialysis items or services to patients. When services are provided under an arrangement, the first facility retains professional responsibility for those services and also for obtaining reimbursement for them. The first facility may bill the patient any applicable coinsurance and deductible amounts. The second facility is permitted to seek payment only from the first facility, and may not bill the patient or the Medicare program. (See S3007.)

3173.7 Dialysis Services Provided Under Arrangements to Hospital Inpatients.—Any nonphysician service provided to a hospital inpatient either must be provided directly by the hospital or be arranged for by the hospital. (See S3101.) Therefore, a hospital may not contract an agreement as described in S3173.6 above, for care (except for physician's care) provided to its inpatients unless a waiver has been granted to the hospital consistent with S3618C. See S3101.B for a description of situations when inpatient dialysis services are covered in hospitals.

3174. HEMOFILTRATION

Hemofiltration is a covered procedure under the Medicare program. Payment for this procedure is at the composite rate. Hemofiltration is a safe and effective alternative treatment to hemodialysis and is performed in 3 weekly sessions. While the procedure may be used for any ESRD patient, it appears to be most advantageous when applied to high-risk unstable patients such as older patients with cardiovascular diseases or diabetes, since it is associated with fewer side effects such as hypotension, hypertension or volume overload.

Hemofiltration is a new method of blood purification for the removal of toxic substances that accumulate in patients with renal insufficiency. In contrast to both hemodialysis and peritoneal dialysis treatments, which eliminate dissolved substances via diffusion across semipermeable membranes, hemofiltration mimics the filtration process of the normal kidney. Solutes are removed by the use of convective transport through semipermeable membranes in a manner similar to that of the glomerular membrane of the normal kidney. The technique requires an arteriovenous access. Hemofiltration is usually performed in facility; since the technique is new to this country, it is unlikely that it will be performed in the home.

3175. HEMOPERFUSION

General

Hemoperfusion is covered under Medicare when furnished as described below for the types of covered conditions described in this instruction. Contractors should use the following as general guidelines of what may be considered covered. As with all items and services, the services must be reasonable and necessary for the diagnosis or treatment of the specific patient involved.

Hemoperfusion is an extracorporeal technique which uses activated charcoal or ion-resins as an artificial kidney for the removal of toxic substances from the blood and for the treatment of acute and chronic renal failure.

A. Covered.—Hemoperfusion is a covered service when it is used in the treatment of life-threatening drug overdose, for patients with or without renal failure effective for services performed on or after September 1, 1979. Hemoperfusion generally requires a physician to be present to initiate treatment and to be present in the hospital or an adjacent medical office during the entire procedure as changes may be sudden. Special staff training and equipment are required.

One or two treatments are usually all that is necessary to remove the toxic compound; additional treatments should be documented. Hemoperfusion may be performed concurrently with dialysis, and in those cases payment for the hemoperfusion should reflect only the additional care rendered over and above the care given for the dialysis.

In addition, the use of hemoperfusion in conjunction with deferoxamine (DFO) for the treatment of patients with aluminum toxicity has been demonstrated to be clinically efficacious and is therefore regarded as a covered service.

B. Noncovered—The effects of using hemoperfusion to improve the results of chronic hemodialysis are not known. Therefore, when used for this purpose, hemoperfusion is not covered because it is not considered reasonable and necessary within the meaning of §1862(a)(1) of the law. In addition, it has not been demonstrated that the use of hemoperfusion in conjunction with deferoxamine (DFO), in treating symptomatic patients with iron overload, is efficacious. There is also a paucity of data regarding its efficacy in treating asymptomatic patients with iron overload. Therefore, hemoperfusion used in conjunction with DFO in treating patients with iron overload is not a covered service; i.e., it is not considered reasonable and necessary within the meaning of §1862(a)(1) of the law.

3178. TRANSPLANTATION

Introduction.—Renal transplantation is a principal form of treatment for patients with ESRD. We have developed a method of reimbursement for the variety of medical services required to support a transplant program, including payment for Medicare's share of the costs of organ procurement.

In addition, Medicare has developed coverage and reimbursement criteria for necessary medical services provided to potential donors and recipients. In some situations these services are provided before the effective date of Medicare entitlement for the potential transplant recipient.

NOTE: Therapeutic Apheresis.—Apheresis is considered an experimental procedure when used to treat kidney transplant recipients for steroid resistant renal allograft rejection episodes and when used prior to kidney transplant as a method of removing lymphocytes to prevent or modify rejection episodes. Therefore, apheresis is not covered under the Medicare program when used for these procedures. (See Coverage Issues Appendix §35-60 for situations when apheresis is covered by Medicare.)

3178.1 Identifying Candidates for Transplantation.—After a patient is diagnosed as having ESRD, the physician should determine if the patient is suitable for transplantation. If the patient is a suitable transplant candidate, a live donor transplant is considered first because of the high success rate in comparison to a cadaveric transplant. Whether one or multiple potential donors are available, the following sections provide a general description of the usual course of events in preparation for a live-donor transplant.

3178.2 Identifying Suitable Live Donors.—Generally, potential live donors include only parents, brothers and sisters, or children. Those who are willing and medically able to donate a kidney are tested to determine whether they are of the same blood type as the recipient. After blood typing, the recipient and the donors are tissue typed. Only those candidates with blood and tissue types similar to the recipient are considered further.

After tissue typing, those medically suitable donors are evaluated on physical, psychological, and social factors. Potential donors who remain after the above testing may be hospitalized for about two days for further evaluation using procedures not appropriately performed on outpatients. These procedures may include intravenous urography and renal arteriography.

If the results of the above tests identify several suitable donors, the most suitable donor is selected and arrangements are made for the transplant. At such time, the donor and recipient will enter the hospital to undergo the excision and transplantation, respectively. When tests do not identify an acceptable living donor, the patient is considered for a cadaveric transplant and placed on hemo- or peritoneal dialysis, if this has not already proved necessary. If the ultimate goal is transplantation, the patient is registered with a kidney transplant registry.

3178.3 Pretransplant Outpatient Services.—All hospital outpatient services provided to live donors and recipients in anticipation of a transplant during the pre-entitlement period and after entitlement, but prior to admission to the hospital for transplantation, are covered. Such services would include kidney recipient registration fees, laboratory tests (including tissue typing of recipient and donors) and general medical evaluations of the recipient and the donor(s). Physicians' services are also covered.

3178.4 Pretransplant Inpatient Services.—The following rules apply to kidney transplant inpatient medical evaluations when the kidney recipient has Medicare entitlement or is in the pre-entitlement period. The pre-entitlement period is that period prior to the patient's actual Medicare entitlement, during which services are furnished in anticipation of a transplant, after the patient has been diagnosed to have end-stage renal disease. If the potential kidney recipient does not have entitlement, or is not in the pre-entitlement period, no services rendered to the kidney recipient or to the related living donor for kidney transplant medical evaluations will be covered by the Medicare program.

3178.5 Living Donor Evaluation, Patient Has Entitlement or is in Pre-Entitlement Period.—When a living donor is admitted to a hospital (before admission for excising the donor kidney) for a medical evaluation in anticipation of a kidney donation, all hospital and physicians' services costs applicable to medical evaluation are considered kidney acquisition service costs. As such, the hospital statistics (charges, patient days, etc.) and the physicians' charges should be treated in accordance with all other kidney acquisition service statistics and the related costs are included in Medicare costs.

When the live donor subsequently enters the hospital for the actual excision, the hospital costs of services rendered to the donor will continue to be treated as kidney acquisition service costs under Part A. However, at that point physician services are no longer considered kidney acquisition services and are not reimbursable under Part A. Instead, during the donors inpatient stay for the excision surgery and during any subsequent donor inpatient stays resulting from a direct complication of the organ donation, physician services are billed under Part B. They are billed in the normal manner but on the account of the recipient at 100 percent of the reasonable charge as determined by the physicians' Medicare carrier. Note that services furnished to kidney donors are covered under the account of the recipient.

Services listed in the following sections are also covered. However, they are not billed as such but become a part of the kidney acquisition costs.

3178.6 Kidney Recipient Admitted for Transplant Evaluation.—When a potential recipient is admitted to a hospital (before admission for the actual transplant) solely for a medical evaluation for an anticipated kidney transplant, all hospital and physicians' services costs applicable to the anticipated transplant are considered kidney acquisition service costs.

3178.7 Kidney Recipient Evaluated for Transplant During Inpatient Stay.—When a recipient is admitted to a hospital for a medical reason other than in anticipation of a transplant, but during the stay, a medical evaluation for an anticipated kidney transplant is performed, all hospital and physicians' services costs applicable to the medical evaluation are considered kidney acquisition service costs. Accordingly, those services will be treated the same as the services above. However, all hospital and physicians' services applicable to the nontransplant related services (i.e., related to the medical services for which the patient was actually admitted) must not be included with kidney acquisition services costs; instead such services must be billed in the same manner as any other inpatient service on the account of the recipient. These latter services may only be billed to the Medicare program if the recipient has actual Medicare entitlement.

3178.8 Kidney Recipient Admitted for Transplantation and Evaluation.—When the medical evaluation for a transplant is performed on the recipient or the living donor during the same inpatient stay in which the actual transplant occurs, all such services will be billed and the costs will be accumulated in the normal manner. For example, all hospital services rendered to the donor will be considered kidney acquisition services. However, all physicians' services rendered to the living donor and all hospital and physicians' services rendered to the recipient will be billed in the same manner as any other inpatient services on the account of the recipient.

3178.9 Post-Transplant Services Provided to Live Donor.—The donor is covered for an unlimited number of days of care in connection with the kidney removal operation. Days of inpatient hospital care used by the donor should not be charged against either party's utilization record. However, the program's assumption of liability is limited to those donor expenses that are incurred directly in connection with the kidney donation. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly attributable to the surgery.

Coverage of kidney donor services includes postoperative recovery services directly related to the kidney donation. The period of postoperative recovery ceases when the donor no longer exhibits symptoms related to the kidney donation. Claims for services rendered more than 3 months after donation surgery will be reviewed carefully. However, follow-up examinations may be covered up to 6 months after the donation to monitor for possible complications. The requirement that additional payment cannot be made for services included in the donor nephrectomy charge still applies.

3178.10 Physicians' Services.—Expenses for physicians' services to the donor are treated as though they had been incurred by the recipient. If the recipient dies, donor expenses actually incurred after death of the recipient will be treated as incurred before the death of the recipient.

3178.11 Coverage After Recipient Has Exhausted Part A.—If the recipient has exhausted Part A benefits while the donor still requires and receives inpatient hospital care, the program continues to pay for such donor care under Part A at 100 percent reimbursement.

3178.12 Cadaver Kidneys.—Costs incurred by the provider in connection with the acquisition of a cadaver kidney are reimbursable by the program through the kidney acquisition cost center. Typical covered costs involved in excising the cadaver kidney include: surgeons' service, operating room, anesthetist, donor evaluation and support, preservation supplies (perfusion materials and equipment), preservation technician, telephone consultation charge, intensive care costs, pathology, central supply costs, organ transportation costs, and transportation costs for a technician. There is no provision in the law for coverage of charges by an agent transporting a kidney for transplant into an eligible beneificary, if the agent bills the program or the patient directly. However, reimbursement may be made to hospitals and included in kidney acquisition costs.

3178.13 Services Involved.—When there is no suitable living donor, a patient with renal failure may be considered for a cadaveric transplant. In such cases, the services provided to recipients of "live donor" kidneys (i.e., tissue typing and other related tests) are also provided to potential recipients of cadaver kidneys. However, because a kidney may not be available for a long period of time, additional services may be provided in the form of direct physician care for the patient's renal condition, and certain tests may be performed on a regular basis to allow the physician to have current information regarding the status of the patient and his suitability for transplant. In addition, the number of mixed lymphocyte cultures which are prepared whenever a kidney is procured that may suit the recipient depends on the number of kidneys which become available for transplant. The cost of registering a potential recipient with a kidney transplant registry is also covered, as well as the services furnished to maintain organ viability after excision; i.e., preservation, and transporting the kidney to the place of transplantation.

3178.14 Tissue Typing Services For Cadaver Kidney.—Tissue typing services for cadaveric kidney recipients are treated in a similar manner to the way in which such services are covered and reimbursed in live donor cases. Tissue typing of the cadaveric organ by the excising hospital becomes an organ acquisition cost which is included in the charges for organs which are supplied by the hospital.

3178.15 Cadaver Excision Yielding Two Kidneys.—When two kidneys are obtained from a cadaver, and both kidneys are shipped to the same transplant hospital or organ procurement agency, the hospital should adjust its normal charges to reflect any increased perfusion, preservation and shipping costs due to the additional kidney. On the other hand, when the kidneys are sent to separate organizations or transplant hospitals, the excising hospital should prorate its charges to the receiving organizations so that the total charges do not exceed the amount that would have been billed if one transplant hospital or agency had received both kidneys.

3178.16 Provider Costs Related To Cadaver Kidney Excisions.—Typical provider costs involved in excising a cadaver kidney whether or not it is eventually transplanted include:

- Intensive care costs;
- Surgeon's services;

- Anesthetist services;
- Operating room;
- Preservation supplies (perfusion materials and equipment);
- Preservation technician's services;
- Donor evaluation and support;
- Pathology;
- Central exchange costs (transportation and packaging);
- Administration costs (overhead items).

3178.17 Noncovered Transplant Related Items and Services.—The following list represents some of the transplant related items and services which are not covered and for which no program payment can be made:

- Travel, room, and board expenses incurred by a live donor;
- Travel, room, and board expenses (to any transplant center) incurred by the recipient;
- Reimbursement for the kidney itself when the live donor or the cadaver donor's next of kin sells the kidney;
- Transportation of the potential cadaveric donor to the transplant hospital (only transportation of the organ is reimbursable as part of the organ procurement charge);
- Pronouncement of death and burial expenses for the cadaveric donor.

3178.18 Other Covered Services.—

A. Tissue Typing.—Tissue typing of the recipient, as well as tissue typing and tests to determine the suitability of a living donor or a cadaveric kidney, are covered as medical expenses, necessary for the treatment of an eligible recipient. The costs of these services are covered under the hospital insurance or medical insurance programs, (Part B coverage after recipient has exhausted Part A) and are reflected in the kidney acquisition costs.

B. Preservation Laboratories.—The services performed by preservation laboratories are medically necessary for the treatment of a beneficiary's illness. A participating hospital is reimbursed for the reasonable cost of such services which are performed by its own laboratory or which the hospital purchases from a freestanding preservation laboratory or organ procurement agency.

C. Registration Fees.—A participating hospital which expects to perform a kidney transplant will be reimbursed for the reasonable cost incurred in listing the patient and his blood characteristics with a professionally recognized organization that maintains a registry of potential transplant candidates, and which provides a regular listing of such patients to hospitals engaged in kidney procurement.

3178.19 Hospitals that Excise But Do Not Transplant Kidneys.—The excising hospital plays an important part in the national organ procurement effort. Most of these hospitals are community hospitals which neither excise kidneys on a regular basis nor perform transplants. A hospital that excises but does not transplant kidneys must be certified to participate in the Medicare program. Where the hospital is not participating in the Medicare program, organs may be accepted from it only if they cannot be obtained from any other source.

A hospital that excises but does not transplant kidneys may perform excisions on cadavers or on live donors; however, regardless of the vital status of the donor, most of the hospital services utilized in the excision are the same.

3180. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF) SERVICES

Section 933 of P.L. 96-499 (the Omnibus Reconciliation Act of 1980) added to the scope of benefits available to beneficiaries under Part B, certain services furnished by CORFs.

A CORF is recognized as a provider of services, reimbursable on the basis of its reasonable costs. The CORF must provide at least the following three services:

- o Physicians' services;
- o Physical therapy; and
- o Social or psychological services.

In addition to this basic package of services, the CORF may furnish and receive reimbursement for as many of the other items and services listed in §3181 as it wishes.

Under regulations which implement the amendment, the facility must have adequate space and equipment necessary to provide any of the services it elects to provide. Additionally, in order to accept a patient, the CORF must be able to provide all of the services required by the patient, as established in the plan of treatment. If the CORF does not have personnel to provide the service, it must arrange for the services to be provided at the CORF, as needed, by outside practitioners. Reimbursement will be made by assigned intermediaries acting in the role of Part B carriers. (See §§3370-3370.2.)

CORF services are subject to the Medicare Part B deductible and coinsurance provisions; i.e., the CORF may bill the beneficiary only the unmet portion of the deductible and 20 percent of its customary charges for covered services.

In enacting this legislation, the Congress indicated its concern that although rehabilitation services were covered in various settings under the provisions of the existing law, there was no provision that would permit the beneficiary to receive a variety of rehabilitation services at a central location. Section 933 provides coverage for a broad array of rehabilitation services furnished on an outpatient basis in a coordinated fashion by a CORF.

3181. COVERED CORF SERVICES AND NONCOVERED SERVICES

A. Covered CORF Services.—The following are covered CORF services:

- o Physicians' services related to administrative functions;

- o Physical therapy, occupational therapy, speech pathology services, and respiratory therapy;

- o Social and psychological services;

- o Nursing care provided by or under the supervision of a registered professional nurse;

- o Prosthetic and orthotic devices, including testing, fitting, or training in the use of such devices;

- Drugs and biologicals which cannot be self-administered;

- Supplies, appliances, and equipment, including the purchase or rental of DME from the CORF; and

- A single home visit to evaluate the potential impact of the home environment on the rehabilitation goals.

B. Noncovered Services.--The statute specifies that no service may be covered as a CORF service if it would not be covered as an inpatient hospital service if provided to a hospital patient. This does not mean that the beneficiary must require a hospital level of care or meet other requirements unique to hospital care. This provision merely requires that the service, if otherwise covered, would be covered if provided in a hospital. Accordingly, coverage determinations for CORF services will be based on established coverage guidelines.

CORF services are not covered if not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member. Thus, there must be potential for restoration or improvement of lost or impaired functions. For example, services involving repetitive services that do not require the skilled services of nurses or therapists, such as maintenance programs or general conditioning or ambulation, are not covered. These services could be performed in the patient's residence by nonmedical personnel such as family members. It is not reasonable and necessary for such services to be performed in an ambulatory care setting by CORF personnel.

3182. PROVISION OF SERVICES

A. Place of Treatment.--In general, all services must be furnished on the premises of the CORF. The only exceptions are the home evaluation (see §3181A) and, effective December 22, 1987, physical therapy, occupational therapy, and speech pathology services. There is no restriction on where these services may be furnished. They may be covered if furnished pursuant to the plan of treatment, and they do not duplicate services for which payment has been made under Medicare.

CORFs have been instructed to clearly identify each service performed off the premises of the facility. Establish controls to guard against the duplication of services provided at the facility and elsewhere. (See §3650.)

B. Personnel Qualification Requirements.--Services must be furnished or supervised by personnel determined to be qualified in accordance with HCFA regulations 42 CFR 485.70.

Determinations regarding whether services are furnished by or under the supervision of qualified personnel are primarily the responsibility of the State agency responsible for certifying the facility. You may assume, in the absence of evidence to the contrary, that the services of a participating CORF are furnished or supervised by qualified personnel. Refer any questions in this regard to the regional office. If there is evidence that services are not being furnished or supervised by qualified personnel, withhold payment until the matter is resolved.

C. Services Furnished Under Arrangements.--CORF services provided under arrangements are subject to the provisions of §3007.

D. Referral for Treatment.--To become a patient of a CORF, the beneficiary must be under the care of a physician who certifies that the beneficiary needs skilled rehabilitation services.

The referring physician must advise the CORF of the beneficiary's medical history, current diagnosis and medical findings, desired rehabilitation goals, and any contraindications to specific activity or intensity of rehabilitation services.

E. Plan of Treatment.--CORF services must be furnished under a written plan of treatment established by a physician. The physician may be either a physician associated with the CORF, or the referring physician if he or she provides a detailed plan of treatment that meets the following requirements.

The plan of treatment must contain the diagnosis, the type, amount, frequency and duration of services to be performed, and the anticipated rehabilitation goals.

The plan of treatment should be sufficiently detailed to permit an independent evaluation of the patient's specific need for the indicated services and of the likelihood that he or she will derive meaningful benefit from them.

The plan of treatment must be reviewed by the CORF physician at least once every 60 days. Following the review, the physician should certify that the plan of treatment is being followed and that the patient is making progress in attaining the established rehabilitation goals. When the patient has reached a point where no further progress is being made toward one or more of the goals, Medicare coverage ends with respect to that aspect of the plan of treatment.

3183 Specific CORF Services

3183.1 Physicians' Services. Certain administrative services provided by the physician associated with the CORF are considered CORF services and are reimbursable to the CORF. These services include: examinations for the purpose of establishing and reviewing the plan of treatment, consultation with and medical supervision of non-physician staff, and other medical and facility administration activities.

Physicians' diagnostic and therapeutic services furnished to an individual patient are not CORF physicians' services. If covered, payment for these services is made by the carrier on a reasonable charge basis subject to the same limitations applicable to physicians' services furnished in outpatient hospital settings.

3183.2 Physical Therapy Services.

The coverage guidelines in §3101.8 apply to physical therapy services provided by CORFs. Note that under those guidelines, maintenance physical therapy, i.e., repetitive services required to maintain a level of functioning, would not be covered. However, the establishment of a maintenance program for a patient whose restoration potential has been reached would be a covered service. This could include examinations, evaluations of the patient's condition, preparation of the maintenance program, and the training of nonskilled persons to carry out the program.

3183.3 Occupational Therapy Services. The coverage guidelines in §3101.9 also apply to occupational therapy services furnished by a CORF.

Note that services involving vocational or prevocational assessment are not covered when they are related solely to vocational rehabilitation; that is, to prepare the patient to qualify for specific employment opportunities, achieve certain work skills, or accommodate a certain work setting. Such services are not considered reasonable and necessary for the diagnosis or treatment of illness or injury.

3183.4 Speech Pathology Services. Speech pathology services are subject to the guidelines in §3101.10A.

Services related to congenital speech difficulties, such as stuttering or lisping, would not be covered unless such services are incident to the treatment of otherwise covered CORF services.

Although in other outpatient settings, a speech pathologist is permitted to establish a plan of treatment, this is not the case with CORF services. Under the statute, all CORF services must be provided under a plan established by a physician. However, as with other specialties, it is expected that the physician will rely heavily on advice from the speech pathologist.

3183.5 Respiratory Therapy Services. Respiratory therapy services furnished by a CORF are covered under the guidelines in §3101.10.

3183.6 Prosthetic and Orthotic Devices. Prosthetic devices, other than dental devices and renal dialysis machines, are covered CORF services. Prosthetic devices are defined as devices that replace all or part of an internal body organ or external body member (including contiguous tissue), or that replace all or part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.

Coverage of a prosthetic device includes all services necessary for formulating its design, material, and component selection; measurement, fittings, static and dynamic alignments; and instructing the patient in its use. Such coverage is included as an integral part of the fabrication of the device.

Orthotic devices are those orthopedic appliances or apparatus used to support, align, prevent, or correct deformities, or to improve the function of moveable parts of the body. As with prosthetic devices, the coverage of an orthosis includes its design, materials, measurements, fabrications, testing, fitting, or training in the use of the orthosis.

3183.7 Social Services. Social services are covered CORF services if they are included in the plan of treatment and contribute to the improvement of the individual's condition. Such services include:

A. Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment, and adjustment to care in the CORF.

B. Assessment of the relationship of the patient's medical and nursing requirements to his or her home situation, financial resources, and the community resources available upon discharge from the CORF.

C. Counseling and referral for casework assistance in resolving problems in these areas.

3183.8 Psychological Services. Covered services include:

- Assessment, diagnosis and treatment of the beneficiary's mental and emotional functioning as it relates to his or her rehabilitation.

- Psychological evaluations of the individual's response to and rate of progress under the treatment plan.

- Assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment.

Although everyone who has a serious illness or injury may suffer from some degree of anxiety, the coverage of psychological services do not automatically extend to every CORF patient. For example, diagnostic testing for a mental problem is covered for a cardiac patient who exhibits excessive anxiety or fear following the acute phase of a cardiac problem. However, the routine testing or treatment of all cardiac rehabilitation patients for mental, psychoneurotic, or personality disorders is not covered.

Family counseling services are covered only where the primary purpose of that counseling is the treatment of the patient's condition; that is, when there is a need to observe the patient's interaction with family members or to assess the capability of family members to aid in the rehabilitation of the patient. Family counseling services that are primarily directed toward the treatment of a family member's problem with respect to the patient's condition are not covered.

3183.9 Nursing Services. Nursing services provided by or under the supervision of a registered professional nurse are covered CORF services.

3183.10 Drugs and Biologicals. Drugs and biologicals are covered when they cannot be self-administered, are administered by or under the supervision of a physician or registered nurse, and are not otherwise excluded from Medicare coverage, such as most injections for immunization. Determinations on whether a drug or biological is of a type that cannot be self-administered is based on the usual method of administration of the form of that drug or biological as furnished to the CORF patient.

Thus, when a patient is given tablets or other oral medication, these are excluded from coverage since the form of the drug given to the patient is usually self-administered. Similarly, if a patient is given an injection that is usually self-injected, such as insulin, this drug is excluded from coverage unless administered in an emergency situation, such as a diabetic coma, or where, because of the patient's mental or physical condition, self-administration is impossible or unwarranted. However, if a patient receives an injection of a drug that is not usually self-injected and that is also available in oral form, that drug is not subject to the self-administerable drug exclusion, since it is not self-administerable in the form in which it was furnished to the patient.

3183.11 Supplies, Appliances, and Equipment.—Covered services include:

- Nonreusable supplies, such as oxygen, bandages, or ceramic tiles, used in the various therapeutic modalities.

- Medical equipment and appliances for the use of patients at the facility.

- Durable medical equipment (DME) for use outside the CORF, whether furnished at the CORF or delivered to the beneficiary's home. The beneficiary may obtain DME from the CORF or other DME supplier. The guidelines in §3113 apply to DME furnished by the CORF. Thus, exercise appliances and other self-help devices that can be used for general conditioning do not qualify as DME. The equipment may be purchased or rented. Payment is made by the intermediary on a reasonable cost basis.

3183.12 Home Environment Evaluation.—One offsite service is permitted - a single home visit to evaluate the potential impact of the home environment on the rehabilitation goals. The purpose of the evaluation is to permit the plan of treatment to be tailored to take into account the patient's home environment. It is not intended that the Medicare program underwrite physical alterations to the home that facilitates the patient's rehabilitation.

The home evaluation is not covered as a routine service for all CORF patients. It is covered only if, in establishing or carrying out the plan of treatment, there is a clear indication that the home environment might adversely affect the patient's rehabilitation. Coverage is limited to the services of one professional who is selected by the CORF.

3185 Psychiatric Services Limitation.—

A. Basis for Limitation—Section 1833(c) of the Act imposes a limitation on reimbursement under Part B for outpatient psychiatric treatment, (i.e., treatment when the beneficiary is not a hospital inpatient). This provision limits the amount of a beneficiary's incurred expenses for those services that are recognized for any calendar year to the lesser of 62.50 percent of those expenses, or a fixed dollar amount as follows: $312.50 for any year before 1988; $562.50 for 1988; and $1,375 for any year after 1988. Payment for the incurred expenses, as limited, is subject to the Part B deductible and coinsurance.

The limitation generally applies only to expenses incurred for services furnished by physicians. However, under the regulations which implement the CORF provision, the limitation also applies to CORF services furnished by physicians and nonphysicians for services related to the treatment of a psychiatric condition, i.e., mental, psychoneurotic, and personality disorders. The term "mental, psychoneurotic, and personality disorders" is defined as the specific psychiatric conditions described in the American Psychiatric Association's *Diagnostic and Statistical Manual - Mental Disorders*.

B. Application of the Limitation.—

1. The CORF psychiatric limitation is not a limit separate from the limitation on physician's outpatient psychiatric services. Physician outpatient services and CORF services for the treatment of a mental, psychoneurotic and personality disorders are combined for purposes of the limitation.

2. The limitation applies only to therapeutic services and to follow-up diagnostic services performed to evaluate the treatment. It does not apply to initial psychiatric or psychological diagnostic testing and evaluation.

3. In applying the fixed dollar amount and 62.50 percent limitations to incurred expenses, use the customary charges for the CORF services. Carriers use reasonable charges for physician services. The $312.50, $562.50, and $1,375 amounts represent 62.50 percent respectively of $500, $900, and $2,200. Therefore, $500, $900, and $2,200 are the maximum amount of customary charges for CORF psychiatric services, plus reasonable charges for outpatient physician psychiatric services, that are covered respectively in any year before 1988, in 1988, and in any year after 1988.

C. Computation.—To compute the CORF's reimbursement for services related to a psychiatric condition:

1. Ascertain the total accumulated covered reasonable charges for outpatient physicians' psychiatric services and covered customary charges for CORF psychiatric services previously processed for the calendar year.

2. If the answer to 1. is $500 or more for any year before 1988, $900 or more for 1988, and $2,200 or more for any year after 1988, no further CORF reimbursement is available for the treatment of the patient's psychiatric condition on the current claim.

3. If the answer to 1. is less than $500 for any year before 1988, less than $900 for 1988, or less than $2,200 for any year after 1988, subtract the amount in 1 from $500, $900, or $2,200, as applicable.

4. Determine the lesser of the customary charges for CORF psychiatric services on the current claim or the figure in 3. The amount so determined is the covered customary charges for CORF psychiatric services.

5. Multiply the amount in 4. by .625. The result is the customary charges for CORF psychiatric services which, subject to Part B deductible and coinsurance, are reimbursable in the current claim.

D. Determining When the Limitation Applies.—

If the CORF services rendered are for both a psychiatric condition and one or more nonpsychiatric conditions, separate the charges for the psychiatric aspects of treatment from the charges for the nonpsychiatric aspects. However, in any case in which the psychiatric and nonpsychiatric components are not readily distinguishable, allocate the charges under the following rules.

1. Psychological services, whether furnished by psychologists or other personnel, are always subject to the limitation, regardless of the patient's diagnosis.

2. Physical therapy, respiratory therapy, speech therapy, and services furnished in connection with prosthetic and orthotic devices and the use of equipment and appliances related to these services, are not subject to the limitation.

3. For those services not specified in 1. and 2. above, such as occupational therapy, determine the primary reason for the patient being referred to the CORF.

a. If the referral is primarily on the basis of a psychiatric condition, all such services are subject to the limitation except as specified in b. below.

b. If the referral is primarily on the basis of a diagnosis of Alzheimer's Disease (coded 331.0 in the International Classification of Diseases 9th Revision) or Alzheimer's or other disorders coded 290.XX in the American Psychiatric Association's Diagnostic and Statistical Manual—Mental Disorders, such services typically represent medical management of the patient's condition (rather than psychiatric treatment) and is not subject to the benefit limitation. However, where a particular service provided a patient with such a diagnosis is primarily for psychological services as specified in 1. above, it is subject to the limitation.

c. If the referral is primarily on the basis of a physical condition, such services are not subject to limitation.

d. If the primary reason for referral is not clear, 50 percent of the customary charges are subject to the limitation.

E. Examples

1. Patient A is referred to the CORF for psychological evaluation and counseling. The plan of treatment includes services that are provided by a psychologist, a psychiatric nurse, a social worker, and an occupational therapist. Since all of the CORF services are furnished in connection with patient A's mental condition, all are subject to the psychiatric limitation.

2. Patient B, who has chronic schizophrenia, is injured in an accident resulting in amputation of his right hand and foot. Following a period of hospitalization, during which he is fitted with an artificial hand and foot, he is referred to the CORF for physical therapy, occupational therapy, and social services. Even though Patient B has a psychiatric condition, the CORF services are not furnished in connection with that condition and are not subject to the psychiatric limitation.

3. Same facts as Example 2, except that after treatment is initiated, it is determined that B's mental condition was aggravated by the results of the accident, and that he also needs psychological counseling and that the occupational therapy and social services should be continued but revised to also take into account his mental state.

The physical therapy still would not be subject to the psychiatric limitation. The psychological counseling would be subject. Because it cannot be clearly established whether the occupational therapy and social services are in connection with his physical or mental problem, 50 percent of the customary charges for these services would be applied to the psychiatric limitation.

A3101.1 Elimination of the Private Room Subsidy.

A. General.—For cost reporting periods beginning after December 31, 1971 and before October 1, 1982, the program has paid the same amount for routine services (excluding intensive care type units) whether the patient had a medically necessary private room, a nonmedically necessary private room, a semiprivate room or ward accommodations (if use of ward accommodations was consistent with program purposes). Under section 111 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Public Law 97-248, the program may ordinarily no longer allow as a reasonable cost the estimated amount by which costs incurred by a hospital or SNF for private room accommodations exceed the costs which would have been incurred by that hospital or SNF for semiprivate accommodations. The program may allow this extra cost only where the use of those accommodations by a Medicare beneficiary is medically necessary. Final regulations reflecting this provision have been issued effective for cost reporting periods beginning on or after October 1, 1982. (47 F.R. 42676, September 28, 1982.)

Under the methodology for reimbursing for routine services for cost reporting periods beginning after December 31, 1971 and before October 1, 1982, the intermediary in most cases did not review a hospital's or SNF's assertions regarding the medical necessity of a private room. The only situation in which the intermediary previously made a determination regarding the medical necessity of a private room was the unusual one in which the hospital or SNF stated that the room was not medically necessary, informed the beneficiary (or his representative) that he would have to pay a specified private room charge differential, and the beneficiary disagreed and requested a determination. With the change in reimbursement guidelines effective for cost reporting periods beginning on or after October 1, 1982, intermediaries will now also have to review on a postpayment sample basis all other hospital and SNF allegations of the medical necessity of a private room.

B. Provider Responsibility.—For cost reporting periods beginning on or after October 1, 1982, a hospital or SNF should submit an HCFA-1453 showing the charges for a private room as fully covered charges (see §3620, Item 19B for the way in which this is done) only if the private room was medically necessary under the guidelines in §3101.1B (Medical Necessity: Need for Isolation) or §3101.1C (Medical Necessity: Admission Required and Only Private Rooms Available). The provider must maintain the documentation needed to establish that the requirements of §3101.1B or §3101.C were met.

C. Intermediary Review Process.— Contact the provider on a postpayment sample review basis with such frequency as seems appropriate, to obtain the provider's explanation of why a private room was medically necessary under the guidelines in subsection B, request any additional information or any documentation that may be needed, and determine whether the private room was in fact medically necessary in the cases reviewed. If the postpayment sample review reveals erroneous allegations of the medical necessity of private rooms, do not attempt to recover the incorrect payments unless:

1. The purported basis for the medical necessity of the private room was the need for isolation but a physician did not order the private room; or

2. The purported basis for the medical necessity of the private room was the nonavailability of semiprivate or ward accommodations but such accommodations were in fact available;

3. The provider made some other obvious error in alleging the medical necessity of a private room.

Whether or not recovery is sought, furnish the provider appropriate remedial training. If this training fails to produce accurate provider determinations regarding the medical necessity of a private room, require the provider to attach the statement justifying the medical necessity of a private room to each HCFA-1453 that shows the charges for a private room as fully covered charges and make a case by case prepayment review of these billings. This case by case review must continue until you find that the provider is making accurate private room determinations.

D. When Charge for Private Room Differential is Permissible.--Denials of private room coverage are not subject to the waiver of liability provisions. However, under section 1866(a)(2)(B)(i) of the Social Security Act, a provider may charge the private room differential described in S3101.1A for a nonmedically necessary private room only if the private room was requested by the beneficiary. Where the provider alleges the medical necessity of a private room but you deny private room coverage on prepayment review, the provider may be considered to have furnished the private room at the request of the beneficiary, and may charge the private room differential, unless the allegation of medical necessity was made in obvious error. If the allegation was made in obvious error, the provider may not be considered to have furnished the private room at the request of the beneficiary and may not charge the differential. When you deny private room coverage in the postpayment sample review, the provider may never charge the differential, because you do not seek recovery unless the allegation of medical necessity was made in obvious error.

A provider may also charge the beneficiary the private room differential, as in the past, where the private room was requested by the beneficiary or his representative with knowledge of the charge and the provider shows the differential as a noncovered charge in the HCFA-1453.

E. Notice and Correction of Bills.—If you deny private room coverage in a prepayment case by case review, correct the bill, notify the provider and advise the provider whether or not the provider may charge the beneficiary the private room differential under the rules described above. If a charge is permissible, notify the beneficiary of the denial, indicating his appeal rights. If you deny private room coverage on postpayment sample review and seek recovery, correct the bill and remind the provider that no charge may be made for the private room differential. In correcting bills, S3620, Item 19 B applies —paragraph 2 if a charge is permissible and paragraph 5 if a charge is not permissible.

F. All-private Room Providers.—In an all-private room provider, the Medicare program continues to pay the full reasonable cost of a private room in all cases, and beneficiaries may not be charged any private room differential.

A.3101.7, Inpatient Services in Connection with Dental Services—For hospital admissions after June 30, 1981, hospital inpatient services which are necessary because of the severity of a noncovered dental procedure are covered. The dental procedure itself is excluded from coverage if it is a service described in §3162. Hospital inpatient services which are necessary for the performance of a dental procedure because of the patient's underlying medical condition and clinical status continue to be covered.

Cross-refer: §§3101.7, 3431B.1, 3610B.10, and 3783.1C.

A3146 Reimbursement for Inpatient Radiology and Pathology.--Sec. 112 of Public Law 97-248 amends section 1833(a)(1) and 1833(b) of the Social Security Act to eliminate the 100 percent reimbursement rate currently applicable to radiological and pathological services furnished to hospital inpatients by physicians who practice in the field of radiology or pathology and have entered into (or on whose behalf there have been entered into) agreements to accept assignments in all cases for these services. Effective for services furnished on or after October 1, 1982, Medicare will pay for these services on the same basis as it pays for other physicians' services, i.e., at 80 percent of the reasonable charges after application of any unmet deductible under §3213. The agreements in question are void with respect to services furnished on or after October 1, 1982. The physician (or entity authorized to bill and receive payment for his services) may decide on a claim by claim basis whether or not to accept assignment with respect to services furnished on or after that date (subject to existing consistency requirements of combined billing when the hospital bills the intermediary for the physician component).

Where a hospital has been combined billing for the physician and hospital components of inpatient radiology and pathology, the different rates of reimbursement now applicable to these components will require the hospital to determine what portion of the hospital charge is for each. In determining the portion of the hospital charge that relates to the physicians' professional services and is subject to coinsurance, the hospital may use one of the methods described in §§2108.4 and 2108.11 of the Provider Reimbursement Manual. In most cases, the use of the optional method will be appropriate. For example, if the combined hospital departmental charges are $800 and the physician receives 25 percent of those charges and spends 80 percent of his time furnishing professional services, then the professional component will be identified on the bill as $160 (800 x .25 x .80) and (assuming the deductible to be met) the coinsurance will be $32 (160 x .20). Any issues that arise regarding the determination of the professional and hospital components of charges that have been combined billed are in the jurisdiction of the intermediary. See §§A3604.6A and A3620, Item 19 for a description of the procedure under which a hospital will submit a single claim to its intermediary for both the professional and hospital components of the charges.

Radiological and pathological physician services furnished before October 1, 1982, will continue to be reimbursed under the provisions in effect at the time the services were rendered even though the claim is filed on or after October 1, 1982.

CHAPTER II
COVERAGE OF SERVICES
TABLE OF CONTENTS
FOR INTERIM MANUAL INSTRUCTIONS

Section

Part-time or Intermittent Home Health Aide and Skilled Nursing Care.................................... 422

Reuse of Bloodlines in ESRD Facilities................ IM 3179

IM 3179 REUSE OF BLOODLINES IN ESRD FACILITIES

Section 9335(k), of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86), as amended by Section 4036(c) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), requires that no dialysis facility may reuse dialysis supplies unless the Secretary of Health and Human Services has established protocols for reuse by July 1, 1988 and the facility follows the protocols. Final regulations providing standards and conditions for the reuse and reprocessing of hemodialyzers and dialyzer caps were published in the Federal Register on October 2, 1987. However, protocols for the reuse of bloodlines are not yet available. Therefore, beginning July 1, 1988, Medicare dialysis facilities may not reuse bloodlines.

We wish to emphasize that this prohibition is strictly a matter of conformance with the law. The Public Health Service advises us that there is no imminent public health hazard involved in the reuse of bloodlines, but work on appropriate protocols has not been completed. Reuse of bloodlines is not associated with any increased risk of hepatitis B virus (HBV) infection in either patients or staff members or with the occurrence of pyrogenic reactions or septicemia in patients.

CHAPTER III

DEDUCTIBLES AND COINSURANCE AMOUNTS

Hospital Insurance (Part A) - Cash Deductible and Coinsurance

	Section	Page
Inpatient Hospital Deductible	3201	67
Coinsurance	3203	67
Basis for Determining the Coinsurance Amounts	3206	68
Exhibit of Deductible and Coinsurance Amounts	3211	68.1

Supplementary Medical Insurance (Part B)--Cash Deductible and Coinsurance

	Section	Page
Supplementary Medical Insurance Incurred Expenses	3212	68.2
Part B Annual Deductible	3213	68.3
Special Carryover Rule for Expenses Incurred Prior to 1981	3213.1	68.4
Part B Coinsurance	3214	68.4
Exceptions to Annual Deductible and Coinsurance	3215	68.4

Blood Deductibles (Part A and Part B)

	Section	Page
Blood Deductibles	3235	70
Part A Blood Deductible	3235.1	70
Part B Blood Deductible	3235.2	70
Items Subject to Blood Deductibles	3235.3	70
Obligation of Beneficiary to Pay for or Replace Deductible Blood	3235.4	71
Distinction Between Blood Costs and Blood Processing Costs	3235.5	72
Blood Furnished to an SNF Patient	3235.6	73

Hospital Insurance (Part A) - Cash Deductible and Coinsurance

3201. INPATIENT HOSPITAL DEDUCTIBLE

The patient is responsible for a deductible amount for inpatient hospital services in each benefit period. The Secretary of Health and Human Services has in the past been required to determine each year the amount of the deductible for the following year. For 1987, however, the amount of the deductible has been set by law at $520. For each year after 1987, the Secretary is required to promulgate the deductible and related coinsurance amounts between September 1 and September 15 of the preceeding year. The deductible will be set at an amount equal to the deductible for the preceeding year, changed by the same percentage as applies to PPS payment rates and adjusted to reflect changes in real case mix. The deductible and related coinsurance amounts for the years through 1987 are shown on the chart in §3211.

For inpatient hospital services rendered in years prior to 1982 and after 1986, the applicable inpatient deductible is the one in effect during the calendar year in which the patient's benefit period begins (i.e., in most cases, the year in which the first inpatient hospital services are furnished in the benefit period). For services rendered in 1982 through 1986, the applicable deductible is the one in effect during the year in which the services were furnished. (For hospital and SNF coinsurance days occuring before 1982, the coinsurance amount is based on the deductible applicable for the calendar year in which the benefit period began, even though the coinsurance days may fall in a subsequent year for which a higher deductible is applicable. For coinsurance days after 1982, the coinsurance amount is based on the deductible applicable for the calendar year in which the coinsurance days occur.)

The deductible is satisfied only by charges for covered Part A services. Expenses for covered services count toward the deductible on an incurred rather than paid basis. Expenses incurred in one benefit period cannot be applied toward the deductible in a later benefit period. Expenses incurred in meeting the blood deductible do not count toward the inpatient hospital deductible.

A reduction in benefit days resulting from confinement in a psychiatric hospital on and immediately preceding the date of entitlement (see § 3104) does not affect the amount of the deductible for which the patient is responsible.

If the actual charge is less than the deductible to be met and the customary charge, the customary charge should be applied to the deductible. (See § 3101.1G for a definition of customary charges.)

3203. COINSURANCE

A. Inpatient Services.—In each benefit period, the patient is responsible for coinsurance amounts equal to one-fourth of the inpatient hospital deductible for each day of inpatient hospital services from the 61st through the 90th days, one-half of the inpatient hospital deductible for each lifetime reserve day (the 91st through the 150th days of inpatient hospital services) and one-eighth of the inpatient hospital deductible for each day of extended care services from the 21st through the 100th days.

The chart in § 3211 should be used to determine the applicable coinsurance amounts for recent years.

Where the actual charge to the patient for the 61st through the 90th days of inpatient hospital services is less than the applicable coinsurance amount, the coinsurance is the actual charge per day. Where the actual charge to the patient for lifetime reserve days is less than the coinsurance amount for those days, the beneficiary may be deemed to have elected not to use the days because he/she would not benefit from their utilization. (See § 3106.2.)

B. DME Furnished as a Home Health Benefit.—The patient is responsible for 20 percent of the reasonable charge for durable medical equipment furnished as a home health benefit on or after July 18, 1984. (Reimbursement to the HHA is the lesser of the reasonable cost or customary charge less the coinsurance, but reimbursement may not exceed 80 percent of the reasonable cost.)

3206. BASIS FOR DETERMINING THE COINSURANCE AMOUNTS

For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible for the year in which the services are furnished.

EXAMPLE: A beneficiary begins a benefit period with admission to a hospital on December 31, 1983 and pays a $304 inpatient hospital deductible. He continues to be hospitalized in the same benefit period until May 31, 1984. Since the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the services were rendered, and since the deductible for 1984 is $356, the coinsurance amount for each day of inpatient hospital services from the 61st through the 90th days will be $89 and for the lifetime reserve days, it will be $178.

PART A - DEDUCTIBLE AND COINSURANCE AMOUNTS

For inpatient hospital services rendered in years prior to 1982 and after 1986, the applicable inpatient deductible is the one in effect during the calendar year in which the patient's benefit period begins (i.e., in most cases, the year in which the first inpatient hospital services are furnished in the benefit period). For services rendered in 1982 through 1986, the applicable deductible is the one in effect during the year in which the services were furnished. (For hospital and SNF coinsurance days occuring before 1982, the coinsurance amount is based on the deductible applicable for the calendar year in which the benefit period began, even though the coinsurance days may fall in a subsequent year for which a higher deductible is applicable. For coinsurance days after 1982, the coinsurance amount is based on the deductible applicable for the calendar year in which the coinsurance days occur.)

YEAR	INPATIENT HOSPITAL			SKILLED NURSING FACILITY	HOME HEALTH AGENCY[1]	BLOOD
	FIRST 60 DAYS	61ST THRU 90TH DAY	60 LIFETIME RESERVE DAYS (Nonrenewable)	21ST THRU 100TH DAY		
	DEDUCTIBLE	COINSURANCE PER DAY Always equal to 1/4 of inpatient hospital deductible	COINSURANCE PER DAY Always equal to 1/2 of inpatient hospital deductible	COINSURANCE PER DAY Always equal to 1/8 of inpatient hospital deductible	NO DEDUCTIBLE NO COINSURANCE (EXCEPT FOR 20 PERCENT COINSURANCE FOR DURABLE MEDICAL EQUIPMENT (eff. 7/18/84))	DEDUCTIBLE First 3 pints (or equivalent units of packed red blood cells) in a benefit period
1980	$ 180	$ 45	$ 90	$ 22.50		
1981	204	51	102	25.50		
1982	260	65	130	32.50		
1983	304	76	152	38.00		
1984	356	89	178	44.50		
1985	400	100	200	50.00		
1986	492	123	246	61.50		
1987	520	130	260	65.00		

---

[1] PRIOR TO JULY 1, 1981, THERE WAS A 100 VISIT LIMITATION

Supplementary Medical Insurance (Part B)

3212. SUPPLEMENTARY MEDICAL INSURANCE INCURRED EXPENSES.

The supplementary medical insurance plan includes coverage for expenses incurred for the following medical and other health services:

- Physicians' services, including surgery, consultation, home office, institutional calls, and services and supplies furnished incident to a physician's professional service;
- Outpatient hospital services furnished incident to physicians' services;
- Outpatient diagnostic services furnished by a hospital;
- Outpatient physical therapy, outpatient occupational therapy, and outpatient speech pathology services;
- Diagnostic X-ray tests, laboratory tests and other diagnostic tests;
- X-ray, radium, and radioactive isotope therapy;
- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;
- Rental or purchase of durable medical equipment for use in the patient's home;
- Ambulance service;
- Prosthetic devices which replace all or part of an internal body organ;
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes;
- Pneumococcal vaccine and its administration; hepatitis B vaccine and its administration, and blood clotting factors for hemophiliac patients and their administration.
- Certain medical supplies used in connection with home dialysis delivery systems;
- ESRD composite rate for all outpatient maintenance dialysis items and services;
- Antigens prepared by a physician;
- Rural health clinic services;
- Comprehensive outpatient rehabilitation facility services;

- Ambulatory surgical facility services furnished in connection with certain surgical procedures; and

- Services furnished in a health maintenance organization by a clinical psychologist, a physician assistant, or nurse practitioner, and services and supplies furnished incident to such services.

Supplementary medical insurance also covers unlimited home health visits for which the Part A intermediary makes payment on the basis of the reasonable cost. Outpatient hospital services are also reimbursed by the Part A intermediary.

Payment may not be made under Part B for services furnished an individual if he is entitled to have payment made for those services under Part A. An individual is considered entitled to have payment made under Part A if the expenses incurred were used to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of request for payment or physician certification.

3213. PART B ANNUAL DEDUCTIBLE

In each calendar year, a cash deductible must be satisfied before payment can be made under the supplementary medical insurance plan. (See §3215 for exceptions.)

- As of January 1, 1982, the deductible is $75.

- From 1973 through 1981, the deductible was $60.

- From 1966 through 1972, the deductible was $50.

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on the reasonable charge. Noncovered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year, i.e., his insurance coverage begins after the first month of a year or he dies before the last month of the year, he is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received by the intermediary. Services which are not subject to the deductible cannot be used to satisfy the deductible.

3213.1 Special Carryover Rule For Expenses Incurred Prior To 1981.--Expenses incurred in the last 3 months of a calendar year prior to 1981, which were applied toward the Part B deductible for the year in which they were incurred, may also be credited towards the deductible for the following year.

NOTE: This deductible carryover provision was repealed effective with expenses incurred on or after October 1, 1981.

3214. PART B COINSURANCE

After the deductible has been satisfied, providers will generally be paid the lesser of the reasonable costs or the customary charges, less 20% of the reasonable charges, but no more than 80% of the reasonable costs, and physicians and other suppliers 80 percent of the reasonable charges, incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the reasonable charges for the items and services. (See §3215 for exceptions.)

3215. EXCEPTIONS TO ANNUAL DEDUCTIBLE AND COINSURANCE

A. The 20 percent coinsurance does not have to be met with respect to the following:

1. Purchased used durable medical equipment (DME) including DME furnished as a home health benefit, if the charge does not exceed 75 percent of the reasonable charge of new equipment.

2. Preadmission Diagnostic Testing services furnished from December 5, 1980 through July 18, 1984.

B. Neither the annual deductible nor the 20 percent coinsurance apply with respect to:

1. Radiology and pathology services furnished before October 1, 1982 to inpatients of qualified hospitals by physicians in the fields of radiology or pathology. (Services furnished on or after July 1, 1981, were exempt from the deductible and coinsurance only if the physician agreed to accept assignment for all radiology or pathology physician services furnished to hospital inpatients);

2. Part B home health services, except that there is a coinsurance of 20 percent of the reasonable charge for durable medical equipment furnished as a home health benefit on or after July 18, 1984.

3. Clinical diagnostic laboratory tests (including specimen collection fees) performed or supervised on or after July 1, 1984, by a physician, laboratory, or other entity reimbursed on an assigned basis.

4. Certain surgical procedures performed by a physician in an ambulatory surgical center or outpatient department of a hospital.

5. Ambulatory surgical facility services in an ambulatory surgical center.

6. Pneumococcal vaccine and its administration furnished on or after July 1, 1981.

NOTE: Services which are not subject to the deductible cannot be used to satisfy the deductible.

Blood Deductibles (Part A and Part B)

3235. BLOOD DEDUCTIBLES

3235.1 Part A Blood Deductible.-- Program payment may not be made for the first 3 pints of whole blood or equivalent units of packed red cells received by a beneficiary in a benefit period. However, payment may be made for blood processing; (i.e., administration, storage, etc.) beginning with the first pint or unit in a benefit period. (See § 3620, Item 19A, for rules on distinguishing between blood charges and blood processing charges.)

The Part A blood deductible applies only to the first 3 pints of blood furnished in a benefit period, even if more than one provider furnished blood. The Part A and Part B blood deductibles are applied separately. The blood deductibles are in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible.

To be covered as a Part A service and count toward the blood deductible, the blood must be furnished on a day which counts as a day of inpatient hospital services or extended care services. (See §§ 3107 and 3137.) Thus, blood is not covered under Part A and does not count toward the Part A blood deductible when furnished to an inpatient after he has exhausted his benefit days in a benefit period, or where the individual has elected not to use lifetime reserve days. However, where the patient is discharged on his first day of entitlement or on the provider's first day of participation, the provider is permitted to submit a billing form with no accomodation charge, but with ancillary charges including blood. (See § 3611B.)

3235.2 Part B Blood Deductible.-- Where blood is furnished on an outpatient basis, it is subject to a Part B blood deductible applicable to the first 3 pints of whole blood or equivalent units of packed red cells received by a beneficiary in a calendar year. It should be noted that payment for blood may be made to the hospital under Part B only for blood furnished in the outpatient setting (see § 3640.6).

The Part B blood deductible applies only to the first 3 pints of blood furnished in a calendar year, even if more than one provider furnished blood. The Part A and Part B blood deductibles are applied separately. The blood deductibles are in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible.

3235.3 Items Subject to Blood Deductibles.-- The blood deductibles apply only to whole blood and packed red cells. The term whole blood means human blood from which none of the liquid or cellular components have been removed. Where packed red cells are furnished, a unit of packed red cells is considered equivalent to a pint of whole blood. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the blood deductible. However, these components of blood are covered as biologicals (see § 3103.3).)

3235.4 Obligation of the Beneficiary to Pay for or Replace Deductible Blood.--A provider may charge the beneficiary or a third party its customary charge for whole blood or units of packed red cells which are subject to either the Part A or Part B blood deductible, unless the individual, another person, or a blood bank replaces the blood or arranges to have it replaced.

A. Replacement.--For replacement purposes, a pint of whole blood is considered equivalent to a unit of packed red cells. A deductible pint of whole blood or unit of packed red cells is considered replaced when a medically acceptable pint or unit is given or offered to the provider or, at the provider's request, to its blood supplier. Accordingly, where an individual or a blood bank offers blood as a replacement for a deductible pint or unit furnished a Medicare beneficiary, the provider may not charge the beneficiary for the blood, whether or not the provider or its blood supplier accepts the replacement offer. Thus a provider may not charge a beneficiary merely because it is the policy of the provider or its blood supplier not to accept blood from a particular source which has offered to replace blood on behalf of the beneficiary. However, a provider would not be barred from charging a beneficiary for deductible blood, if there is a reasonable basis for believing that replacement blood offered by or on behalf of the beneficiary would endanger the health of a recipient or that the prospective donor's health would be endangered by making a blood donation. Once a provider accepts a pint of replacement blood from a beneficiary or another individual acting on his behalf, the blood is deemed to have been replaced, and, the beneficiary may not be charged for the blood, even though the replacement blood is later found to be unfit and has to be discarded.

When a provider accepts blood donated in advance, in anticipation of need by a specific beneficiary, whether the beneficiary's own blood, that is, an autologous donation, or blood furnished by another individual or blood assurance group, such donations are considered replacement for pints or units subsequently furnished the beneficiary.

B. Adjustment of Provider's Cost Reimbursement to Reflect Deductible Amounts Collected.--At the end of the year when program reimbursement for blood is being computed, the cost of all unreplaced deductible and unreplaced nondeductible blood supplied will be reduced by the amount the provider collected from beneficiaries or other parties for unreplaced deductible pints. If more blood is donated by, or on behalf of, a beneficiary than is needed for full replacement on a pint-for-pint or unit basis, the value of the excess blood is not deducted from the amount payable to the provider. But, such donations would tend to reduce the cost of blood to the provider.

3235.5 Distinction Between Blood Costs and Blood Processing Costs.--Since the blood deductible applies only to blood costs, and does not apply to blood processing costs, it is necessary that providers distinguish between those two costs for purpose of Medicare cost reporting in accordance with the following rules:

A. Blood Costs.--In general, a provider's blood costs will consist of amounts it spends to procure blood, including:

1. The cost of such activities as soliciting and paying donors and drawing blood for its own blood bank, and

2. Where a provider purchases blood from an outside blood source (e.g., a commercial or voluntary blood bank or a blood bank operated by another provider) an amount equal to the amount of credit which the outside blood source customarily gives the provider if the blood is replaced.

B. Blood Processing Costs.--In general, a provider's blood processing costs will consist of amounts spent to process and administer blood after it has been procured, including:

1. The cost of such activities as storing, typing, cross-matching, and transfusing blood,

2. The cost of spoiled or defective blood, and

3. Where a provider purchases blood from an outside blood source, the portion of the outside blood source's blood fee which remains after credit is given for replacement; i.e., the amount which cannot be credited or rebated by replacement of the blood. Thus, where an outside blood source charges the provider the same amount, whether or not the blood is replaced, the entire blood fee is a blood processing cost to the provider.

NOTE: The above rules for distinguishing blood costs and blood processing costs where blood is obtained from an outside blood source apply only where the source charges the same for blood furnished Medicare beneficiaries as it charges for blood furnished nonbeneficiaries and gives the same credit for blood which is furnished Medicare beneficiaries as for blood which is furnished nonbeneficiaries.

Where an outside blood source charges providers more for blood furnished Medicare beneficiaries than for blood furnished nonbeneficiaries, or gives a larger credit for blood replaced by nonbeneficiaries than it gives for blood replaced by beneficiaries, the program will use only the lower charge and higher credit as a basis for determining the provider's reasonable costs for blood furnished by that particular blood source.

EXAMPLE: The XYZ Blood Bank operates a blood assurance plan under which it does not charge for blood furnished members of the plan, unless the member is a Medicare beneficiary, in which case a charge is made only for nondeductible pints. It charges for all blood furnished nonmembers of the plan regardless of their Medicare status. Since the XYZ Blood Bank charges hospitals for blood furnished members who are Medicare beneficiaries, but does not charge where the member is not a Medicare beneficiary, providers serviced by XYZ are paying more for blood furnished to members who are Medicare beneficiaries than for blood furnished nonbeneficiaries. Accordingly, amounts which providers pay the XYZ Blood Bank for blood furnished to Medicare beneficiaries who are members of the blood bank's blood assurance plan may not be recognized as a reasonable cost, nor may providers charge Medicare beneficiaries for such blood since blood is a covered inpatient hospital service. However, since the blood bank charges the same amount for blood furnished to all nonmembers of its blood assurance plan (i.e., whether or not the nonmembers are entitled to Medicare), reimbursement may be made to hospitals for blood furnished by the blood bank to nonmembers who are Medicare beneficiaries.

3235.6 Blood Furnished to an SNF Patient.--Extended care services covered under Part A include unreplaced blood (after satisfaction of the three pint blood deductible) and processing costs beginning with the first pint. However, blood transfusions are ordinarily performed by hospitals and not by SNF's. Thus, in the usual case, where an SNF patient needs blood, a participating hospital will provide the blood and the laboratory services and perform the transfusion for the SNF. In such a case, the hospital's charge for such blood and services is a blood cost and/or a blood processing cost to the SNF (see § 3235.5 for rules for distinguishing between blood costs and blood processing costs where blood is obtained from an outside source). The SNF's charges to the beneficiary must be in accordance with § 3235.4. (Note: Ambulance transportation of the patient between the hospital and SNF for the purpose of obtaining a blood transfusion is covered under Part B if the conditions for coverage of ambulance services are met. See § 3114.)

In the unusual situation where the SNF stores, cross-matches, or types blood, rather than having this done by a qualified hospital or independent laboratory, the SNF must, as a condition of participation, meet Standard (j) of section 405.1028 of the Regulations on Conditions of Participation for Hospitals. Where the SNF only transfuses blood to inpatients, it would be required to meet only factors (1), (3), (4), (6) and (9) of section 405.1028(j). (See section 405.1128 of Regulations on Conditions of Participation for Skilled Nursing Facilities.) (42 CFR 405, Subpart K.)

CHAPTER IV

REQUIREMENTS FOR PAYMENT

Section Page

Filing for Payment

Filing a Request for Payment and Claim for Payment.......... 3301 74.1
Request for Payment.. 3302 74.1
    Billing Form as Request for Payment.................. 3302.1 74.1
    Request for Payment on Provider Record............... 3302.1 74.3
    Signature on the Request for Payment by Someone Other Than the Patient............................ 3302.5 74.4
    Request for Payment as a Claim for Hospital Insurance Entitlement............................. 3302.6 75.5
    Refusal by Patient to Request Payment Under the Program.................................... 3302.7 75.5
Filing Claims for Payment.................................... 3305 75.6
    Definition of a Claim for Payment.................... 3305.1 75.6
    Establishing Date of Filing.......................... 3305.2 75.6
    Use of Postmark to Establish Filing Date............. 3305.3 75.6

Time Limits--Cost Reimbursement

Time Limits for Requests and Claims for Payment for Services Reimbursement on a Reasonable Cost Basis........ 3307 75.7
    Usual Time Limit..................................... 3307.1 75.7
    Extension of Time Limit Due to Delay in Transmitting Reply to Notice of Admission or Start of Care....... 3307.2 75.8
    Extension of Time Limit Where Late Filing Is Due to Administrative Error........................ 3307.3 75.8
Effect on Beneficiary and Provider of Late Filing or Beneficiary's Refusal to File....................... 3308 75.11
Filing Claim Where Usual Time Limit Has Expired............ 3309 75.12
Part A Institutional Provider Services and Part A and Part B Home Health Services......................... 3309.1 75.12
    Part B Services Other Than Home Health Services (HCFA-1483 Billings)..................... 3309.2 75.13
Claims for Payment for Emergency Hospital Services and Services Outside the United States.................... 3310 75.13
Appeals.. 3311 75.14

Time Limits--Part B Charge Claims

Time Limit for Filing Part B Reasonable Charge Claims....... 3312 75.14
    Extension of Time Limit Due to Administrative Error... 3312.1 75.14
    Definition of a Part B Reasonable Charge Claim........ 3312.2 76

REQUIREMENTS FOR PAYMENT

	Section	Page
Time Limit Where Provider Has Billed Improperly for Professional Component	3312.3	76
Time Limit for Combined Billing	3312.4	76.1
Responsibility When Claim Not Filed Timely	3312.5	76.1

Restrictions on Provider Conditions for Admission

	Section	Page
Waiver of Health Insurance Benefits as a Condition of Admission	3313	76.1
Hospital Prepayment Requests and Requirements	3314	76.1
Requiring Prepayment as a Condition of Admission is Prohibited	3314.1	76.1
When Prepayment May Be Requested	3314.2	76.2
Hospital May Require Prepayment for Noncovered Services.	3314.3	76.2
Compliance with Agreement	3314.4	76.3

Certification and Recertification by Physicians for Hospital Services

	Section	Page
Certification and Recertification by Physicians--General	3315	76.3
Failure to Certify or Recertify	3315.1	76.4
Professional Standards Review Organization (PSRO) Performs Review	3315.2	76.4
Who May Sign Certification or Recertification	3316	76.4
Certification for Hospital Admissions for Dental Services	3316.1	76.5
Inpatient Hospital Services Certification and Recertification	3317	76.5
Timing of Certifications and Recertifications	3319	76.6
Inpatient Psychiatric Hospital Services Certification and Recertification	3320	78
Inpatient Tuberculosis Hospital Services Certification and Recertification	3321	79
Certification for Hospital Services Covered by the Supplementary Medical Insurance Program	3322	80
Delayed Certifications and Recertifications	3323	81
Timing of Certification and Recertification for Beneficiary Admitted before Entitlement	3324	82

Certification and Recertification by Physicians for Home Health Services

	Section	Page
Content of the Physician's Certification	3326	82
Method and Disposition of Certification	3327	83
Recertification	3328	83
Delayed Certification	3329	83.1

REQUIREMENTS FOR PAYMENT

	Section	Page

Certification and Recertification by Physicians for Extended Care Services

	Section	Page
Certification and Recertification by Physicians--Extended Care Services	3333	84
Who May Sign Certification or Recertification	3334	84.1
Certifications	3335	84.1
Recertifications	3336	84.1
Timing of Recertifications	3337	84.2
Delayed Certifications and Recertifications	3338	84.2
Disposition of Certification and Recertification Statements	3339	84.2

Tuberculosis and Psychiatric Hospital Records

	Section	Page
Tuberculosis and Psychiatric Hospital Records	3345	84.3
Inpatient Psychiatric Hospital Services	3345.1	84.3
Inpatient Tuberculosis Hospital Services	3345.2	84.3

Certification and Recertification for Outpatient Services

	Section	Page
Physician's Certification and Recertifications for Outpatient Physical Therapy and Speech Pathology Services	3350	84.5

Health Maintenance Organizations

	Section	Page
Participation of Health Maintenance Organizations (HMO's) in Medicare	3360	84.7
Definition of Emergency, Urgently Needed, and Other Covered Services	3360.1	84.9
Intermediary Involvement With Reimbursement for HMO Services	3360.2	84.10

Comprehensive Outpatient Rehabilitation Facilities

	Section	Page
Payment for Services Furnished by Comprehensive Outpatient Rehabilitation Facilities (CORFs)	3370	84.11
General	3370.1	84.11
Intermediary Designation	3370.2	84.11

Filing for Payment

3301. FILING A REQUEST FOR PAYMENT AND CLAIM FOR PAYMENT

Medicare payment of reasonable costs may not be made for hospital services, extended care services, or home health services furnished under Part A or Part B, or outpatient physical therapy or speech pathology services furnished under Part B by a rehabilitation center or public health agency, unless the beneficiary or his representative files a timely written request for payment and the provider files a timely claim. (See §§ 3307-3312.5 for an explanation of time limits.)

The provider should ask the patient to complete the request for payment at the time the covered services begin, if he is or may be a Medicare beneficiary, i.e., he is at least age 65 or there is other reason to believe he may be a beneficiary. If the beneficiary does not file his request upon admission or start of care, he may file it later with the provider or (less preferably) with an intermediary, carrier, or HCFA. Once the patient or his representative has filed his request for payment with the provider, the provider (including an emergency or foreign hospital which has elected to bill the program) must file a claim for payment (billing) with its intermediary (Health Care Financing Administration in the case of an emergency, foreign, or direct-dealing hospital.) (See §§ 3308 for provider and beneficiary liability where a claim is not filed timely.)

3301.1 Claims for Payment in Alcohol and Drug Abuse Cases-- The law requires providers to observe more stringent rules when disclosing medical information for claims processing purposes from the records of alcohol and drug abuse patients than when disclosing information for other Medicare beneficiaries. Since the standard consent statement on the provider billing form is not sufficient authority under the law to permit the provider to release information from the records of alcohol or drug abuse patients, more explicit consent statements are required.

Providers participating in the Medicare program that raise issues of confidentiality with intermediaries should be advised to obtain written consent from beneficiaries in each alcohol or drug abuse case. This written consent, which will allow the provider to disclose the records of the patient, should include all of the following:

1. The name of the organization (hospital, etc) which is to make the disclosure;

2. The name or title of the person or organization to which disclosure is to be made (e.g. the Health Care Financing Administration, including the appropriate intermediary or carrier, specified by name);

3. The name of the patient;

4. The purpose or need for disclosure (e.g. for processing a claim fo Medicare payment and for such evaluation of the treatment program as is legally and administratively required in the overall conduct of the Medicare program);

5. The specific extent or nature of information to be disclosed (e.g. all medical records regarding the beneficiary's treatment, hospitalization and/or outpatient care including treatment for drug abuse or alcoholism);

6. A statement that the beneficiary may revoke his consent at any time to prohibit disclosures on or after date of revocation;

7. A statement specifying a date (not to exceed 2 years), event, or condition upon which consent will expire without revocation;

8. The date on which the consent is signed; and

9. The signature of the patient; or the signature of his authorized or legal representative.

If the beneficiary wishes, the consent statement may be expanded to permit disclosure by the provider to any other person, organization, or program, such as PSRO, as appropriate. Authorization may also be given to HCFA and its contractors to redisclose specific information to third party payers for complementary insurance purposes.

The provider should keep the consent statement with the patient's medical and other records. The duration of the consent statement is not to exceed 2 years, after which it must be renewed by the beneficiary if further disclosures are necessary.

3302. REQUEST FOR PAYMENT

3302.1 Billing Form as Request for Payment.-- Each of the billing forms (Inpatient Hospital and Skilled Nursing Facility Admission and Billing, Form HCFA-1453; Provider Billing for Medical and Other Health Services, Form HCFA-1483; Home Health Agency Report and Billing, Form HCFA-1487; Provider Billing for Patient Services by Physicians, Form HCFA-1554; and Request for Medicare Payment, Form HCFA-1490) contains a patient's signature line incorporating the patient's request for payment of benefits, authorization to release information, and assignment of benefits. When the billing form is used as the request for payment, it must be signed. The request for payment will then be forwarded to the intermediary or carrier, or to HCFA where the provider deals directly with the Government.

A. The billing form as request for payment will be signed in connection with each inpatient hospital or skilled nursing facility admission, even though multiple admissions may occur during the same spell of illness. Only one request for payment has to be signed, however, for each inpatient admission even though an extended stay occasions multiple billings. Where a provider billing form is used as the request for payment for Part B services, a signature is required with each billing.

E. When the home health agency billing form is used as the request for payment, a single signed request ordinarily suffices for each plan. However, a subsequent signed request for payment is required if the patient's care is transferred from one home health agency to another.

Where a beneficiary wants information released to another health insurer or to a State Assistance Agency listed in item 14 of form HCFA-1487, the following authorization must be typed in the signature block (Item 15) before the beneficiary signs the form: "I authorize release of information about this claim to those listed in Item 14, upon their request."

3302.2 Request for Payment on Provider Record.—In place of signatures on billing forms, a participating provider (hospital, skilled nursing facility, home health agency, outpatient physical therapy provider, or comprehensive rehabilitation facility), ESRD facility, or independent rural health clinic may use a procedure under which the signature of the patient (or his representative under 3302.5) on its records will serve as the request for payment for services of the provider, for physician services for which the provider is authorized to bill under §3604.1, and for any other physician services furnished in the provider. In the case of physician services, claims may be submitted on either an assigned or unassigned basis.

To implement this procedure, the provider must incorporate language to the following effect in its records:

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patient.

NAME OF BENEFICIARY
HI CLAIM NUMBER

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (name of provider), including physician services. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

For services furnished to inpatients of a hospital, or SNF, the request is effective for the period of confinement. For services furnished by or in a provider on an outpatient basis, the request is effective until revoked. If a patient objects to part of the request for payment, the provider should annotate the statement accordingly and notify any physician affected.

best copy available

representative of an institution (other than the provider) usually responsible for his care, or a representative of a governmental entity providing welfare assistance, if present at time of admission or start of services, should be asked and permitted to sign on his behalf.

A. Provider Signs Request.—If, at the time of admission or start of care, the patient cannot be asked to sign the request for payment and there is no person present exercising responsibility for him, an authorized official of the provider may sign the request. Except in the outpatient case described below, where the patient is not physically present, a provider should not routinely sign the request on behalf of any patient. If experience reveals an unusual frequency of such provider-signed requests from a particular provider, the matter will be subject to review by the intermediary.

The hospital or SNF need not attempt to obtain the patient's signature where the physician sends a specimen (e.g., blood or urine sample) to a laboratory of a participating hospital or SNF for analysis, the patient does not go to the hospital or SNF, but the tests are billed through that provider. The hospital or SNF may sign on behalf of the patient and should note in the space provided for the patient's signature in Item 12 on the Provider Billing for Medical and Other Health Services (SSA-1483) and any accompanying Provider Billing for Patient Services by Physicians (SSA-1554), "Patient not physically present for tests." This does not apply in cases in which the patient actually goes to the hospital or SNF laboratory for tests and the provider fails to obtain the patient's signature while he is there.

If it is impractical to obtain the patient's signature because a home health agency does not make a visit to his home (e.g., the physician certifies that the patient needs a certain item of durable medical equipment but no visits are certified), the agency may furnish the equipment and need not obtain the patient's signature. An agency representative should sign on behalf of the patient and write in Item 12 of the SSA-1483 "Patient not visited."

B. Patient Dies.--If the patient dies before the request for payment is signed, it may be signed by the legal representative of his estate, or by any of the persons or institutions (including an authorized official of the provider) who could have signed it had he been alive and incompetent.

A request for payment for inpatient hospital services filed with the hospital may serve as an application for HI entitlement when filed by or on behalf of a live patient, but not when filed on behalf of a deceased patient. (See § 3302.5.)

C. Need for Explanation of Signer's Relationship to Patient.--When someone other than the patient signs the request for payment, the signer will submit a brief statement explaining his relationship to the patient and the circumstances which made it impracticable for the patient to sign. The provider will forward this statement with its billing, or retain it in its files if the signature is obtained on the provider's own record. The intermediary will generally accept such a statement as representing the true facts of the case in the absence of evidence to the contrary. If such a statement is not forwarded, and development is needed for some other reason, the intermediary will ask the provider to furnish the explanation of relationship and circumstances. However, processing the claim should not ordinarily be delayed to obtain the explanation if nothing else prevents payment.

3302.6 Request for Payment as a Claim for Hospital Insurance Entitlement.--To become entitled to hospital insurance, an individual must not only be eligible, but must also, prior to his death, apply for such entitlement (or for monthly social security benefits) with SSA. Even though he meets all eligibility requirements, if he does not file the necessary application before death, he cannot be entitled to Part A benefits and no payment can be made under the HI program for his hospital services.

Occasionally a patient aged 65 or over who is admitted to a hospital, though eligible, has never applied for monthly benefits and has no health insurance card. In very rare instances he may have a card even though he has not filed the necessary application. To protect the eligible patient, his estate, and the hospital against the possibility that timely application will not be filed with SSA, a written request for title XVIII payment filed with the hospital may serve as an application for hospital insurance entitlement filed with SSA. The request must be filed with the hospital prior to the death of the patient. A presribed application form properly executed must be filed with SSA within 6 months of the date of SSA's written notice to a proper applicant of the need for such application. Section 308 of the Hospital Manual contains the details of this procedure.

This function of the written request as an informal claim for HI entitlement under certain conditions is distinct from its far more general and basic function as a request that payment may be made on behalf of an entitled individual to the provider. A request for payment in this latter sense can validly be executed after the death of the entitled individual.

3302.7 Refusal by Patient to Request Payment Under the Program.--A patient on admission to a hospital or skilled nursing facility may refuse to request Medicare payment and agree to pay for his services out of his own funds or from other insurance. Such patients may have a philosophical objection to Medicare or may feel that they will receive better care if they pay for services themselves or they are paid for under some other insurance policy. The patient's impression that another insurer will pay for the services may or may not be correct, as some contracts expressly disclaim liability for services covered under Medicare. Where the patient refuses to request Medicare payment, the provider should obtain his signed statement of refusal wherever possible. If the patient (or his representative) is unwilling to sign, the provider should record that the patient refused to file a request for payment but was unwilling to sign the statement of refusal.

In any event, there is no provision which requires a patient to have covered services he receives paid for under Medicare if he refuses to request payment. Therefore, a provider may bill an insured patient who positively and voluntarily declines to request Medicare payment. However, if such a person subsequently changes his mind (because he finds out his other insurance will not pay or for another reason) and requests payment under the health insurance program within the prescribed time limit, the provider must bill the intermediary. If the provider is reimbursed under Medicare it should then refund to the patient any amounts he paid in excess of the permissible charges.

Where a patient who has declined to request payment dies, his right to request payment may be exercised by the legal representative of his estate, by any of the persons or institutions mentioned in the second paragraph of § 3302.4, by a person or institution which paid part or all of the bill, or in the event a request could not otherwise be obtained, by an authorized official of the provider. This permits payment to the provider for services which would not otherwise be paid for and allows a refund to the estate or to a person or institution which paid the bill on behalf of the deceased.

See § 3308 for affect on beneficiary and provider of refusal to file.

3305. FILING CLAIMS FOR PAYMENT

3305.1 Definition of a Claim for Payment.--A provider has filed a claim for an item or service reimbursable on a cost basis if it submits to its intermediary an SSA billing form that includes the item or service. The fact that the item or service is shown on the wrong form (e.g., Part B ancillary services on an SSA-1453 rather than SSA-1483), or under the wrong item of the form, (e.g., a blood processing service under "blood") is immaterial if it is clear or can be established that the provider was claiming reimbursement for the item or service.

3305.2 Establishing Date of Filing.--Whenever the last day for timely filing of a claim for payment falls on a Saturday, Sunday, legal holiday, or other day all or part of which is a nonworkday for Federal employees because of Federal statute or executive order, the claim will be considered timely if it is filed on the next workday.

3305.3 Use of Postmark to Establish Filing Date.--Where the provider claim is submitted to the intermediary by mail, if it is material and to the advantage of the provider, the claim can be considered filed on the day the envelope was postmarked in the United States. Thus, where an undated claim is received by the intermediary in the mail early in the month after the filing date, the envelope should, if practical, be retained. If, in such a case, an envelope with a legible postmark is not available, a 7-day tolerance will usually apply. For example, a claim for services provided in May 1976 received by an intermediary on or before January 10, 1978, may be presumed by the intermediary, in the absence of evidence to the contrary, to have been mailed on or before January 3, 1978 (which is the date the time limit expires because it is the first Federal workday after Saturday, December 31). This rule will be applicable where the claim was mailed within the contiguous 48 States and the District of Columbia and received by an intermediary within such States. In other cases, the reasonable tolerance may be longer and will depend on the usual mailing time under the particular circumstances.

Time Limits--Cost Reimbursement

3307. TIME LIMITS FOR REQUESTS AND CLAIMS FOR PAYMENT FOR SERVICES REIMBURSED ON A REASONABLE COST BASIS

Program payment of reasonable costs may not be made under Part A or Part B for provider services (including emergency services) unless the beneficiary or his representative has filed a timely request for payment, and the provider has filed a timely claim. (See § 3301.)

3307.1 Usual Time Limit.--Effective with claims filed after December 31, 1974, the beneficiary request and the provider claim must be filed on or before December 31 of the calendar year following the year in which the services were furnished except as provided in §§ 3307.2 and 3307.3 below. Services furnished in the last quarter of the year are considered furnished in the following year; i.e., the time limit is 2 years after the year in which such services were furnished.

EXAMPLE 1: A Medicare beneficiary received inpatient hospital services at General Hospital in September 1974. The beneficiary signed a request for Medicare payment at the time of admission. The hospital immediately submitted an admission notice and received a prompt reply. The provider billing for the services must be filed with the intermediary on or before December 31, 1975, the close of the year following the year in which the services were furnished.

EXAMPLE 2: A Medicare beneficiary received diagnostic tests at the outpatient department of General Hospital in November 1974 but did not inform the hospital of his entitlement to Part B of Medicare at that time. His request for Medicare payment must be filed with the provider and the provider billing must be filed with the intermediary by December 31, 1976, the close of the year following the year the services were "furnished." (The services furnished in November 1974 are deemed to be furnished in 1975.)

3307.2 Extension of Time Limit Due to Delay in Transmitting Reply to Notice of Admission or Start of Care.--For purposes of the time limit in § 3307.1, a provider shall be deemed to have filed a claim for payment for inpatient hospital services, posthospital extended care services, or home health services on the date it submitted an admission or start of care notice for such services, provided the claim is submitted within 60 days after the intermediary or Social Security Administration, as appropriate, replied to the admission or start of care notice. Where the provider is establishing timely filing of the claim on this basis (i.e., the claim would not otherwise be timely filed), it should so note on the billing or an attachment to the billing, and indicate the date the admission notice was sent and the date the reply was received.

3307.3 Extension of Time Limit Where Late Filing Is Due to Administrative Error.—Where SSA error (i.e., misrepresentation, delay, mistake, or other action of SSA or its intermediaries or carriers) causes the failure of the provider to file a claim for payment within the time limit in § 3307.1, the time limit will be extended through the last day of the sixth calendar month following the month in which the error is rectified by notification to the provider or beneficiary, but not beyond December 31 of the third calendar year after the year in which the services were furnished. (For services furnished during October - December of a year, the time limit may be extended no later than the end of the fourth year after that year.)

The administrative error which prevents timely filing of the claim may affect the provider directly (or indirectly, i.e., by preventing the beneficiary or his representative from filing a timely request for payment). Situations in which failure to file within the usual time limit in § 3307.1 will be considered to have been caused by administrative error include but are not limited to the following:

1. The failure resulted because the individual's entitlement to HI or SMI was not established until long after the month for which it is effective (e.g., a beneficiary is awarded 2 years of retroactive coverage).

2. The failure resulted from SSA's failure to notify the individual that his entitlement to HI or SMI had been approved, or in giving him (or his representative or the provider) cause to believe that he is not entitled to HI or SMI.

3. The failure resulted from misinformation from SSA or the intermediary or carrier, e.g., that certain services were not covered under HI or SMI, although in fact they were covered.

4. The failure resulted from excessive delay by SSA, the intermediary, or the carrier in furnishing information necessary

for the filing of the claim (see § 3307.2 concerning delay in replying to the provider's admission or start of care notice).

5. The failure resulted from advice by SSA or an authorized agent for SSA that precluded the filing of a claim until the provider receives certain information from the intermediary (e.g., a hospital following manual instructions does not file a billing for outpatient services where the services are expected to be paid for by workmen's compensation; but the hospital learns after the expiration of the time limit of the ultimate denial of workmen's compensation liability).

Any claim involving situations other than those listed above, where it appears that an extension of the time limit might be justified on the basis of administrative error should be submitted with a recommendation, before payment, to Social Security Administration, Beneficiary Eligibility Branch, BHI, 1-H-5 East Building, Baltimore, Maryland 21235. Also, any claim, whether involving the situations listed above or others, in which administrative error prevented timely filing until after the close of the third year following the year in which the services were furnished (fourth year, in the case of services furnished in the October - December quarter) should be submitted to that address for advice before denial action.

EXAMPLE 1: Information submitted in connection with a claim for services during the period May 1974 - September 1974, filed in March 1976, shows that the beneficiary's application for HI was initially denied. He was first notified on January 15, 1976, that he had HI effective May 1974. Under these circumstances, the intermediary may pay appropriate HI benefits for the services. Although the usual time limit expired December 31, 1975, the error in this case--delay in establishing HI entitlement--was not corrected until January 15, 1976, thus extending the time limit to July 31, 1976.

EXAMPLE 2: An individual requested enrollment in SMI in March 1975, the month before he attained age 65. He received covered outpatient services in July 1975, but did not request payment because he had received no notice of his SMI entitlement. Such notice was mailed to him on October 3, 1976. Although the regular time limit for the services in July 1975 expired on December 31, 1976, the claim will be considered promptly and timely filed if it is filed on or before April 30, 1977 (within the 6-month period following the month in which the notice was sent).

A. Developing Administrative Error.--Where administrative error is alleged to be responsible for late filing, the necessary evidence would ordinarily include:

1. A statement from the beneficiary, his representative or the provider, depending on whom the error directly affected, as to how he learned of the error, and when it was corrected, and one of the following:

2. A written report by the agency (SSA, carrier, intermediary) based on agency records, describing how its error caused failure to file within the usual time limit; or

3. Copies of an agency letter or written notice reflecting the error; or

4. A written statement of an agency employee having personal knowledge of the error.

However, the statement of the beneficiary, his representative, or the provider is not essential if the other evidence establishes that his failure to file within the usual time limit resulted from administrative error, and that he filed a claim within 6 months after the month in which he was notified that the error was corrected. There must be a clear and direct relationship between the administrative error and the late filing of the claim. Where the evidence is in the intermediary's own records, it should note the claims file to this effect.

B. Coordinating Claims Which Involve Administrative Error.--Where the initial allegation of administrative error on the part of the Government is made to SSA, the servicing social security office (SSO) will forward any necessary report, statement and/or other evidence to the intermediary and will obtain and forward a request by the beneficiary or his representative for Medicare payment if such request was not previously filed with the provider or intermediary. The intermediary will then obtain a billing from the provider if not previously submitted.

If an allegation that administrative error caused late filing is made to the intermediary or if the information furnished by the SSO is incomplete the intermediary will request the necessary evidence (see A above) from the SSO servicing the beneficiary. Such request may be made on Form SSA-1980 (Carrier or Intermediary Request for SSA Assistance) and, unless regional office instructions provide otherwise, will be made through the parallel SSO. (See § 3706.) Where another carrier or intermediary allegedly caused the delay, the request for necessary information and evidence may be made by letter directly to the other carrier or intermediary.

Where covered expenses in excess of deductible and coinsurance exceed $100 and the provider has assigned responsibility for the late filing to the beneficiary (or his representative), corroboration of such responsibility should be obtained since otherwise the beneficiary could be forced to pay substantial charges for which he may not be liable. If the provider has not obtained a written explanation of the circumstances from the beneficiary, and there is no other corroboration of such responsibility, the intermediary should request the assistance of the SSO in obtaining it. Corroboration may be in the form of a signed statement, a report of the oral explanation given by the beneficiary (or his representative or relative) of the late filing, or pertinent information in the SSO's own files.

C. Intermediary Decides Whether Time Limit Will Be Extended.—The intermediary has the responsibility for deciding, on the basis of all pertinent circumstances, whether a late claim may be honored. The intermediary may ordinarily accept a statement from some other component which shows whether there was an administrative error which could reasonably have prevented or deterred the claimant from filing within the usual time limit. Similarly, the intermediary will ordinarily accept a statement from the component which corrected the error as to whether and when this was done. However, where information submitted to the intermediary by another component involved in HI or SMI administration is incomplete or questionable, the intermediary may request clarification.

3308. EFFECT ON BENEFICIARY AND PROVIDER OF LATE FILING OR BENEFICIARY'S REFUSAL TO FILE

A. Provider Is Responsible for Not Filing Timely.—Where the beneficiary request was filed timely (or would have been filed timely had the provider taken action to obtain a request from the patient whom the provider knew or had reason to believe might be a beneficiary) but the provider is responsible for not filing a timely claim, the provider may not charge the beneficiary for the services except for such deductible and/or coinsurance amounts as would have been appropriate if Medicare payment had been made. The beneficiary is charged utilization days. (See § 3610.1B.)

B. Patient Refuses to Request Medicare Payment or Provider Is Unaware of His Eligibility.—The provider may charge the beneficiary for covered services where no timely request for payment is filed by or on behalf of the beneficiary because:

(1) the beneficiary refused to file. (The deductible is credited to his SSA record and utilization days are charged.) Or

(2) the patient failed to bring his entitlement or possible entitlement to the attention of the provider and the provider had no other reason to believe the patient had Medicare. If the patient later brings his entitlement to Part A or Part B (whichever is required for payment for the services) to the provider's attention after the time limit and the bill is not filed timely, the deductible and coinsurance will not be credited and utilization days will not be charged.

C. Late Filing Reveals Continuation of Benefit Period.—The services furnished in (2) above could affect a benefit period in which later services were furnished by linking together what were originally thought to be two benefit periods. For example: Claims were timely filed and payment made for 75 days of inpatient hospital services at hospital A during the period July 20 - October 3, 1975, and 25 days of inpatient hospital services furnished at hospital C during the period January 15 - February 9, 1976. After the expiration of the time limit, the beneficiary requested payment for 2 days of inpatient hospital services furnished at hospital B during the period November 26 - 28, 1975. Although the untimely request for payment for 2 days did not result in charging the 2 days against his utilization record, it did reveal that the stay in hospital C was in the same benefit period as the stay in A. Thus, assuming that lifetime reserve days were previously exhausted, only 15 days of coverage were available for the stay in hospital C and overpayment was made for the remaining 10 days of the stay.

Do not collect any overpayment from either the beneficiary or provider based on the continuation of a benefit period that was revealed when the beneficiary filed a late request for payment as illustrated in the example above, unless evidence shows that the overpayment was the result of fraud or similar fault. (See §3709.1.) Collection of such an overpayment would be inequitable since it would impose another penalty because of the late filing, in addition to the denial of the late bill.

Since corrected bills are required in such overpayment cases, follow the procedure in §3711.8 to assure that the provider does not have the overpayment recouped in the cost settlement. Report the overpayment to SSA by letter.

3309. FILING CLAIM WHERE USUAL TIME LIMIT HAS EXPIRED

As a general rule, where you receives a late filed claim submitted by a provider with no explanation attached as to the circumstances surrounding the late filing, assume that the provider accepts responsibility for the late filing.

Where it comes to the attention of a provider that health services which are or may be covered were furnished to a beneficary but that the usual time limit in §3307.1 on filing a claim for such services has expired, the provider should take the following action.

3309.1 Part A Institutional Provider Services and Part A and Part B Home Health Services.--Where the provider accepts responsibility for late filing, it should file a no-payment bill. (See §§3610ff.) Where the provider believes the beneficiary is responsible for late filing, it should also file a no-payment bill and attach a statement explaining the circumstances which led to the late filing and giving the reasons for believing that the beneficiary (or other person acting for him) is responsible for the late filing and, if practicable, attach the statement of the beneficiary as to his view on these circumstances.

Where the provider believes SSA or its agents are responsible for the late filing, it should file a regular payment bill and attach a statement explaining the circumstances which led to the late filing. If SSA, you, or carrier error prevented the beneficiary or his representative from filing a timely request for payment, if practicable, the provider should obtain the written explanation of the beneficiary as to the circumstances.

3309.2 Part B Services Other Than Home Health Service.--Where the provider accepts the responsibility for the late filing, it submits a no-payment bill.

Where the provider believes the beneficiary is responsible for late filing, it files a no-payment bill, attaches a statement explaining the circumstances which led to late filing and setting forth reasons for belief that the beneficiary (or person acting for him) is responsible for the late filing and, if practicable, attaches the statement of the beneficiary as to his view of the circumstances. Where the provider believes SSA or its agent is responsible for the late filing, it proceeds as in §3309.1.

3310. CLAIMS FOR PAYMENT FOR EMERGENCY HOSPITAL SERVICES AND SERVICES OUTSIDE THE UNITED STATES

The time limit for requests and claims for payment for emergency hospital services and hospital services outside the United States, whether or not the hospital has elected to bill the program, is the same as for participating hospitals. (See §§3307ff.) Where the hospital has not elected to bill Medicare, the beneficiary claims payment for emergency hospital services in the United States and hospital services outside the United States.

The beneficiary may also claim payment for physician and ambulance services furnished in connection with foreign hospitalization. The time limit for claims involving these services is the same as for other services reimbursed on a reasonable charge basis. (See §3312.)

The claim for emergency hospital services and other services outside the United States will be considered timely filed if filed with any carrier or intermediary within the time limit.

3311. APPEALS
Where the beneficiary does not agree with the determination that the claim was not filed timely or with the assignment to him of the responsibility for the late filing, the usual appeal rights are available to him, i.e., reconsideration, hearing (if the amount in controversy equals $100 or more), etc. (See §§ 3780ff.) Where the provider is protesting the denial of payment or the assignment of responsibility, no formal channels of appeal are available. However, the intermediary may, at the request of the provider, informally review its initial determination.

Time Limits--Part B Charge Claims

3312. TIME LIMIT FOR FILING PART B REASONABLE CHARGE CLAIMS
For Medicare payment to be made for a claim for physician and other Part B services reimbursable on a reasonable charge basis (including those services for which the charge is related to cost) the claim must be filed no later than the end of the calendar year following the year in which the service was furnished, except for services furnished in the last 3 months of a year, where the time limit is December 31 of the second year following the year in which the services were rendered. This time limit was effective with claims filed after March 1968. (See §§ 3305.2 and 3305.3 for effect of Federal nonworkdays and rules applicable to claims received in the mail.)

EXAMPLE: An enrollee received laboratory tests at a nonparticipating hospital in August 1975. The claim for reimbursement for such services must be billed on or before December 31, 1976. If the tests were performed in October 1975, the claim must be filed on or before December 31, 1977.

3312.1 Extension of Time Limit Due to Administrative Error.--Consideration of possible extension of the time limit on Part B reasonable charge claims will be initiated only if there is a basis for belief that the claimant (the enrollee or his representative or assignee) has been prevented from timely filing by an administrative error; for example, he states that official misinformation caused the late filing, or the social security office calls to the intermediary's attention a situation in which such error has caused late filing.

Where administrative error (that is, misrepresentation, delay, mistake, or other action of SSA or its intermediaries or carriers) causes the failure of the beneficiary or the providers, physicians, and suppliers to file a claim for payment within the time limit specified in § 3312, the same evidence requirements and development procedures apply as set forth in § 3307.3.

312.2 Definition of a Part B Reasonable Charge Claim.--For purposes of this time limit, a claim is any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program for medical services of a specified nature to an identified enrollee. For example, a note from the enrollee's spouse or a bill for ancillary services in a nonparticipating hospital could constitute a claim for payment.

If such a claim is mailed or delivered to SSA or to any carrier or intermediary within the time limit, the claim is filed timely provided the necessary claims information (e.g., SSA-1490 and itemized bill in the case of an enrollee-filed claim, SSA-1483 in the case of a nonparticipating hospital-filed claim) is submitted within the time limit or, if later, within 6 months after the month in which the claimant is advised to furnish it.

312.3 Time Limit Where Provider Has Billed Improperly for Professional Component.--In some cases, a hospital or other provider may have incorrectly billed for a Part B professional component as a provider expense. For example, a physician's services were erroneously considered entirely administrative in nature and the error was not discovered until the final cost settlement. Where the claim which included the physician services was filed within the time limit, it establishes protective filing for a subsequent perfection of a Part B claim. Such claims will be considered filed as of the date the incorrect billing was submitted to the intermediary provided the usual claims information (e.g., the SSA-1554 in the case of a hospital-filed claim) is submitted within 6 months after the month in which the notice was sent that payment for the patient care services was disallowed.

The perfected claim may be filed by the physician on the basis of assignment, or by the hospital (where the hospital has a contractual arrangement to bill and receive payment for the physician's services) or may be filed by the patient on the basis of an itemized bill. The carrier and intermediary should make their own arrangements regarding exchange of information and submission of the delayed claims. When there are claims for more than one patient or more than one claim for a single patient it is preferable that they be submitted as a group.

A provider claim filed within the Part B time limit will not establish a filing date for the related professional component where such component was recognized and not included in the provider bill, e.g., no claim was filed for the professional component as a nonprovider expense because the physician and hospital could not agree on the exact amount of the component charge or who would bill for it.

3312.4 Time Limit for Combined Billing.--Where the hospital bills for physician and hospital services under the combined billing procedure (see § 3604.1) presume that the billing is timely filed as to the physician component if it is timely filed as to the hospital component and that it is not timely as to the physician component if it is not timely filed as to the hospital component.

3312.5 Responsibility When Claim Not Filed Timely.--Where the time limit has expired on services reimbursable on a reasonable charge basis, there is no requirement that a billing be filed. However, where a person (or organization) accepts assignment within the time limit but fails to submit a timely claim, he is barred by the terms of the assignment from collecting from the patient or others amounts in excess of the deductible and coinsurance for the services involved.

Restrictions on Provider Conditions for Admission

3313. WAIVER OF HEALTH INSURANCE BENEFITS AS A CONDITION OF ADMISSION

It is not permissible for a provider to require as a condition of admission or treatment that a patient agree to waive his right to have provider services paid for under Medicare. Requiring such a "waiver" is inconsistent with the provider's contract with SSA and the waiver is not binding on the patient. Each participating provider agrees not to charge an individual (except for specified deductible and coinsurance amounts) for services for which such individual is entitled to have payment made or for which he would be so entitled if the provider complied with the procedural and other requirements of the program. Further, under this provision the provider must refund any amounts incorrectly collected.

Where a patient who has signed such a waiver nevertheless requests payment under the health insurance program, the provider must bill the intermediary for the services and refund any payments made by the patient or on his behalf in excess of permissible charges.

3314. HOSPITAL PREPAYMENT REQUESTS AND REQUIREMENTS

3314.1 Requiring Prepayment as a Condition of Admission Is Prohibited.--Hospitals may not require advance payment of the Part A inpatient deductible or coinsurance as a condition of admission for inpatient services. In addition, hospitals may not require that the beneficiary prepay any Part B charges as a condition of his admission except when all of the following conditions are met and when they are met, the hospital can collect no more than any unmet Part B cash deductible: (Where the patient does not have Part B entitlement, see § 3314.3.)

A. The hospital regularly requires prepayment from all other patients who have comparable insurance or other protection assuring satisfaction of substantially all hospital charges or costs.

B. The beneficiary is expected to incur expenses for the services of a salaried physician employed by the hospital and such services are subject to the cash deductible and coinsurance provisions of Part B. (Radiological and pathological services performed by physicians in the fields of radiology and pathology are not subject to either the deductible or coinsurance. See § 3146C.) A hospital cannot deny admission to a beneficiary for failure to prepay physician charges which the hospital is collecting only on behalf of a physician.

C. The beneficiary has medical insurance (Part B) coverage but has not met his Part B deductible or cannot, upon being asked, submit evidence that he has met the deductible.

3314.2 When Prepayment May Be Requested.--In admitting a beneficiary, hospitals may request the deductible or coinsurance amounts only where it appears that the patient will owe such amounts and it is the hospital's routine and customary policy to request similar prepayment from nonbeneficiary patients with hospital insurance (or similar benefits) which leaves them responsible for a small part of the cost of their hospital services. In admitting the patient, such a hospital should ascertain whether he has medical insurance coverage, and where he does, should ask if he has an Explanation of Monthly Benefits form showing his deductible status. If a beneficiary with medical insurance coverage shows that he has met the Part B cash deductible, the hospital should not request or require prepayment of the deductible.

Except in the rare cases where prepayment may be required, any request for payment must be made as a request and without undue pressure; the beneficiary (and his family) must not be given cause to fear that admission will be denied for failure to make the advance payment.

Hospitals should insure that all their admitting office personnel are informed and kept fully aware of the hospital's policy on prepayment, which must be consistent with this section. For this purpose, and for the benefit of the hospital and the public, it would be desirable that a notice be posted prominently in the admitting office or lobby of the hospital to the effect that no patient will be refused admission for inability to make an advance payment or deposit if Medicare is expected to pay for his hospital costs.

3314.3 Hospital May Require Prepayment for Non-Covered Services.--With regard to noncovered services (i.e., personal comfort items, a private duty nurse, etc.), a hospital may deny such services for which the beneficiary has not paid or offered satisfactory assurance of payment if that is the hospital's practice with its nonbeneficiary patients. For example, a hospital need not furnish a private room or TV set to a patient who requests it but is unable to prepay or offer the assurance of payment which the hospital usually requires.

In cases where the aged person has exhausted his covered inpatient hospital benefits and in cases where an aged applicant cannot supply satisfactory evidence of entitlement under Part A, the hospital is free to apply to such persons its usual policy with respect to requiring prepayment or other assurance of payment where the patient has no insurance. Also, for that small minority of beneficiaries receiving covered inpatient services who are not enrolled for medical insurance (Part B), a hospital is free to apply its usual policy on prepayment or assurance of payment with regard to services of salaried physicians provided by the hospital.

3314.4 Compliance with Agreement.-- It is anticipated that most hospitals will conform to the policy set forth in this instruction. However, the intermediary should be alert for any information that would indicate the possibility of a violation. The Health Care Financing Administration (HCFA) regional offices should refer to the intermediary for investigation the names of hospitals which, according to beneficiary complaints, require prepayment or apply undue pressure to obtain prepayments in violation of the rules above. Intermediaries should contact the appropriate hospital officials to review with them the policy on prepayments, and try to obtain the hospital's agreement to discontinue this practice. Noncompliance will be considered in determining whether the hospital is honoring its agreement under which the hospital may not charge for services for which payment may be made under the Medicare program. A report of the results of the contact should be forwarded to the regional office.

Certification and Recertification by Physicians for Hospital Services

3315. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS-- GENERAL.

Payments may be made for covered hospital services only if a physician certifies and recertifies to the medical necessity for the services at designated intervals of the hospital inpatient stay. Appropriate supporting material may be required. The physician certification or recertification statement must be based on a current evaluation of the patient's condition.

For patients admitted to a general hospital whether or not the patients are under the prospective payment system (PPS), which is applicable to patients who are discharged in hospital fiscal years beginning on or after October 1, 1983 a physician's certificaton is not required at the time of admission for inpatient services. For services continued over a period of time or for a day outlier case (i.e., an appropriately admitted case results in an extraordinary long stay) or for a PPS cost outlier case (i.e. an appropriately admitted case results in the expenditure of extraordinary resources) a physician must certify or recertify the continued need for the services at specified intervals. (See § 3319 for timing of physicians certification and recertification. See § 3637.5 for definition of outlier.) Psychiatric and tuberculosis hospitals (which are excluded from PPS) are required to obtain a physician's certification on admission.

Hospitals will not transmit physician certification and recertification statements to the intermediary, or to the Health Care Financing Administration (HCFA) if the hospital deals directly. The hospital must itself certify, on the appropriate billing form, that the required physician certificaton and recertification statements have been obtained and are on file. The physician certification and recertification statements will be retained in the hospital's files where they will be available for verification, if needed.

A hospital must also have available in its files a written description of the procedure it adopts on the timing of certifications and recertifications, that is, the intervals at which the necessary certification statements will be required and whether review of long-stay cases by the utilization review committee will serve as an alternative to recertification by a physician in the case of the second or subsequent recertification.

3315.1 Failure to Certify or Recertify.-- If a hospital fails to obtain the required certification and recertification statements in an individual case, program payment cannot be made in that case.

If the hospital's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's refusal to certify based on other grounds (e.g., he objects in principle to the concept of certification and recertification), the hospital may not bill the program or the beneficiary for covered items or services. The provider agreement which the hospital files with the Secretary precludes it from charging the patient for covered items and services.

3315.2 Professional Standards Review Organization (PSRO) Performs Review.-- In those hospitals where a conditionally designated or operational PSRO has assumed responsibility for the performance of review, the PSRO statutory physician certification requirements will apply in lieu of Medicare's physician certification requirements. Such hospitals will not be required to comply with the physician certification requirements set forth in §§ 3317 and 3319. Intermediaries reviewing bills from these hospitals will no longer be responsible for verifying their certifications (see §3620, Item 29). Where a PSRO determines that a patient no longer requires hospital care and that continued care could be appropriately provided in an SNF, the inpatient hospital stay may continue to be covered as long as the patient needs a covered level of SNF care and no SNF bed is available in the area. Hospital records must adequately document the lack of available SNF beds. The patient's physician should place the patient in an SNF as soon as a bed becomes available.

3316. WHO MAY SIGN CERTIFICATION OR RECERTIFICATION.

A certification or recertification statement must be signed by the attending physician responsible for the case, or by another physician who has knowledge of the case and is authorized to do so by the attending physician, or by a member of the hospital's medical staff with knowledge of the case.

Ordinarily for purposes of certification and recertification, a "physician" must meet the definition in §§3030 and 3030.3.

3316.1 Certification for Hospital Admissions for Dental Services.—The attending doctor of dental surgery or of dental medicine is authorized to certify that the patient's underlying medical condition and clinical status, or the severity of the dental procedure, requires the patient to be admitted to the hospital for the performance of the dental procedure (see §3101.7); and to recertify the patient's continuing need for hospitalization when required. This applies even if the dental procedure is not covered.

3317. INPATIENT HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION

A Contents of Statement.—A certification or recertification statement must contain the following information:

o an adequate written record of the reason for either:

— continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study, or

— special or unusual services for cost outlier cases for hospitals under the prospective payment system (PPS);

o the estimated period of time the patient will need to remain in the hospital and, for cost outlier cases, the period of time for which the special or unusual services will be required; and

o any plans for posthospital care.

B. Selection by Hospital of Format and Method for Obtaining Statement.—The individual hospital determines the method by which certifications and recertifications are to be obtained and the format of the statement. Thus, the medical and administrative staffs of each hospital may adopt the form and procedure they find most convenient and appropriate.

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Health Care Financing Administration where the hospital deals directly with the government) to determine that the certification and recertification requirements are, in fact, met. The certification or recertification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate form could be used. If all the required information is included in progress notes, the physician's statement could indicate that the individual's medical record contains the information required and that continued hospitalization is medically necessary.

C. Criteria for Continued Inpatient Stay.—A physician who certifies or recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital's utilization review committee (§§3421ff).

These criteria include not only medical necessity, but also the availability of out-of-hospital facilities and services which will assume continuity of care. A physician should certify or recertify need for continued hospitalization if the physician finds that the patient could receive treatment in an SNF but no bed is available in the participating SNF. Where the basis for the certification or recertification is the need for continued inpatient care because of the lack of SNF accommodations, the certification or recertification should so state. The physician is expected to continue efforts to place the patient in a participating SNF as soon as the bed becomes available.

D. Utilization Review (UR) in Lieu of Separate Recertification Statement.—For cases not subject to PPS and for PPS day outlier cases a separate recertification statement is not necessary where the requirements for the second or subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the hospital's UR plan. However, it is necessary to satisfy the certification and recertification content standards. It would be sufficient if records of the UR committee show that consideration was given to the three items mentioned above— the reasons for continued hospitalization (e.g., consideration was given to the need for special or unusual care in cost outlier status under PPS), estimated time the patient will need to remain in the hospital (e.g., the time period during which such special or unusual care would be needed), and plans for posthospital care.

3319. TIMING OF CERTIFICATIONS AND RECERTIFICATIONS.

A. Admissions on or after January 1, 1970 for Non-PPS hospitals.—For services furnished to beneficiaries admitted on or after January 1, 1970, the initial certification is required no later than as of the 12th day of hospitalization. A hospital may at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories. The first recertification is required no later than as of the 18th day of hospitalization. Subsequent recertifications must be made at intervals established by the UR committee (on a case-by-case basis), but in no event may the interval between recertifications exceed 30 days.

The UR committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed.

A hospital can, if it wishes, coordinate its physician recertifications with the process of review by the UR committee of longstay cases not subject to PPS, and for PPS day - outlier cases. At the option of the hospital, review of a stay of extended duration under the hospital's utilization review plan may take the place of the second and any subsequent physician recertifications. (Such review may be the initial review, or a second or subsequent review of an extended case by the UR committee.)

Where review of an extended stay case by the UR committee is deemed to take the place of a physician recertification, it would be possible for the recertification to be made later than the specified day, because the review of an extended duration case may be made at any time within the 7-day period following the last day of the period of extended duration defined in the utilization review plan. Such a recertification will be treated as a delayed recertification; however, no explanation for the normal delay is required.

B. Patients Discharged During Hospital Fiscal Years Beginning on or after October 1, 1983 Under PPS -- For cases subject to the prospective payment system (PPS), certification is not required at the time of admission for inpatient services. The admission is reviewed by a hospital review organization upon discharge of the patient. For day and cost outlier cases the certification is required as follows:

(1) For day - outlier cases, certification is required no later than one day after the hospital reasonably assumes that the case meets the established outlier criteria, or no later than 20 days into the hospital stay, whichever is earlier.

The first and subsequent recertifications are required at intervals established by the utilization review committee, on a case-by-case basis if it so chooses, but not less than every 30 days.

(2) For cost - outlier cases, if possible, certification must be made before the hospital incurs cost for which it will seek cost outlier payment. However, certification is required no later than the date on which the hospital requests cost outlier payment or 20 days into the hospital stay, whichever is earlier.

For cost outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee, on a case-by-case basis if it chooses.

As previously stated the UR committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed. (See § 3319A above if a hospital wishes to coordinate its physician recertifications with the process of review by the UR committee of long-stay cases not subject to PPS, and for PPS day - outlier cases). Review by the UR committee used in place of recertification for PPS day outlier cases is considered timely if performed within 7 days after the physician recertification would have been required.

C. Admissions Between January 3, 1968, and December 31, 1969.-- For services furnished to beneficiaries admitted on or after January 3, 1968, and prior to January 1, 1970, the procedures in A. above were applicable but the timing of the certification and recertification was at longer intervals. The initial certification was required no later than as of the 14th day of hospitalization. The first recertification was required no later than as of the 21st day of hospitalization. Subsequent recertifications must have been made at intervals established by the utilization review committee (on a case-by-case basis if it so chooses) but not exceeding 30 days.

3320. INPATIENT PSYCHIATRIC HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION.

The requirements for physician certification and recertification for inpatient psychiatric hospital services are similar to the requirements for certification and recertification for inpatient hospital services. However, there is an additional certification requirement: At the time of admission or as soon thereafter as is reasonable and practicable, a physician (the admitting physician or a medical staff member with a knowledge of the case) must certify the medical necessity for inpatient psychiatric hospital services. As a result, the first and second recertification for psychiatric hospital services correspond to the initial certification and first recertification requirements for inpatient hospital services (see §3319).

For services furnished to beneficiaries admitted on or after January 1, 1970, the first recertification is required no later than as of the 12th day of hospitalization. The second recertification is required no later than as of the 18th day of hospitalization. Subsequent recertifications must be made at intervals established by the utilization review committee (on a case-by-case basis) but in no event may the interval between recertifications exceed 30 days.

For services furnished to beneficiaries admitted before January 1, 1970, the first recertification was required no later than as of the 14th day of hospitalization. The second recertification was required no later than as of the 21st day of hospitalization and subsequent recertifications at intervals of no more than 30 days thereafter.

There is also a difference in the content of the certification and recertification statements. The required physician's statement should certify that the inpatient psychiatric hospital admission was medically necessary, for either (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

The physician's recertfication should state (1) that inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either (a) treatment which could reasonably be expected to improve the patient's condition, or (b) diagnostic study; and (2) that the hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

For convenience, the period covered by the physician's certification and recertification is referred to a period during which the patient was receiving active treatment (see § 3102.1). If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

3321. INPATIENT TUBERCULOSIS HOSPITAL SERVICES CERTIFICATION AND RECERTIFICATION.

The requirements for physician certification and recertifications for inpatient tuberculosis hospital services are similar to the requirements for certification and recertification for inpatient hospital services. However, there is an additional certification requirement: At the time of admission or as soon thereafter as is reasonable and practicable, a physician (the admitting physician or a medical staff member with a knowledge of the case) must certify the medical necessity for inpatient tuberculosis hospital services. As a result, the first and second recertifications for tuberculosis hospital services correspond to the initial certification and first recertification requirements for inpatient hospital services (see § 3319).

For services furnished to beneficiaries admitted on or after January 1, 1970, the first recertification is required no later than as of the 12th day of hospitalization. The second recertification is required no later than as of the 18th day of hospitalization. Subsequent recertifications must be made at intervals established by the utilization review committee (on a case-by-case basis) but in no event may this interval between recertifications exceed 30 days.

For services furnished to beneficiaries admitted before January 1, 1970, the first recertification was required no later than as of the 14th day of hospitalization. The second recertification was required no later than as of the 21st day of hospitalization and subsequent recertifications at intervals of no more than 30 days thereafter.

There is also a difference in the content of the certification and recertification statements.

The physician's certification should state that the inpatient tuberculosis hospital admission was medically necessary for treatment which could reasonably be expected either to (1) improve the patient's condition, or (2) render the condition noncommunicable.

The physician's recertification should state (1) that inpatient tuberculosis hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for treatment which could reasonably be expected either to (a) improve the patient's condition, or (b) render the condition noncommunicable; and (2) that the hospital records indicate such medical necessity.

For convenience, the period covered by the physician's certification and recertifications is referred to as a period during which the patient was receiving active treatment. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition), program payment can no longer be made even though the patient has not yet exhausted his benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

3322. CERTIFICATION FOR HOSPITAL SERVICES COVERED BY THE SUPPLEMENTARY MEDICAL INSURANCE PROGRAM.

A physician must certify that medical and other health services covered by medical insurance which were provided by (or under arrangement made by) the hospital were medically required.

Physician certification is not required for the following outpatient services furnished on or after January 3, 1968: (a) hospital services and supplies incident to physicians' services rendered to outpatients (see § 3112.2) and (b) diagnostic services furnished by a hospital or which the hospital arranges to have furnished in other facilities operated by or under the supervision of the hospital or its medical staff (see §§ 3112.3ff.).

Hospitals must obtain a physician's certification with respect to services furnished to outpatients that are not covered as outpatient hospital therapeutic, or diagnositc services under (a) or (b) above.

Primarily, this means that a certification statement is needed for diagnostic services furnished under arrangements by a facility that is not operated by or under the supervision of the hospital or its organized medical staff (see §§ 3112.3), e.g., services obtained from an independent laboratory.

This certification requires a brief description of the services and the signature of the physician. It need be made only once for a course of treatment. Where services are provided on a continuing basis, such as a course of radium treatments, the physician's certification may be made at the beginning or end of the course of treatment, or at any other time during the period of treatment.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary (or the Health Care Financing Administration where the hospital deals directly with the Government) to determine that the certification requirement is in fact met. Therefore, the certification could be entered or pre-printed on a form the physician already has to sign; or a separate certification form could be used.

Certification by a physician in connection with ambulance services furnished by a participating hospital is required. In cases in which the hospital provides ambulance service to transport the patient form the scene of an accident and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify as to the medical need for the ambulance service.

In addition, physician's certifications are required for the rental and purchase of durable medical equipment (see § 3113), outpatient physical therapy (see §3149.1), and outpatient speech pathology services (see § A3148).

3323. DELAYED CERTIFICATIONS AND RECERTIFICATIONS.

Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the appropriate content requirements delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the hospital considers relevant for purposes of explaining the delay. The hospital will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

3324. TIMING OF CERTIFICATION AND RECERTIFICATION FOR BENEFICIARY ADMITTED BEFORE ENTITLEMENT.

If an individual is admitted to a hospital (including a psychiatric or tuberculosis hospital) before he is entitled to hospital insurance benefits (for example, before he reaches age 65), the following exception is applicable when he does become entitled.

No certification is required as of the date of admission or entitlement. Certifications and recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he became entitled. (The time limits for certification and recertification are computed from the date of entitlement instead of the date of admission.) Other than the above mentioned exception, see §§ 3319-3329 for the applicable requirements for content, signature, and timing of certifications and recertifications. For example, if a patient became entitled on September 1, 1968, but was admitted to a general hospital 1 week prior to that date, the certification was required no later than September 14; the first recertification no later than September 21; subsequent recertifications were required at intervals not to exceed 30 days. Similarly, if a patient became entitled on March 1, 1983, but is admitted prior to that date, the first certification is required no later than March 12; the second no later than March 18, and so forth.

Certification and Recertification By Physicians For Home Health Services

3326. CONTENT OF THE PHYSICIAN'S CERTIFICATION.

Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services unless a physician certifies that:

A. The home health services are or were required because the individual is or was confined to his home (except when receiving outpatient services);

B. The individual needed skilled nursing care on an intermittent basis or needed physical or speech therapy, or effective July 1, 1981 through November 30, 1981, needed occupational therapy;

C. A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and

D. The services are or were furnished while the individual was under the care of a physician.

In addition, for services received under hospital insurance prior to July 1, 1981, the physician must also certify that services were needed to treat any of the conditions for which the beneficiary received inpatient hospital or posthospital extended care services during the related hospital or extended care facility stay. Effective July 1, 1981, the prior inpatient stay requirement for home health services under hospital insurance is eliminated. Where services are provided under supplementary medical insurance, it is not necessary to relate the need for these services to a period of prior hospitalization or a stay in an extended care facility.

Since the certification is closely associated with the plan of treatment, the same physician who establishes the plan must also certify to the necessity for home health services. Certifications must be obtained at the time the plan of treatment is established or as soon thereafter as possible.

See § 3315.1 for the effects of failure to certify or recertify.

3327. METHOD AND DISPOSITION OF CERTIFICATIONS.

There is no requirement that the certification, or recertification discussed below, be entered on any specific form or handled in any specific way, as long as the intermediary can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician will be retained by the home health agency, but the agency must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file in the agency when it forwards the request for reimbursement to the intermediary.

3328. RECERTIFICATION.

Under both the hospital insurance and supplementary medical insurance programs, when services are continued for a period of time, the physician must recertify at intervals of at least once every 2 months that there is a continuing need for services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every two months) is required for the review of the plan. Effective December 1, 1981, the physician must recertify that an individual needs or needed skilled nursing care on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, needs or continues to need occupational therapy. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertifications is up to the individual agency.

3329. DELAYED CERTIFICATION.

The home health agency should obtain certifications and recertifications as promptly as possible. Payment will not be made unless the necessary certifications have been secured. In addition to complying with the usual content requirements, delayed certifications and recertifications must include an explanation for the delay and any other evidence the agency considers necessary in the case. The format of delayed certifications and recertifications and the method by which they are obtained, will be left to the agency.

Certification and Recertification by Physicians for Extended Care Services

3333. CERTIFICATION AND RECERTIFICATION BY PHYSICIANS--EXTENDED CARE SERVICES.

Payment for covered posthospital extended care services may be made only if a physician makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished.

The skilled nursing facility is responsible for obtaining the required physician certification and recertification statements and for retaining them in file for verifications, if needed, by the intermediary (or by the Health Care Financing Administration, if the skilled nursing facility deals directly with the government). The skilled nursing facility determines the method by which the physician certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, as long as the approach adopted by the faciltiy permits a verification to be made that the certification and recertification requirement is in fact met. Certification and recertification statements may be entered on or included in forms, notes, or other records a physician normally signs in caring for a patient, or a separate form may be used. Except as otherwise specified (see § 3338), each certification and recertification statement is to be separately signed by a physician.

If the facility's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's refusal to certify based on other grounds (e.g., he objects in principle to the concept of certification and recertification), the facility may not bill the program or the beneficiary for covered items or services. The provider agreement which the facility files with the Secretary precludes it from charging the patient for covered items and services.

If a physician refuses to certify because, in his opinion, the patient does not require skilled nursing care on a continuing basis for a condition for which he was receiving inpatient hospital services, the services are not covered and the facility can bill the patient directly. The reason for the physician's refusal to make the certification must be documented in the facility records. For such documentation to be adequate, there must be some statement in the facility's records, signed by a physician or a responsible facility official, indicating that the patient's physician feels that the patient does not require skilled nursing care on a continuing basis for any of the conditions for which he was hospitalized.

3334. WHO MAY SIGN CERTIFICATION OR RECERTIFICATION

A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case.

Ordinarily, for purposes of certification and recertification, a "physician" must meet the definition contained in § 3030.3.

3335. CERTIFICATION

The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled nursing care on a continuing basis for any of the conditions for which he was receiving inpatient hospital services, including services of an emergency hospital (§ 3012) prior to transfer to the SNF. Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

If ambulance service is furnished by a skilled nursing facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case including the physician who requested the ambulance or the physician who examines the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

3336. RECERTIFICATIONS

The recertification statement must meet the following standards as to its contents: it must contain an adequate written record of the reasons for continued need for extended care services, the estimated period of time the patient will need to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician has to meet the content standards, unless, for example, all of the required information is in fact included in progress notes, in which case the physician's statement could indicate that the individual's medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

If the circumstances require it, the first recertification and any subsequent recertifications must state that the continued need for extended care services is for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he had received inpatient hospital services.

Where the requirements for the second or a subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the utilization review plan, a separate recertification statement is not required. It is sufficient if the records of the utilization review committee show consideration was given to the recertification content standards.

3337. TIMING OF RECERTIFICATIONS

The first recertification must be made no later than as of the 14th day of inpatient extended care services. An skilled nursing faciltiy can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the 14-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

At the option of the skilled nursing facility, review of a stay of extended duration, pursuant to the facility's utilization review plan, may take the place of the second and any subsequent physician recertifications. The skilled nursing facility should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the utilization review committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.

3338. DELAYED CERTIFICATIONS AND RECERTIFICATIONS

Skilled nursing facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the skilled nursing facility considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

3339. DISPOSITION OF CERTIFICATION AND RECERTIFICATION STATEMENTS

Skilled nursing facilities do not have to transmit certification and recertification statements to the intermediary or the Administration; instead, the facility must itself certify, in the admission and billing form, that the required physician certification and recertification statements have been obtained and are on file.

Tuberculosis and Psychiatric Hospital Records

3345. TUBERCULOSIS AND PSYCHIATRIC HOSPITAL RECORDS

The law requires that psychiatric and tuberculosis hospital records contain certain specific information concerning the individual patient's condition and the nature of the treatment provided.

3345.1 In the case of inpatient psychiatric hospital services the hospital records must show that the services were furnished to the patient during periods when he was receiving intensive treatment services, admission and related services necessary for a diagnostic study, or equivalent services. As noted in § 3314, the physician recertification for inpatient psychiatric hospital services must include a statement that the hospital records so indicate.

3345.2 In the case of inpatient tuberculosis hospital services the hospital records must show that the services were furnished to the patient during periods when he was receiving treatment (including diagnostic services) which could reasonably be expected to improve his condition or render it noncommunicable. As noted in § 3315, the physician recertification for inpatient tuberculosis hospital services must include a statement that the hospital records so indicate.

Certification and Recertification for Outpatient Services

3350. PHYSICIAN'S CERTIFICATION AND RECERTIFICATION FOR OUTPATIENT PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY SERVICES.

A. Content of the Physician's Certification.--No payment may be made for outpatient physical therapy, occupational therapy, or speech pathology services unless a physician certifies that:

1. the services are or were furnished while the patient was under the care of a physician (see § 3148.2);

2. a plan for furnishing such services is or was established by the physician, physical therapist, occupational therapist, or speech pathologist and periodically reviewed by the physician. (See § 3148.3); and

3. the services are or were required by the patient.

Since the certification is closely associated with the plan of treatment, the same physician who establishes or reviews the plan must certify to the necessity for the services. Certification should be obtained at the time the plan of treatment is established or as soon thereafter as possible. "Physician" means a doctor of medicine, a doctor of osteopathy (including an osteopathic practitioner), or a doctor of podiatric medicine legally authorized to practice by the State in which he performs the services. In addition, physician certifications or recertifications by doctors of podiatric medicine must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable State law, and the policy of the institution or agency with respect to which the services are performed.

B. Recertification.--When outpatient physical therapy, occupational therapy, or speech pathology services are continued under the same plan of treatment for a period of time, the physician must recertify at intervals of at least once every 30 days that there is a continuing need for such services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of treatment is reviewed since the same interval (at least once every 30 days) is required for the review of the plan. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertification is up to the individual provider.

C. Method and Disposition of Certifications.--There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way as long as the fiscal intermediary or carrier can determine, where necessary, that the certification and recertification requirements are met. The certification by the physician will be retained by the provider, but the provider must certify on the billing form that the requisite certification and recertifications have been made by the physician and are on file when it forwards the request for reimbursement to you.

D. Delayed Certification.-- (See § 3323.)

3360. PARTICIPATION OF HEALTH MAINTENANCE ORGANIZATIONS (HMO'S) IN MEDICARE

Section 1876 of the Social Security Act permits a Medicare beneficiary eligible for Part A and Part B, or Part B only, to choose to have covered items and services furnished through a health maintenance organization (HMO), by enrolling in a qualified organization which has entered into a contract with the Secretary to participate as an HMO under Medicare. An HMO is defined, for Medicare purposes, as a public or private organization which provides either directly or through arrangements with others, a comprehensive range of health services to enrolled members who live within a specified service area, on a predetermined periodic rate or periodic per capita rate basis without regard to the frequency or extent of covered services furnished to any particular member, and which meets other statutory requirements. An HMO's service area is defined as the geographic area in which the HMO offers the full range of its services to its members. It may be distinguished from the HMO's enrollment area which may include locations outside the HMO's service area where it offers less than its full range of services (e.g., an HMO may cover house calls in emergencies in its service area, but not for members who live outside the service area).

A. Mature and Developing HMO's.—Under regulations published in the Federal Register July 2, 1975, organizations may qualify for participation under Medicare as either mature or developing HMO's. A "mature HMO" refers to an organization which has a current enrollment of at least 5,000 members; provides all health services covered under Part A and Part B that are available to nonmembers in the HMO's service area; and which meets all the applicable qualification requirements set forth in sections 405.2003-405.2012 of Subpart T of Regulations No. 5, including requirements related to operating history, composition of membership, range of services, etc. An organization which does not meet all the applicable statutory and regulatory requirements for a "mature HMO," may still qualify for participation under Medicare as a "developing HMO" if it meets certain less demanding requirements established in the regulations and demonstrates the capability of meeting the full statutory and regulatory requirements for a "mature HMO" within 3 years. For example, the regulations do not require developing HMO's to furnish the comprehensive range of covered services that mature HMO's are required to provide. (This 3-year time requirement may be waived by the Secretary for good cause.)

B. Cost-Basis and Risk-Basis HMO's.—For reimbursement purposes, a distinction is made between HMO's which contract with the Medicare program on an incentive (or risk) basis and those which contract on a cost-basis. A cost-basis HMO is either a mature or developing HMO which enters into a cost reimbursement contract with the Secretary under section 1876 of the act. Such HMO's are reimbursed by the Medicare program for the reasonable cost of providing covered items or services to Medicare enrollees. On the other hand, a risk-basis HMO is a mature HMO which meets additional size and experience requirements (e.g., where the HMO serves an urban geographic area it must have a current enrollment of at least 25,000 prepaid members) and elects to enter into an incentive reimbursement contract with the Secretary (for additional information on the size and experience requirements for risk-basis HMO's, see section 405.2004(a)(1) and (a)(2) of Subpart T of Regulations No. 5). Such HMO's are reimbursed by the Medicare program on the basis of a comparison of the HMO's incurred cost and the Adjusted Average Per Capita Cost (AAPCC) which is the average cost of providing covered items or services in the HMO's enrollment area to Medicare beneficiaries not enrolled in the HMO, actuarially adjusted to reflect the makeup of the HMO's Medicare enrollment. If the risk-basis HMO's incurred cost is less than the AAPCC, the HMO may earn a "savings" up to prescribed limits; if the risk-basis HMO's incurred cost exceeds the AAPCC, the HMO absorbs the "loss" which may be carried forward and offset against future savings. (See § 3360A for definitions of mature and developing HMO's.)

A risk-basis HMO must assume financial responsibility for a wider range of services for its enrollees than is required of a cost-basis HMO. A mature HMO that opts for a cost reimbursement contract is required to furnish its Medicare enrollees directly, or through arrangements, all of the Part A and Part B items and services covered under Medicare which are available to individuals (nonenrollees) residing in the organization's service area. On the other hand, a risk-basis HMO must provide the same range of covered Medicare services required of cost-basis, mature HMO's, and must also assume financial responsibility for covered items and services furnished to its Medicare enrollees by a physician, supplier, or provider of services outside the HMO, even in the absence of the HMO's prior approval, where such services are: (1) emergency services (see § 3360.1A); or (2) urgently needed services (see § 3360.1B) furnished to enrollees while they are temporarily absent (see § 3360.1B) from the HMO's service area; or (3) other covered Medicare items or services which are determined by the Secretary not to have been made reasonably available by the HMO to its Medicare enrollees (see § 3360.1C).

C. In-Plan and Out-of-Plan Services.--For purposes of these instructions, covered items or services furnished Medicare enrollees by an HMO, either directly through its facilities or through arrangements with others, are termed "in-plan". Where covered items or services are provided by a physician, supplier of services, or provider of services outside the HMO, such items or services are termed "out-of-plan".

D. Source of Covered Services.--The type of Medicare reimbursement contract (see § 3360C) which an HMO has with the Secretary is important to a beneficiary because those beneficiaries enrolled in risk-basis HMO's can have payment made by Medicare only for covered services they receive through the HMO, and for emergency services, urgently needed services, and other covered services which the Secretary determines have not been made reasonably available by the HMO (see § 3360.1). Such a beneficiary is referred to as a "restricted" beneficiary. However, if the beneficiary moves out of the HMO's enrollment area, this restriction ceases to apply the month following the month in which he moves. The beneficiary then has the same status as a beneficiary enrolled in a cost-basis HMO.

Beneficiaries enrolled in cost-basis HMO's can have payment made for covered services they receive through the HMO or from sources other than the HMO. Such a beneficiary is referred to as an "unrestricted" beneficiary.

3360.1 Definition of Emergency, Urgently Needed, and Other Covered Services.--

A. Emergency Services.--Emergency services are covered inpatient or outpatient medical and other health services provided by an appropriate source within or outside the HMO's service area, which may not be delayed until facilities or suppliers of services of the HMO (or alternatives authorized by the HMO) can be used without possible serious effects on the health of the patient. Such services must be or must appear to be needed immediately to prevent the death of the enrollee or serious impairment of his health, and are considered emergency services as long as the transfer of the enrollee to the appropriate provider of services of the HMO (including those with which the healthmaintenance organization has an arrangement) or an alternative designated by the HMO is precluded because of the risk to the enrollee's health, or the distance and nature of illness involved would make such transfer unreasonable.

B. Urgently Needed Services.--Urgently needed services are covered services which enrollees require in order to prevent a serious deterioration in their health while they are temporarily absent from the HMO's service area. While the immediacy of need for these services is not as great as it is for emergency services, the medical need is such that the provision of medical services cannot be delayed until the enrollee returns to a place where he could receive the HMO services. In this context, the term, "temporarily absent," refers to circumstances, such as a vacation trip, where the enrollee has left the HMO's service area, but intends to return within a reasonable period of time. An enrollee whose primary place of residence is in either the HMO's service area or enrollment area, but who resides in a temporary home elsewhere for a number of weeks up to a reasonable limit that may be established by the HMO, would also be considered temporarily absent from the HMO's service area during those periods of time when such enrollee is residing in the temporary home.

C. Other Covered Services.--Other covered services are services which are determined by the Secretary not to have been made reasonably available by the HMO to its Medicare enrollees.

3360.2 Intermediary Involvement With Reimbursement for HMO Services.--Services for HMO members who are Medicare beneficiaries are reimbursed either through the HMO itself or through the intermediary. The HMO may select from a number of options the one method by which its bills will be handled. Intermediaries will receive admission notices for all Medicare inpatient services for enrolled members of HMO's (see §§ 3555ff.). The jurisdiction of the subsequent inpatient bills is indicated in the "R-trailer" of the query reply. The intermediary will also determine jurisdiction of forms HCFA-1483 from information in the query reply (§ 3555.2). The contents of the "R-trailer" are described in § 3512.8.

In addition to the option codes in the R-trailer, the intermediary will have a listing (See § 3558), which shows which providers of services have arrangements with a particular HMO, or are owned by a particular HMO. If the services were furnished by a provider, owned by, or having an arrangement with the beneficiary's HMO, the intermediary will assume that the services were furnished in-plan.

If the services are out-of-plan and the R-trailer shows Codes A or B, the intermediary will refer to its HMO service area directory to help develop whether a service might be covered as being urgently needed if the emergency requirements are not met.

Intermediary actions in relation to query responses and receipt of Part A bills are described in §§ 3555ff.

When the HMO has jurisdiction of its bills, HCFA makes the interim capitation payments to the HMO, a periodic accounting, and an end-of-year adjustment.

When the intermediary has jurisdiction over bills for services to HMO members, the intermediary processes the bills (including services in HMO-owned facilities) in the same manner it presently processes bills for non-HMO beneficiaries. If the intermediary or HMO has jurisdiction over bills for services in an HMO-owned facility, the facility must have a provider number (the same as any other provider not owned by an HMO).

COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES

3370. PAYMENT FOR SERVICES FURNISHED BY COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFs)

3370.1 General--The Omnibus Reconciliation Act of 1980 (Public Law 96-499, Section 933) defines CORFs (Comprehensive Outpatient Rehabilitation Facilities) as a distinct type of Medicare provider and adds CORF services as a new benefit under Medicare Part B.

CORFs certified as meeting health, safety, and other standards prescribed by the Secretary will be eligible for reimbursement by a fiscal intermediary for the services it renders on a reasonable cost basis. Diagnostic and therapeutic services furnished to an individual patient by a physician are not CORF physician services. If covered, these services will be reimbursed on a reasonable charge basis by the area carrier subject to the physician reimbursement limitation on services furnished in an outpatient setting.

3370.2 Intermediary Designations--CORFs associated with a certified provider facility will be reimbursed by the provider's current intermediary. However, for all "free standing" or independent CORFs, HCFA has designated the following intermediaries. Except as noted below, CORFS will be serviced by the designated intermediary in its State.

STATE	INTERMEDIARY
Alabama	Blue Cross and Blue Shield of Alabama
Alaska	Blue Cross and Blue Shield of Washington and Alaska
Arizona	Blue Cross and Blue Shield of Arizona, Inc.
Arkansas	Arkansas Blue Cross and Blue Shield, Inc.
California	Blue Cross of California (Woodland Hills)
Colorado	Blue Cross of Colorado
Connecticut	Aetna
Delaware	Blue Cross of Delaware

District of Columbia	Group Hospitalization, Inc. (Washington, D.C.)
Florida	Blue Cross & Blue Shield of Florida, Inc.
Georgia	Blue Cross of Georgia/Columbus, Inc.
Hawaii	Hawaii Medical Service Association
Idaho	Blue Cross of Idaho Health Services
Illinois	Health Care Service Corporation (Chicago, Ill)
Indiana	Mutual Hospital Insurance, Inc. (Indianapolis, Inc.)
Iowa	Blue Cross of Iowa, Inc.
Kansas	Blue Cross of Kansas, Inc.
Kentucky	Blue Cross and Blue Shield of Kentucky, Inc.
Louisiana	Blue Cross of Louisiana (Louisiana Health Service and Indemnity Co.)
Maine	Associated Hospital Service of Maine
Maryland	Blue Cross of Maryland, Inc.
Massachusetts	Aetna
Michigan	Blue Cross and Blue Shield of Michigan
Minnesota	Blue Cross of Minnesota
Mississippi	Blue Cross and Blue Shield of Mississippi, Inc.
Missouri	Blue Cross Hospital Service, Inc., of Missouri (St. Louis, Missouri)

Montana	Blue Cross of Montana
Nebraska	Mutual of Omaha Insurance Company
Nevada	Aetna
New Hampshire	New Hampshire-Vermont Health Service, Inc.
New Jersey	The Prudential Insurance Company of America
New Mexico	New Mexico Blue Cross and Blue Shield, Inc.
New York	Blue Cross and Blue Shield of Greater New York
North Carolina	Blue Cross and Blue Shield of North Carolina
North Dakota	Blue Cross of North Dakota
Ohio	Hospital Care Corporation (Cincinnati, Ohio)
Oklahoma	Blue Cross and Blue Shield of Oklahoma
Oregon	Blue Cross of Oregon
Pennsylvania	Blue Cross of Western Pennsylvania (Pittsburgh)
Puerto Rico	Cooperativa de Seguros De Vidas
Rhode Island	Hospital Service Corporation of Rhode Island
South Carolina	Blue Cross and Blue Shield of South Carolina
South Dakota	Blue Cross of Western Iowa and South Dakota

Tennessee	Blue Cross and Blue Shield of Tennessee (Chattanooga, Tennessee)
Texas	Group Hospital Service, Inc. (Dallas, Texas)
Utah	Blue Cross of Utah
Vermont	New Hampshire-Vermont Health Services, Inc.
Virginia	Blue Cross of Virginia (Richmond, VA)
Virgin Islands	Cooperativa de Seguros De Vidas
Washington	Blue Cross of Washington and Alaska
West Virginia	Blue Cross Hospital Service, Inc. (Charleston, West Virginia)
Wisconsin	Blue Cross/Blue Shield United of Wisconsin
Wyoming	Blue Cross of Wyoming

Certain designated intermediaries will service CORFs across State lines in keeping with their longstanding service areas in the following cases.

Group Hospitalization, Inc.--services the District of Columbia; Prince Georges and Montgomery Counties in Maryland; Arlington County, Fairfax County, and the cities of Alexandria, Falls Church and Fairfax in Virginia.

Blue Cross of Western Iowa and South Dakota--services all of South Dakota and 26 counties in Iowa.
Oregon Blue Cross--services Oregon and Clark County in Washington, a suburb of Portland.

St. Louis Blue Cross--services Missouri, and Johnson and Wyandotte Counties in Kansas

Chattanooga Blue Cross--services Walker, Dade and Catossa Counties in Georgia.

A3316 Who May Sign Certification or Recertification.--The phrase "doctor of podiatry or surgical chiropody" in section 1861(r)(3) of the Social Security Act has been changed in the 1980 Amendments to read "doctor of podiatric medicine."

Effective January 1, 1981, a podiatrist is considered a "physician" for the purpose of making the required physician certification and recertifications of the medical necessity for Part A and Part B services if the podiatrist's performance of these functions is: (1) consistent with the policy of the institution or agency with respect to which he performs them; and (2) legally authorized by the State.

Cross refer: Section 3316

A.3316.1, Certification of Need for Hospital Admissions for Dental Procedures--Effective with admissions after June 30, 1981, the attending doctor of dental surgery or of dental medicine is authorized to certify that the patient's underlying medical condition and clinical status, or the severity of the dental procedure, requires the patient to be admitted to the hospital for the performance of the dental procedure (see § A3101.7). This applies even if the dental procedure is not covered.

Cross-refer: §3316.1.

Rev. 925

CHAPTER V

SPECIAL PROVISIONS RELATED TO PAYMENT FOR INTERIM MANUAL INSTRUCTIONS

Section

Government Subrogation Rights in Liability Insuarance Claims.. IM 3419.11

Revised Waiver of Liability Procedures for Providers......... IM 3430

Grace Periods Allowable Under Waiver of Liability............ IM 3441

Determining the Amount of Indemnification................... IM 3446.6

Medicare As Secondary Payer for Disabled Individuals......... IM 3492

CHAPTER V

SPECIAL PROVISIONS RELATED TO PAYMENT

Refunds

	Section	Page
Refunds	3401	87
Return or Other Disposition of Moneys Incorrectly Collected	3401.1	87.1
Appropriate Time Limits Within Which Provider Must Dispose of Sums Incorrectly Collected	3401.2	87.1
Provider Agreement May Be Terminated	3401.3	87.1
Former Participating Providers of Service	3401.4	87.2
Documentation Guide List	3401.5	87.2
Intermediary Request for Information Required for the Development of Provider Refunds	3401.6	87.3

Workers' Compensation

General	3407	87.4
Definitions	3407.1	87.5
Effect of Payments Under a Workers' Compensation Plan	3407.2	87.6
Secondary Medicare Payments	3407.3	87.6
Workers' Compensation Cases Involving Liability Claims	3407.4	87.7
Possible Coverage of Work Related Services Under Automobile Medical or No Fault Insurance or an Employer Group Health Plan	3407.5	87.8
Contested Workers' Compensation Claims	3407.6	87.8
Lump-Sum Compromise Settlement	3407.7	87.8
Lump-Sum Commutation of Future Benefits	3407.8	87.9
Right of Recovery	3407.9	87.9
Private Right of Action	3407.10	87.10
Conflicting Claims by Medicare and Medicaid	3407.11	87.10
Authorities for Agreeing to Compromise or Waive Medicare's Claim	3407.12	87.11
Provider Handling of Cases Involving Work-Related Conditions	3408	87.11
Workers' Compensation Has Paid or Is Expected to Pay	3408.1	87.11
Workers' Compensation Denies Payment	3408.2	87.12
Responsibility of Provider Where Benefits May Be Payable Under the Federal Black Lung Program	3408.3	87.13
Responsibility of Provider to Document Cases in Which There Is a Possibility of Workers' Compensation Coverage	3408.4	87.13
Contractor Identification of Claims with Possible Workers' Compensation Coverage	3409	87.14
General Information	3409.1	87.14
Sources of Information	3409.2	87.14
Investigation and Evaluation Guides	3409.3	87.15
Action by Intermediary Where There Is Indication of Possible Workers' Compensation Coverage (Other Than Federal Black Lung Benefits)	3409.4	87.16

SPECIAL PROVISIONS RELATED TO PAYMENT

	Section	Page
Action by Intermediary Where Facts Indicate Medical Benefits May Be Payable by DOL Under Federal Black Lung Program	3409.5	87.16
Special DOL Coverage Rules	3409.6	87.17
Medicare Payment	3409.7	87.17
Questionable Cases	3409.8	87.17
Federal Black Lung Program Address	3409.9	87.17
DOL's Acceptable Diagnosis List	3409.10	87.18
DOL's Approved Procedure List	3409.11	88.2
Party Requests That Medicare Accept Less Than its Claim	3410	89
Notification of Other Part A Intermediary or Part B Carriers	3410.1	89
Medicare Made Party to Workers' Compensation Hearing	3411	89
Time Limit for Filing Workers' Compensation Claim Has Expired	3412	90
Beneficiary Accepted a Compromise Lump-Sum Settlement of a Workers' Compensation Claim	3413	90
Intermediary Actions Where Medicaid Also Has Requested Refund	3414	90
Conditional Medicare Payments	3415	90.1
Effect of Lump-Sum Compromise Settlement	3416	90.1
Lump-Sum Payment Which Represents Commutation of Future Benefits	3416.1	90.3
Apportionment of a Lump-Sum Compromise Settlement of Contested Workers' Compensation Claim	3416.2	90.3
Overpayment Due to Workers' Compensation Coverage	3417	92.1
Duplicate Payment Received by Provider	3417.1	92.1
Medicare Paid for Services Which Should Have Been Paid for by Workers' Compensation	3417.2	92.1

Liability Insurance

	Section	Page
General Effect of Liability Insurance on Medicare Payments	3419	94.1
Effect of Payment by Liability Insurer on Deductibles and Utilization	3419.1	94.3
Definitions	3419.2	94.3
Provider Billing Rights and Responsibilities	3419.3	94.3
Provider Actions	3419.4	94.5
Identification of Liability Situations	3419.5	94.6
Development to Ascertain if Liability Claim Has Been or Will Be Filed	3419.6	94.8
Action by Intermediary Where a Liability Claim Is Filed	3419.7	94.9
Liability Claim Is Filed and There Is Also Coverage Under Automobile Medical or No Fault Insurance	3419.8	94.10
Coordination with Other Part A Intermediaries or Part B Carriers Where There Is A Possibility of Automobile or Liability Insurance Payment	3419.9	94.10
EXHIBITS	3419.10	94.10

SPECIAL PROVISIONS RELATED TO PAYMENT

CHAPTER V

Utilization Review

	Section	Page
Utilization Review Plan	3420	95
Physician Members of UR Committee	3420.1	95
Definition of Continued Stay--Beneficiary Admitted Before Entitlement	3420.2	96
Limitations on Payment for Inpatient Services	3421	96
Availability and Appropriateness of Other Facilities and Services	3421.1	96.2
Failure to Make Timely Review of Cases	3421.2	96.2A
Assuring Proper Utilization in Short Stay Cases	3422	96.2B
Relationship of PSROs to the Assurance of Proper Utilization in Short Stay Cases	3422.1	96.3

Limitation on Liability of Beneficiary and Provider Where Medicare Claims Are Disallowed

	Section	Page
Limitation of Liability for Provider Claims under Parts A and B of Medicare Program	3430	96.3B
Applicability of Limitation of Liability to Items or Services Furnished by Providers of Services Payable Under Part A	3431	96.3C
Prior Hospitalization and Transfer Requirements for SNF Coverage as Related to Limitation of Liability	3431.1	96.3D
Application of Limitation of Liability to SNF and Hospital Claims for Services Furnished in Noncertified or Inappropriately Certified Beds	3431.3	96.3E
Determining Liability For Services Furnished in a Noncertified SNF or Hospital Bed	3431.4	96.3E6
Determining Liability for Provider Claims under Section 1879	3432	96.3E7
Determining Beneficiary's Liability	3432.1	96.3E7
Determining Provider Liability	3432.2	96.3F
Criteria for Presuming That SNF, HHA or Hospice Meets Limitation of Liability Requirements	3433	96.3I
Newly Participating SNF, HHA or Hospice	3433.1	96.3I
SNF, HHA or Hospice Changing Intermediaries	3433.2	96.3I
Reevaluating Favorable Presumption	3433.3	96.3I
Notifying ROs of Excessive Denial Rates	3433.4	96.3J
Reevaluating Favorable Presumption for Prior Period	3433.5	96.3J
Determining Denial Rate for Favorable Presumption	3434	96.3J
SNF Denial Rate Calculation	3434.1	96.3J
HHA Denial Rate Calculation	3434.2	96.3K
Hospice Denial Rate Calculation	3434.3	96.3L

SPECIAL PROVISIONS RELATED TO PAYMENT

	Section	Page
Random Sample Size	3434.4	96.3L1
Favorable Presumption Sampling Guidelines	3434.5	96.3L1
Precision of Favorable Presumption Determination	3434.6	96.3L4
Time Period for Calculating Denial Rate	3434.7	96.3N
Effect of Change in Favorable Presumption	3434.8	96.3N
Low Utilization Providers	3434.9	96.3N
Treatment of Day or Visit Determinations Later Reversed	3434.10	96.3N
Determining Whether Provider Had Knowledge of Non-coverage of Services	3439	96.3O
Notifying Patient of Noncoverage	3439.1	96.3Q
Verifying Provider Notification Procedure	3439.2	96.3Q
Improper Coverage Decisions	3439.3	96.3R
Establishing When Beneficiary Is on Notice of Noncoverage	3440	96.3R
Determining Date of Notice	3440.1	96.3R1
Documentation of Notice	3440.2	96.3S
Payment Under Limitation of Liability	3441	96.3S
When to Make Limitation of Liability Decisions	3442	96.3T
Preparation of Denial Notices	3443	96.3U
Applicability of the Limitation of Liability Provision to Claims for Ancillary, Outpatient Provider and Rural Health Clinic Services Payable Under Part B	3444	96.3U
Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services	3444.1	96.3U
Determining Provider Liability in Claims for Ancillary and Outpatient Services	3444.2	96.3V
Bill Processing and Workload Reporting	3445	96.3V
Indemnification Procedures for Claims Falling Within the Limitation of Liability Provisions	3446	96.3W
Intermediary and Social Security Office Responsibility in Indemnification Claims	3446.1	96.3W
Conditions for Indemnification	3446.2	96.3W
Development and Documentation of Indemnification Requests	3446.3	96.4
Beneficiary Requests Indemnification, But Had No Financial Interest in the Claim	3446.4	96.4A
Questionable Indemnification Requests Procedure	3446.5	96.4A
Determining the Amount of Indemnification	3446.6	96.4B
Notifying the Provider	3446.7	96.4B
Making Payment under Indemnification	3446.8	96.4C
Exhibits	3446.9	96.4C
Exhibit 1 - Guide Language to Beneficiary or His Representative Explaining Limitation of Liability and Possible Right to Indemnification		96.4D
Exhibit 1A - Letter to Provider		96.4E
Exhibit 2 - Letter to Beneficiary Who Requests Indemnification		96.4F

SPECIAL PROVISIONS RELATED TO PAYMENT

Section Page

Indemnification Procedures Under Waiver of Liability

Indemnification Procedures for Claims Falling Within the Waiver of Liability Provision........................ 3446 96.4B
  Intermediary and Social Security Office Responsibility in Indemnification Claims............................ 3446.1 96.4B
  Conditions for Indemnification.......................... 3446.2 96.4B
  Development and Documentation of Indemnification Requests... 3446.3 96.4C
  Beneficiary Requests Indemnification, But Had No Financial Interest in the Claim................... 3446.4 96.4D
  Questionable Indemnification Requests Procedure.......... 3446.5 96.4D
  Determining the Amount of Indemnification................ 3446.6 96.4E
  Notifying the Provider................................... 3446.7 96.4E
  Making Payment under Indemnification..................... 3446.8 96.4F
  Exhibits... 3446.9 96.4F
  Exhibit 1 - Letter to Provider.......................... 96.4G
  Exhibit 2 - Letter to Beneficiary Who Requests Indemnification.. 96.4H
  Exhibit 3 - Letter to Someone Other Than Beneficiary Who Requests Indemnification.............. 96.4I
  Exhibit 4 - Statement of Claimant or Other Person........ 96.4J

Program Integrity

Medicare Program Integrity -- General...................... 3450 96.5
Program Integrity Defined.................................. 3452 96.5
Medicare Fraud Distinguished from Abuse.................... 3454 96.6
  Definition of Key Terms.................................. 3454.1 96.6
Reporting Title 18 Requirements for Abuse Cases............. 3455 96.8
  Medicare/Medicaid Abuse Report Form (HCFA-51)............ 3455.1 96.8C
  Postpayment Medical Review (Abuse Cases) Summary Report -- Medicare (HCFA-60).......................... 3455.2 96.8H
Stages in the Developmental Process........................ 3456 96.8I
Role of Intermediaries..................................... 3458 96.8I
Program Integrity Complaints Resolved by Intermediaries...... 3459 96.8J
  Information Required on Program Integrity Complaints..... 3459.1 96.8J
  Explanation of Information Required on Complaints........ 3459.2 96.8J
Fraud in Connection with Claims............................ 3460 96.9
Identifying Potential Fraud Situations..................... 3462 96.11
Preliminary Intermediary Action In Potential Fraud or Abuse Cases.. 3464 96.12
Withholding Payment When There is a Strong Indication of Fraud or Abuse.. 3466 96.13
Overpayments in Fraud and Abuse Cases...................... 3468 96.14
  Fraud.. 3468.1 96.14
  Abuse.. 3468.2 96.14a

SPECIAL PROVISIONS RELATED TO PAYMENT

	Section	Page
Resumption of Payment to a Supplier or Provider -- Continued Surveillance After Detection of Fraud or Abuse	3470	96.14a
Case Records and Controls	3472	96.14b
Intermediary Coordination with Part B Carriers	3474	96.15
Cases Involving Possible Forgery of Endorsement of Health Insurance Checks	3476	96.15
Theft of Medicare Checks From an Intermediary's Office	3478	96.17
Handling Negotiable Instruments	3479	96.17
Referral of Cases Involving Possible Unethical or Unprofessional Conduct by a Practitioner	3480	96.17
Administrative Sanctions - General	3482	96.19
Role of Intermediaries	3482.1	96.19
Administrative Remedies Considered Initially	3482.2	96.20
Authority to Suspend, Exclude, or Terminate Payment to Practitioners, Providers, and Suppliers of Services	3483	96.22
Basis for Exclusion Under Section 1862 or Termination Under Section 1866	3483.1	96.22
Identification of Potential Exclusion or Termination Cases	3483.2	96.23
Development of Potential Exclusion or Termination Cases	3483.3	96.23
Contents of Sanction Recommendation	3483.4	96.23B
Notice of Administrative Sanction Action	3483.5	96.23C
Notification to Other Agencies	3483.6	96.23C
Effective Date of Suspensions/Exclusions/Terminations	3483.7	96.23D
Denial of Payment to Beneficiaries	3483.8	96.23E
Appeals Process	3483.9	96.23E
Reinstatements	3483.10	96.23E
Monthly Notification of Sanction Actions	3483.11	96.23E
Civil Monetary Penalties Law	3484	96.23F
Office of Inspector General Regional Office Contacts	3486	96.24

Limitations on Assignment of Claims

	Section	Page
Assignment of a Provider's Right to Payment	3488	96.25
Payment to an Agent	3488.1	96.26
Payment to a Bank	3488.2	96.27
Correcting Unacceptable Payment Arrangements	3488.3	96.28
Sanctions for Prohibited Payment Arrangement	3488.4	96.30
Prohibition of Assignments by Beneficiaries	3488.5	96.33

Automobile Medical and No Fault Insurance

	Section	Page
Services Reimbursable under Automobile Medical or No Fault Insurance	3489	3-96.33
General	3489.1	3-96.33

SPECIAL PROVISIONS RELATED TO PAYMENT

	Section	Page
Definitions	3489.2	3-96.33b
Provider Actions	3489.3	3-96.33c
Processing of Claims Indicating Possibility of Payments Under Automobile Medical or No Fault Insurance	3489.4	3-96.33d
Automobile Medical or No Fault Insurance Does Not Pay All Charges Because of Deductible or Coinsurance Provision in Policy	3489.5	3-96.33k
Services Covered Under Automobile Medical or No Fault Insurance and Liability Claim Also Filed	3489.6	3-96.33k
Allocation of Recovered Medicare Payments	3489.7	3-96.33k
Claimant's Right to Take Legal Action Against an Automobile Medical or No Fault Insurer	3489.8	3-96.33K

Limitation on Payment for Services To ESRD Beneficiaries

	Section	Page
Limitation on Payment for Services to Individuals Entitled to Benefits Solely on the Basis of End Stage Renal Disease Who Are Covered by Employer Group Health Plans	3490	96.35
General	3490.1	96.35
Definitions	3490.2	96.35
Retroactive Implementation	3490.3	96.36
Processing of Current Claims	3490.4	96.37
Determining the 12-Month Period During Which Medicare May Be Secondary Payer	3490.5	96.40B
Effect of Changed Basis for Medicare Entitlement	3490.6	96.41
Subsequent Periods of ESRD Entitlement	3490.7	96.41
Amount of Secondary Medicare Payments Where Employer Group Health Plan Pays in Part for Items and Services	3490.8	96.41
Employer Group Health Plan Pays in Full	3490.9	96.42
Effect of Secondary Payments on Part A Utilization	3490.12	96.42
Effect of EGHP Payments on Deductible and Coinsurance	3490.13	96.43
Limitation on Right of Provider or Facility to Charge a Beneficiary	3490.14	96.43
Responsibility of Providers of Services and Renal Dialysis Facilities	3490.15	96.43
Action by Intermediary When EGHP Erroneously Pays Primary Benefits	3490.17	96.44
Referral to RO of Cases Involving Discrimination Against ESRD Patients	3490.18	96.44
Claimant's Right to Take Legal Action Against an EGHP	3490.19	96.45

SPECIAL PROVISIONS RELATED TO PAYMENT

Section Page

Limitation on Payment for Services to Employed Beneficiaries Age 65 and Over

Limitation on Payments for Services to the Employed Aged and The Aged Spouses of Employees Who Are Covered by Employer Group Health Plans.................. 3491 96.47
- General... 3491.1 96.47
- Definitions....................................... 3491.2 96.48
- Individuals Subject to Limitation on Payment......... 3491.3 96.52
- Individuals Not Subject to Limitation on Payment..... 3491.4 96.53
- Identification of Cases by Providers of Services..... 3491.5 96.54
- Identification of Cases and Action Where There Is Indication of Possible EGHP Coverage.............. 3491.6 96.54
- Action by Providers Where Medicare Is Secondary to Employer Group Health Plan........................ 3491.7 96.54
- Limitation on Right of Provider or Facility to Charge a Beneficiary............................. 3491.8 96.56
- Effect of EGHP Payments on Deductible and Coinsurance.. 3491.9 96.56
- Employer Plan Denies Claim for Primary Benefits...... 3491.11 96.56
- Referral of Cases to Regional Office................. 3491.12 96.56A
- Amount of Secondary Medicare Payments Where EGHP Pays in Part for Items and Services................... 3491.13 96.56B
- Effect of Secondary Payments on Part A Utilization... 3491.14 96.56B
- Recovery of Incorrect Primary Medicare Payments..... 3491.15 96.56C
- Advice to Providers, Physicians and Beneficiaries.... 3491.16 96.56G
- Incorrect EGHP Primary Payments..................... 3491.17 96.56G
- Claimant's Right to Take Legal Action Against an EGHP.................................. 3491.18 96.56G
- Special Rules For Services Furnished By Source Outside EGHP Prepaid Health Plan.......................... 3491.19 96.56G

Medicare as Secondary Payer for Disabled Individuals

Medicare as Secondary Payer for Disabled Individuals........ 3492 96.57

3401. REFUNDS.

In its agreement for participation, the provider has agreed not to charge any individual or other person (e.g., relatives, other insurance carriers, or welfare) for items and services covered by the health insurance program other than allowable charges and deductibles and coinsurance amounts. The provider also agreed to make provision for the refund (or other required disposition) of any moneys incorrectly collected from the individual or other person on his behalf.

Amounts incorrectly collected and not refunded represent improper charges for covered services under the provisions of section 1866(a)(1) of the Social Security Act, and a provider's retention of these moneys without making provision for refund (or other required disposition) constitutes a violation of its provider agreement.

A. Moneys incorrectly collected means amounts in excess of allowable charges and deductible or coinsurance amounts, if applicable, paid to a provider of services by an individual (or other person on his behalf) as payment for covered items and services for which the individual is entitled to have payment made under the Medicare program.

B. A majority of incorrect collections are made inadvertently and may involve a simple error on the part of the provider in billing a beneficiary. However, there are other situations where incorrect collections may be made, such as:

1. In a retroactive entitlement case (§ 3001), where the beneficiary (or other person) paid for covered services and later becomes entitled to have payment made for them under Medicare;

2. Where payment was initially denied and a subsequent finding is made (e.g., as the result of a reconsideration or hearing decision) that payment for all or part of the same services may be made;

3. Where the beneficiary or other person has protested a direct charge by a provider; and

4. Where a claim for payment is submitted by a provider under the guarantee of payment provisions. (See § 3714.)

Adequate safeguards must be instituted to assure that providers refund moneys incorrectly collected. Therefore, in the situations described above (and other situations recognized by you), ascertain on an individual case basis whether the provider has already received reimbursement for covered services from the individual or other person (e.g., relatives, other insurance carriers, or welfare) before making Medicare payment. (See §3401.6.) If the provider advises, in writing, that it has not been reimbursed by the individual or other person for covered services, payment can be made. If the provider has already been reimbursed in whole or in part, see § 3401.1.

Where the provider has overcollected deductible and coinsurance amounts for Part B services, make direct refund to the beneficiary. (See the bill review instructions in §§ 3640.7 and 3650.)

3401.1 Return o. Other Disposition of Moneys Incorrectly Collected.-- A provider of services in possession of any incorrect collection is required to refund or make final disposition of the money in accordance with applicable State law. If refund or final disposition will be delayed for a prolonged period, the provider is required to set aside the money in a separate account until refund or final disposition can be made. Until the provider advises, in writing, that it has properly refunded or disposed of the money or, as necessary, set aside the money, withhold an amount equal to such incorrect collection against amounts otherwise due the provider, except in a guarantee of payment case withhold the full amount due the provider for the guarantee period.

A. Refund.-- Refund is to be made to the beneficiary (or any other person) from whom the provider collected the moneys. If the beneficiary or other person cannot be located after the provider has made a reasonable effort including an attempt at contact by mail at the last known address, check HCFA's records in an effort to learn the individual's address. If the individual to whom refund is to be made still cannot be located or has died, the provider is to make final disposition of the moneys in accordance with the law of the State in which the provider is situated.

B. Moneys Set Aside.-- In some situations refund or final disposition may be delayed for a prolonged period (e.g., where the beneficiary's whereabouts is being developed or where there is a delay in the appointment of a legal representative to dispose of the estate of a deceased individual). When such a delay in making refund or final disposition is encountered, the provider of services is required to set the funds aside in a separate account identified by the name of the individual to whom the payment is due. These amounts will be carried on the provider's records in this manner until refund or final disposition, as provided in paragraph A above, can be made.

3401.2 Appropriate Time Limits Within Which Provider Must Dispose of Sums Incorrectly Collected.-- Refund or final disposition in accordance with applicable State law of sums incorrectly collected should be accomplished as promptly as possible. In any event, refund, final disposition, or as necessary, setting funds aside in a separate account should be accomplished within a period of 60 days after the provider is notified that an incorrect collection was made.

In discharging your administrative functions, you should attempt through discussion with the provider to effect timely disposition of sums incorrectly collected. You should also maintain adequate controls to insure that refunds or final dispositions are made on a timely basis.

3401.3 Provider Agreement May Be Terminated.-- Advise the RO of any problems which may arise in establishing the existence of an incorrect collection and in disposing of it. Where there is a continued or recurring failure to refund or otherwise dispose of incorrectly collected funds, HCFA may in an extreme case terminate the provider agreement.

3401.4 Former Participating Providers of Service.-- Once a provider of services has become a participating provider, it remains responsible, notwithstanding the subsequent termination of its program participation, for the required refund or final disposition of any moneys incorrectly collected for covered services furnished to Medicare beneficiaries during the effective period of its provider agreement. Incorrect collection situations involving former participating providers may occur as the result of a beneficiary's or other person's allegation of having paid the former provider for covered services, or as the result of a reconsideration, hearing, or judicial decision which entitles the beneficiary to have program payment made for covered services furnished by the former provider.

A. Former Participating Provider Cooperates.-- Where the former participating provider (or an authorized representative) is available and cooperative, any required claims development should be completed, the amount of any moneys incorrectly collected should be established, and final disposition made, in the same manner as for currently participating providers. Any program payment due the provider on behalf of the beneficiary should be paid after disposition of any incorrect collections.

Program payments released to a former provider are to be reflected as a live item under "Retroactive Adjustments" on the Monthly Intermediary Financial Report. (See Part A, Part 1, § 1414ff.) However, before making payment to a former provider which continues to have a financial obligation to the Medicare program, e.g., an unrecovered overpayment, undertake an appropriate recomputation and adjust the former provider's final cost settlement.

This includes advising the former provider, in writing, of any changes in the previously determined settlement and updating the overpayment case file.

B. Former Participating Provider Does Not Cooperate.-- Where the information available shows or alleges that an incorrect collection was made and all reasonable efforts to locate and/or secure the cooperation of the former provider have been exhausted, document the case and refer it to the RO. (See § 3401.5.) Once the case has been referred, notify the RO of any direct contact received from the former provider on this matter. The RO will advise you of any subsequent actions to be taken.

Where the information available does not show or allege that an incorrect collection was made, record the circumstances of the individual case in the former provider's final cost settlement (overpayment) records. This may be done by a short memorandum, and should indicate the documentation, information, etc., necessary to resolve the issue. Where a former provider contact is known, advise him or her of the action taken. If the former provider subsequently cooperates (e.g., by claiming payment, submitting requested information, advising whether it has made an incorrect collection), the case should then be processed as in paragraph A above.

3401.5 Documentation Guide List.-- The following is a guide list for use in documenting cases involving situations where the information available shows or alleges that an incorrect collection was made and you have been unable to locate or secure the cooperation of a former provider. (See § 3401.3B.) As available and appropriate to the individual case, the documentation forwarded to the RO should include:

A. A copy of the beneficiary's or other person's allegation that he made payment to the former provider for covered services.

B. A copy of any reconsideration, hearing, or judicial decision which may be involved.

C. A copy of reports relating to consultative efforts with the former provider and copies of related correspondence with the provider.

D. A copy of all pertinent claims forms that were filed by the former provider for services furnished to the beneficiary during the period in question. If the provider has not filed a claim, secure status information for the involved beneficiary. (See § 3507.3, query code 5.)

E. A report on the final cost settlement status of the former provider (e.g., underpaid, overpaid, any amounts due and used to reduce an overpayment).

F. For those cases where you are unable to determine the amount of program payment due the provider (generally, where you have been unable to complete the necessary claims development), a written opinion based on available medical records, billings, etc., as to the probability for having program payment made. Attempt to secure any pertinent medical, billing, etc., information which would assist you in giving this opinion. This would include, for example, any information which can be made available from your own records or by contacting other providers, including the successor-owner where the provider has undergone a change of ownership.

3401.6 Intermediary Request for Information Required for the Development of Provider Refunds.— The means used to contact a provider in a refund situation (§3401.B) is discretionary, either by telephone or mail. Inform the provider of the situation for which it may have made an incorrect collection and the actions it is required to take to fulfill its program obligation. Follow the procedure explained below in your refund development.

The Office of Management and Budget (OMB) has approved your requesting the following information from providers for the resolution of refund situations. You may not routinely collect information other than that given on this list. You may have forms printed requesting the provider to complete all applicable information on the list. However, if you elect to do so, the form you produce must have the OMB approval number printed in the upper right-hand corner of the first page. It should read:

Form Approved
OMB No. 0938-0383

The items of information that may be collected for refund situations are:

A. Ascertain whether an incorrect collection was made with respect to the covered services furnished to the beneficiary.

B. If an incorrect collection was made:

1. The amount of the incorrect collection; and

2. The amount refunded, the name and address of the person or entity to whom the refund was paid, and the provider's explanation when refund was made to a person or entity other than from whom the provider collected the money; or

3. The amount set aside in a separate account in the provider's records, the name on the account, and the provider's reason for setting the money aside; or

4. The amount disposed of in accordance with applicable State law and the name and address of the person or entity to whom the money was paid; or

5. Other disposition or explanation by the provider.

C. Signature and title of authorized provider representative and the date.

The information collected for refund situations must be limited to those items given on the list. A distinction is drawn between information which is sought routinely and that which is sought non-routinely. The distinction is based on a requirement in the Paperwork Reduction Act that OMB approval be obtained when the identical question is posed to ten or more members of the public in a given year. Since the three (3) numbered items on the above list are OMB approved, you may ask for this information whenever necessary. OMB approval is not required when information for a specific application is requested annually from fewer than ten members of the public. You may use this exemption to seek additional information to resolve a refund situation on an exemption basis, i.e., the information requested is not sought on a routine basis.

Workers' Compensation

3407. GENERAL

Payment under Medicare may not be made for any items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or any State. If it is determined that Medicare has paid for items or services which can be or could have been paid for under WC, the Medicare payment constitutes an overpayment.

This limitation also applies to the WC plans of the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands.

It also applies to the Federal WC plans provided under the Federal Employees' Compensation Act, the U.S. Longshoremen's and Harbor Workers' Compensation Act and its extensions, and the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal Black Lung Program). These Federal programs provide WC protection for Federal civil service employees and certain other categories of employees not covered, or not adequately covered, under State WC programs; e.g., coal miners totally disabled due to pneumoconiosis, maritime workers (with the exception of seamen), employees of companies performing overseas contracts with the United States government, employees of American companies who are injured in an armed conflict, employees paid from non-appropriated Federal funds (such as employees of post exchanges), and offshore oil field workers. The Federal Employers' Liability Act, which covers merchant seamen and employees of interstate railroads, is not a WC law or plan for purposes of this exclusion. Similarly, some States have employers' liability acts. These also are not considered WC acts for purposes of this exclusion.

All WC acts require that the employer furnish the employee with necessary medical and hospital services, medicines, transportation, apparatus, nursing care, and other necessary restorative items and services. However, in some States there are limits to the amount of medical and hospital care provided. For specific information regarding the WC plan of a particular State or territory, contact the appropriate agency of the individual State or territory.

If payment for services cannot be made by WC because they were furnished by a source not authorized by WC, such services can be paid for by Medicare.

The beneficiary is responsible for taking whatever action is necessary to obtain payment under WC where payment under that system can reasonably be expected (e.g., timely filing a claim, furnishing all necessary information). If failure to take proper and timely action results in a loss of WC benefits, Medicare benefits are not payable to the extent that payment could reasonably have been expected under WC.

3407.1 Definitions

A. Workers' Compensation Law or Plan.— A WC law or plan is a government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. Although WC programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well.

B. Workers' Compensation Agency.—The term "workers' compensation agency" means any governmental entity that administers a Federal or State WC law. This term includes workers' compensation commissions, industrial commissions, industrial boards, workers' compensation insurance funds, workers' compensation courts and, in the case of Federal workers' compensation programs, the U.S. Department of Labor.

C. Workers' Compensation Carrier.-- The term "workers' compensation carrier" means any insurance carrier authorized to write WC insurance under the state or federal law, the state compensation fund where the state administers the WC program, and the beneficiary's employer where the employer is self-insured.

D. Lump Sum Commutation Settlement.--The beneficiary accepts a lump sum payment which compensates for all future medical expenses and disability benefits related to the work injury or disease.

E. Lump Sum Compromise Settlement.--A settlement which provides less in total compensation than the individual would have received if the claim had not been compromised. This may occur when compensability is contested.

F. HCFA's Claim.--Is the amount that is determined to be owed to the Medicare program. This is the amount that was paid out by Medicare, less any applicable procurement costs.

3407.2 Effect of Payments Under a Workers' Compensation Plan

A. General.--No Medicare payment may be made if WC has paid an amount:

- Which equals or exceeds the gross amount payable by Medicare without regard to deductible and coinsurance;
- Equals or exceeds the provider's charges for Medicare covered services; or
- Which the provider accepts or is required under the WC law to accept as payment in full.

B. Deductibles.--Payments made under WC cannot be applied toward the Medicare deductibles.

C. Benefit Utilization.-- In most instances, where an injury or illness is covered under a WC plan, that plan pays all hospital and medical expenses. Where this is the case, services paid for under WC are not counted against the individual's entitlement to 90 days of inpatient hospital services, 60 lifetime reserve days, or 100 days of skilled nursing facility services. However, if a Medicare secondary payment is made, benefit utilization is charged in accordance with §3679 C3 & H3 for providers reimbursed on a cost reimbursement basis and §3685A3 for hospitals reimbursed on a prospective payment basis.

3407.3 Secondary Medicare Payments

A. General.--If WC pays for Medicare covered services (including outpatient services) an amount which is less than the provider's charges and less than the gross amount payable by Medicare, as defined below (without considering the effect of the

Medicare deductible or coinsurance or the payment by WC), and the provider does not accept and is not required, under the WC law to accept the payment as payment in full, Medicare secondary payments can be made.

B. Amount of Secondary Payments.--The Medicare secondary payment is the gross amount payable by Medicare minus the amount paid by WC for Medicare covered services, minus any applicable deductible or coinsurance amount.

The gross amount payable by Medicare is:

o The current Medicare interim reimbursement amount (as defined in §3683) for providers reimbursed on a reasonable cost basis;

o The Medicare payment rate as defined in §3685, for providers reimbursed on a prospective payment basis;

o The composite rate for maintenance dialysis services; or

o The reasonable charge for separately billable items furnished by independent ESRD facilities. (See §3644.1.)

C. Charges Included Non-Work Related Items or Services.--If WC does not pay all of the charges because only a portion of the services is compensable, i.e., the patient received services for a condition which was not work related concurrently with services which were work-related, secondary Medicare benefits may be paid in accordance with paragraph B above, to the extent that the services are not covered by any other source which is primary to Medicare (see §3679 for billing procedures). A provider is permitted, under WC law, to charge an individual or the individual's insurer for services which are not work related.

3407.4 Workers' Compensation Cases Involving Liability Claims.--Most State laws provide that if an employee is injured at work due to the negligent act of a third party, the employee cannot receive payments from both WC and the third party for the same injury. Generally, WC benefits are paid while the third party claim is pending. However, once a settlement of the third party claim is reached or an award has been made, WC may recover the benefits it paid from the third party settlement and may deny any future claims for that injury up to the amount of the liability payment made to the individual.

If WC does not pay for services or recovers benefits it previously paid for services solely because a third party is determined to be liable, Medicare is not secondary under this provision, to the extent of the nonpayment or recovery by WC. However, Medicare may be secondary for services covered under the liability insurance provision. Consider these cases under the policies in §§3419ff.

3407.5 Possible Coverage of Work Related Services Under Automobile Medical or No Fault Insurance or Employer Group Health Plan.--Where services are covered in part by WC and also under automobile medical or no-fault insurance, WC pays first, the automobile medical or no-fault insurance pays second and Medicare would be the residual payer. (See §3489ff.) If the individual is covered by an EGHP, and is age 65 or over or is under age 65 and entitled to Medicare solely because of ESRD, or is entitled as an active individual, including the member of the family of such individual, who is entitled to benefits on the basis of disability, the employer plan coverage may also be primary to Medicare. (See §§3491ff., 3490ff..) Section 3408.1B for provider billing where there is also coverage by another primary payer.

3407.6 Contested Workers' Compensation Claims

A. General.--An employee may appeal the refusal of an employer to pay WC benefits, or an employer may appeal the award of benefits to an employee by the WC agency. Such appeals are generally heard by a hearing officer or judge of the agency, with further appeal to the WC agency or appeals board and from there to the courts. Sometimes contested claims are settled by compromise between the parties with the approval of the WC agency.

In general, a decision by a State WC agency on a contested claim, or a compromise settlement which has been approved by a WC agency, should be accepted as a basis for applying the WC limitation, except where the settlement did not make reasonable provision for payment under WC of all work-related medical expenses. Thus, where an individual has been denied WC benefits for a particular illness or injury, allow claims for treatment of that condition, unless the decision or settlement is clearly inconsistent with the medical facts and applicable State law and has the effect of shifting to the Medicare program, liability for medical expenses which are the responsibility of the State WC program. Where it is clear that an attempt was made to shift responsibility to the Medicare program, deny the Medicare claim. In your denial notice explain your conclusions in detail and state that the beneficiary may wish to request a reopening under the WC law.

B. Conditional Medicare Payment.--There is frequently a long delay between the occurrence of an injury and the decision by the State WC agency in cases where compensability is being contested. A denial of Medicare benefits pending the outcome of the final decision means that beneficiaries might be required to advance their own funds to pay for expenses which are eventually borne by either WC or Medicare. To avoid imposing a hardship on Medicare beneficiaries pending such decision, conditional Medicare payments may be made. Such payments are conditioned upon reimbursement to the trust fund if it is later determined that the services are covered by WC.

3407.7 Lump Sum Compromise Settlement.--If a WC agency approves a lump sum settlement of a case where compensability is contested, the lump sum settlement is deemed to be a WC payment, even if the settlement agreement stipulates that there is no WC liability. (See §§3416 and 3417.)

If the beneficiary agrees to a compromise lump sum settlement, i.e., a settlement which provides less in total compensation than the individual would have received if the claim had not been compromised, and the settlement has given reasonable recognition to the income replacement objectives of the WC law, the settlement may be accepted as a basis for applying the WC limitation.

Medicare does not accept manipulation of any settlement proceedings intended to shift liability to the Medicare program. Where such manipulation is apparent, Medicare denies payment.

If the individual signed a final release of all rights under WC (which precludes the possibility of further WC benefits) medical expenses incurred after the date of the final release are reimbursable under Medicare, insofar as such subsequent medical expenses were not contemplated by and incorporated into the settlement.

Where the settlement specifies that a portion of the settlement is for future medical expenses Medicare may not pay for those expenses until such time that the beneficiary has submitted bills related to the injury or illness totalling the amount of the lump sum settlement allocated to medical treatment.

See §3416 for further discussion of lump sum settlements and examples of how this provision is applied.

Where the award does not identify the items of medical or hospital expense it is intended to cover, the amount of the award allocated to medical and hospital expense incurred up to the date of the award is applied at the prevailing WC schedule in that jurisdiction in the following manner. First to those services covered by WC but not by Medicare. Second to expenses covered by WC and by Part B (including any deductible and coinsurance.) Third any remainder of the WC settlement is treated as payment for provider services.

Calculate the sum of the award deemed to be payment of medical and hospital expenses in accordance with §3416.2.

3407.8 Lump Sum - Commutation of Future Benefits.--When a beneficiary accepts a lump-sum payment that represents a commutation of all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the medical condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump sum is made, until such time that the beneficiary presents medical bills related to the injury equal to the total amount of the lump sum settlement allocated to medical treatment.

3407.9 Right of Recovery.--All Medicare payments are conditioned on reimbursement to the appropriate Trust Fund, when notice or other information is received that payment with respect to the same items or services has also been made, or could be made, under a WC law or plan of the United States or a State.

Section 1862(b)(1) as amended, now expressly provides that:

A. The Government may recover directly from employers and WC carriers, Medicare benefits it paid for services that are reimbursable under WC. The Government may recover from WC whether or not the beneficiary is filing a WC claim with respect to the injuries.

B. The Government may recover benefits it paid for services that are covered under WC, from any entity that has been paid by an employer or by a WC carrier.

C. The Government is subrogated to the right of any entity to receive payment from an employer or a WC carrier. "Subrogation" literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the Government is given whatever rights the beneficiary or any other entity had against the employer and the WC carrier to the extent that Medicare has made payments to or on behalf of the beneficiary.

D. The Government may join or intervene in any WC claim where the compensability of the injury is at issue.

3407.10 Private Right of Action.--Section 1862(b)(5) provides that where an individual is awarded WC benefits but the WC carrier does not pay primary benefits, the Medicare beneficiary has a right to take legal action against the WC carrier and can collect double the amount that would have been payable had primary benefits been paid. If such litigation is successful the Medicare program can recover the amount paid by Medicare.

3407.11 Conflicting Claims by Medicare and Medicaid.--Under the law (§1862(b)(1)), Medicare has the right to recover its benefits from WC before any other entity, including a State Medicaid agency. Also Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by WC. In other words, Medicare's recovery rights where WC is primary payer are higher than and take precedence over the rights of any other entity.

The superiority of Medicare's recovery right over those of other entities including Medicaid, derives from the Medicare statute, which provides that where Medicare has made a conditional payment for services covered by a WC plan:

- HCFA may recover Medicare benefits directly from the employer or WC carrier;
- HCFA is subrogated to the right of the Medicare beneficiary and the right of any other entity to payment under the WC plan; and
- HCFA may recover its payments from any entity that has been paid under WC.

If Medicare and Medicaid both have claims against WC, Medicare's right to recover its benefits from WC or from a beneficiary that has been paid by WC is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort and, therefore, does not pay its benefits until after Medicare has paid.

Medicare's priority right of recovery from insurance plans that are primary to Medicare, does not violate the concept of Medicaid being payer of last resort. Under §1862(b) of the Social Security Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by a third party which is primary to Medicare. Where WC pays promptly, Medicare makes no payment for any services covered by WC. Delay of the WC payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, where WC pays the charges, or if it pays less and the provider is obligated to accept that amount as payment in full, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid would have the effect of creating a Medicare payment where none is authorized under the law or improperly increasing the amount of any Medicare secondary payment.

Moreover, the right of Medicaid agencies to recover their benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. Since the beneficiary can assign to the State a right no higher than his own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is higher than that assigned to the State. (See §3414.)

3407.12 Authorities for Agreeing to Compromise or Waive Medicare's Claim.-- A beneficiary may offer to refund to you less than the full amount of Medicare's claim against a WC settlement. HCFA may accept such an offer either as:

A. A compromise under authority in the Federal Claims Collection Act (FCCA).

HCFA may agree to compromise a claim for reimbursement from WC settlements under the FCCA, if:

- The individual does not have the present or prospective ability to pay the full amount of the claim within a reasonable period;
- It is determined that it would be difficult to prevail in this case before a court of law; or
- The cost of collecting the claim is likely to be more than the amount collected. All claims in excess of $20,000 must be referred to the Department of Justice.

The limit of HCFA's authority to compromise claims independently under the FCCA is $20,000.

B. Waiver Authority Under §1870(c) of the Social Security Act.--Medicare claims (see §3407.1F for definition) that do not involve the Federal Claims Collection Act (FCCA) could be considered for waiver based on "economic hardship" or "equity and good conscience."

C. Cases you feel could qualify under A or B above should be sent to:

Health Care Financing Administration
Overpayment Section
P.O. Box 120
Baltimore, Maryland 21203

3408. PROVIDER HANDLING OF CASES INVOLVING WORK-RELATED CONDITIONS

3408.1 Workers' Compensation Has Paid or Is Expected to Pay.—

A. General.—Where there is indication that WC may pay for the services, the provider bills the WC carrier. If WC pays for all of the services (whether at the provider's customary charge rate or at a special WC rate) the provider completes a no-payment bill (see §3624 and §3679B). If WC pays only a portion of the charges, the provider bills Medicare in the manner described in §3679C for providers reimbursed on a cost basis and §3685C for hospitals reimbursed on a prospective payment basis.

B. Possible Coverage Also Under Auto Medical or No Fault Insurance or Employer Group Health Plan.--Where services are covered in part by WC and also under automobile medical or no-fault insurance, or there is primary coverage by an EGHP, Medicare would be the residual payer only. (See §3489ff. 3491ff., 3490ff. and IM 3492 respectively.)

Accordingly, whenever WC pays in part for provider services and the provider does not accept and is not obligated to accept such payment as payment in full, the provider takes steps to assure that a claim is submitted to any other insurer that is primary to Medicare.

If the services are related to an automobile accident, the provider ascertains whether its records show coverage under automobile medical or no-fault insurance. Where the provider's records do not show such coverage, the provider contacts the beneficiary to ascertain whether such coverage exists. If there is coverage under automobile medical or no-fault insurance, the provider submits the unpaid portion of the bill to the automobile insurer and follows the instruction in §3489.3B.

If there is no coverage under automobile medical or no-fault insurance, but another insurer is shown on the bill, and there is indication of primary EGHP coverage under §§3490ff, 3491ff or IM 3492, the provider bills the other insurer for the services not paid for by WC. The provider follows the instructions in §3490ff. or §3491ff., as appropriate, and bills the other insurer because, in the case of a beneficiary who is injured on the job and who is covered by private health insurance, it is assumed that the individual is employed and that the other insurance is an EGHP.

If the services provided to the Medicare beneficiary are not related to an automobile accident (see §§3489ff.) and there is no indication of primary EGHP coverage under §§3490 or 3491, the provider bills Medicare for secondary Medicare payments determined in accordance with §3407.3.

If any instances in which Medicare makes secondary payments the appropriate value code as defined in §3604 (items 46 - 49) is to be shown.

3408.2 Workers' Compensation Denies Payment.--If the provider's WC claim is denied, the provider determines whether any other Medicare Secondary Payer provisions apply and bill as appropriate. If no other primary payers are available, the provider submits (A) a bill in accordance with the regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in items 28-32, and (B) a supplementary statement calling attention to the fact that WC has denied payment or annotate item 94 remarks with the reason for the denial.

3408.3 Responsibility of Provider Where Benefits May Be Payable Under the Federal Black Lung Program.--

A. Identification of Cases.--Providers are instructed to identify beneficiaries who may be entitled to benefits under the Federal Black Lung Program.

B. Situations in Which Provider Bills the Department of Labor. (DOL).-- Where it appears that a beneficiary may be entitled to receive medical benefits under the Federal Black Lung Program administered by DOL, the provider will bill DOL in the following situations:

1. Diagnosis Is Black Lung Related.--(See §3409.10 for DOL's Acceptable Diagnosis List.) The provider bills all services to DOL, and includes its DOL assigned provider number on the billing form.

2. Diagnosis Is Not Black Lung Related.--

a. The bill is for an inpatient stay during which some black lung covered procedures were furnished. See §3409.11. for a listing of such procedures and the circumstances under which they are covered by the black lung program. The provider bills all services to DOL.

b. The bill is for outpatient services which include one or more black lung related procedures. The provider bills DOL only for those procedures which are reimbursable under the black lung program. (See §3409.11.)

c. DOL Does Not Pay for All of the Services.--If a provider bills DOL in accordance with a. or b. above, but DOL doesn't pay for the services in full, the provider bills Medicare as provided in §3679 attaching a copy of DOL's denial notice. The denial notice should give the specific reason for nonpayment. If a claim is denied because of the provider's failure to obtain a DOL provider number or to furnish documentation needed by DOL, payment may not be made under Medicare.

3408.4 Responsibility of Provider to Document Cases in Which There Is a Possibility of Workers' Compensation Coverage.--Information supplied by the provider is one of the means of alerting you to actual or potential WC coverage in specific cases involving work-related conditions. A condition is considered to be work-related if it resulted from an accident that occurred on the job or from an occupational disease. The billing form is completed in accordance with §3679 when any of the following conditions apply:

A. The physician or the patient states that the condition is work-related;

B. The condition, or serious aggravation thereof, resulted from an accident which occurred in the course of the individual's employment, e.g., the patient fell from a scaffold while at work;

C. The diagnosis is one which is commonly associated with employment, e.g., pneumoconiosis (including silicosis, asbestosis, and "black lung" disease in the case of a coal miner); radiation sickness, anthrax, undulant fever; dermatitis due to contact with industrial compounds; and lead, arsenic, or mercury poisoning;

D. The beneficiary previously received WC for the same condition;

E. There is indication that a WC claim is pending; or

F. There is other indication that the condition arose on the job.

Providers of services are expected to inquire of the beneficiary or representative at the time hospitalization is ordered or at the time of admission, whether the condition is work-related. When the patient or his physician indicates that the condition is work-related or there is other indication that the condition is work-related (e.g., when any of the conditions in B. through F. above exist), the provider is required to ask the patient or his physician, wherever possible, whether WC is expected to pay for the services. (Generally, where hospital services are covered under a WC program, the services will be authorized in advance by the WC carrier or the employer.)

If the patient denies that WC benefits are payable for a condition which the provider believes may be covered by WC, a supplementary statement will be attached to the billing form containing information about the circumstances of the accident and the reasons it is claimed that WC benefits are not payable.

3409. CONTRACTOR IDENTIFICATION OF CLAIMS WITH POSSIBLE WORKERS' COMPENSATION COVERAGE

3409.1 General.--Identify potential WC cases as well as initiate any ensuing investigation as promptly as possible since a delayed determination that WC payment can reasonably be expected, coupled with failure by the patient to file under that system, may result in delay or even loss of benefits under both WC and Medicare. Where the supplementary information submitted by the provider in accordance with §3408.4 clearly indicates, under the guidelines in §3409.3, that the services are not covered under WC, Medicare benefits are payable without further investigation. However, where it appears that the services may be compensable, undertake an investigation to ascertain the extent to which payment under WC can reasonably be expected.

3409.2 Sources of Information

A. General.--The primary sources indicating WC coverage may be involved are the beneficiary, the provider, his physician, or his employer. When the information obtained from these initial sources indicates that further information is needed, contact the employer's compensation carrier or the State WC agency. (Although in most jurisdictions the WC program is administered by a State Commission or board, there often is no central record of WC cases until a hearing is requested or some action taken to docket a proceeding.) In some cases it is necessary to obtain copies of any decisions made by the WC agency, or settlements approved by the agency.

B. Trailer Code and Automatic Notice Procedure.--When a beneficiary has received WC payments on a prior claim, HCFA generates a Y Trailer containing Code E in response to your query. If the beneficiary had a prior claim paid under the Federal Black Lung Program, a Y Trailer containing Code H is sent in response to your query. When the Master Record indicates that the beneficiary has WC coverage, HCFA generates a Y Trailer, Code 1 in response to your query and a Y trailer containing Code 2 is generated when the HI Master Record indicates that the beneficiary is entitled to Federal black lung benefits (see SS3512.8 and 3535.1 for an explanation of these Trailer Codes.) Also, a Part B automatic notice with a disposition code 36 is sent to all intermediaries of record when a beneficiary for whom an outpatient bill had previously been received becomes entitled to WC. (See S3535.)

C. Data Exchange from Workers' Compensation Agencies.--Transfers of information on claimants for WC benefits, who also may be Medicare beneficiaries, have been negotiated with many State WC agencies. Information from such data transfers provide a valuable source for identifying beneficiaries who may be entitled to WC benefits. If you are not receiving information either directly from the State agency or from the lead contractor contact your RO to determine the possibility of such a data transfer in your State. Also use the MSP Regional Data Exchange as a source of WC coverage information. (See S3696.)

3409.3 Investigation and Evaluation Guides.--The following are general guidelines for investigating and evaluating the likelihood of WC coverage in various situations in which the condition appears to be work-related but the beneficiary has not filed a claim for WC benefits. If the investigation indicates that WC benefits could be paid for the services in question, deny benefits and notify the beneficiary that Medicare benefits are not payable for services covered under WC. Advise the beneficiary to file for WC if he has not already done so and that in the event a WC claim is filed and denied, the Medicare claim may be reopened. Further advise the beneficiary that if the reason for denial of WC benefits is due to the beneficiary's failure to timely file a claim, Medicare payment will not be made. Document your determination with the facts obtained in your investigation.

A. Beneficiary States He Does Not Wish to Report the Condition to His Employer.--Deny benefits when a beneficiary states that he is not requesting payment under WC for expenses incurred in connection with an on-the-job injury because he does not wish to report his illness or injury to his employer.

B. Beneficiary States He Is In Noncovered Employment.--A beneficiary's statement that he is in a category of employment which is clearly not covered under WC can be accepted in the absence of any reason to doubt its accuracy. (See S3407.1A for categories of employees not generally covered under WC.)

C. Beneficiary States Employer or Carrier Denies Condition Is Work-Related or States He Has Exhausted His Workers' Compensation Benefits.--Obtain confirmation of the beneficiary's statement from the employer, the WC carrier, or the State WC agency. If such confirmation is obtained the claim can be paid.

D. Beneficiary States Condition Did Not Arise While Performing His Job Duties.--If a beneficiary states that the injury or illness occurred while engaged in an activity not related to the job, e.g., while on a personal errand or outside of working hours, obtain an explanation as to how the injury or illness occurred and why the injury or illness is not covered under WC. The beneficiary's statement may be accepted in the absence of reasonable doubt as to its accuracy.

3409.4 Action by Intermediary Where Facts Indicate Reasonable Likelihood of Workers' Compensation Coverage (Other Than Federal Black Lung Benefits).--Where the information obtained under the guidelines in §§3409, 3512.8, and 3535.1 indicates that there is a reasonable likelihood that services for which Medicare benefits have been claimed can be paid for under a WC plan other than the Federal black lung program, deny the Medicare claim. The notice to the provider and beneficiary should:

o State that the services are not covered under Medicare because the law prohibits payment for services which are reimbursable under a WC law or plan;

o Advise the provider to submit a claim to the beneficiary's WC carrier (or employer if the employer is self-insured) and;

o Inform the provider that if the WC carrier does not pay for all of the services, he should resubmit the claim to Medicare for further consideration with a copy of any notification received from the WC carrier explaining why the services are not reimbursable under WC.

3409.5 Action by Intermediary Where Facts Indicate Medical Benefits May Be Payable By DOL Under Federal Black Lung Program.--If you learn from the beneficiary, the provider, or by means of the Y-trailer code (per §§3409.2B., 3512.8 and 3535.1, or the automatic notice with disposition code 36 (per §3535), that the beneficiary is entitled to receive medical benefits from the Department of Labor (DOL) under the Federal Black Lung Program, deny the entire bill in any of the following situations:

o The bill is for inpatient services and the diagnosis shown on the billing form (one must be obtained if not shown) is a condition attributable to pneumoconiosis (see the respiratory related conditions listed in §3409.10 below), and there is no indication that the claim has already been considered by DOL. If DOL has already considered the claim and denied some or all of the services for reasons other than lack of a DOL provider number or insufficient documentation (per §3408.3B2.c. DOL's denial notice must give the specific reason for the denial), process the unpaid charges per §3679ff. or §3685.

o The bill is for inpatient services and the bill includes a medical procedure which is covered under the black lung program (see paragraph F below for a listing of such procedures and the circumstances under which they are covered under the black lung program).

o The bill is for outpatient services and the diagnosis and all of the services are black lung related regardless of whether the condition is acute or chronic. (See §§3409.10 and 3409.11 but disregard the category codes as they only apply to inpatients).

3409.6 Special DOL Coverage Rules.--DOL pays for certain ancillary items and services and for specific drugs relating to the treatment of pneumoconiosis (black lung disease) when a beneficiary is in an SNF. However, DOL does not make any reimbursement for room and board charges in SNFs. In some instances, DOL covers certain items and services under limited conditions only. In such cases, a Certificate of Medical Necessity (CMN) is required. This DOL form (CM-893) is completed by the prescribing physician and must be approved by DOL before it reimburses for the services or items. Approvals may be given for a specific time only and in such case it is not necessary to submit a copy of the CMN with each bill during the approved period. A CMN is also required for the payment by DOL for home health services. Such services are reimbursed by DOL when a beneficiary returns home following hospitalization for an acute pulmonary condition and the physician prescribes follow-up care in the home, or the beneficiary is home bound due to his pulmonary condition and require physician-prescribed home care for that condition. Additionally, CMNs are required for pulmonary rehabilitation.

If the CMN is rejected by DOL, then the items or services can be billed to Medicare with a copy of the DOL denial attached. However, if the individual's condition changes and test results confirm this, submit a new CMN to DOL for review. Any items or services billed to DOL are not to be billed to the Medicare program unless a denial has been received from DOL.

3409.7 Medicare Payment.--If the bill is for outpatient services, Medicare may pay for any service that is not related to black lung disease (e.g., treatment of diabetes, fracture). Deny any bill for the coverage of services or drugs needed to treat the black lung conditions. (See §3679 F for billing procedures.)

3409.8 Questionable Cases.--If there is a question regarding whether a procedure is related to black lung disease, develop the issue with the provider.

3409.9 Federal Black Lung Program Address.--Where benefits are being denied because all or part of the services are reimbursable under the black lung program, advise the provider to submit a claim to the following address:

Federal Black Lung Program
P. O. Box 740
Lanham, MD 20706

Section 3722.4, MISC-15 is the applicable standard denial paragraph. Advise the provider that if DOL does not pay for all the services, to resubmit the claim, with a copy of DOL's explanation of its payment.

In a very small number of cases involving beneficiaries entitled to Federal black lung benefits, the coal mine operator rather than DOL is responsible for the miner's medical treatment. In these instances there is no Y-trailer code or disposition code 36. Handle such cases under §3409.4 and advise the provider to submit the claim to the coal mine operator or its WC carrier.

3409.10 DOL's Acceptable Diagnosis List.--The following is DOL's "Acceptable Diagnosis List" (ADL). DOL will pay for an inpatient stay only if the primary diagnosis (the diagnosis that precipitated the inpatient care) is any one of the acute conditions. (Black lung pneumoconiosis, chronic obstructive pulmonary disease (COPD) are not acute conditions. A diagnosis coded "A" is acceptable to DOL as a primary admitting diagnosis for inpatient services or emergency room care only when concurrent diagnoses or the discharge diagnoses/summary indicate pulmonary disease as the primary acute condition.

DOL'S ACCEPTABLE DIAGNOSIS LIST (ADL)

CODE ICD-9-CM	CATEGORY	DISEASE/CONDITION
5130	(A)	Abscess: Lung and Mediastinum
2762	(B)	Acidosis - respiratory (only when due to pulmonary disease)
2763	(B)	Alkalosis - respiratory (only when due to pulmonary disease)
5163	(B)	Alveolocapillary block - pulmonary
4171	(B)	Aneurysm - pulmonary circulation
500	(B)	Anthracosilicosis
500	(B)	Anthracosis
5180	(A)	Atelectasis
0310	(A)	Bacterial disease, pulmonary infection by mycobacterium
4820 thru 4829	(A)	Bacterial pneumonia

DOL'S ACCEPTABLE DIAGNOSIS LIST (ADL) (CONT.)

CODE ICD-9-CM	CATEGORY	DISEASE/CONDITION
1160	(A)	Blastomycosis (pulmonary ONLY)
4939	(B)	Bronchial asthma
494	(B)	Bronchiectasis
4661	(A)	Bronchiolitis acute
4660	(A)	Bronchitis - acute
2312	(A)	Cancer Bronchus and Lung
7991	(A)	Cardio-respiratory failure unless associated with M.I. (Myocardial infarct) or renal failure
7865	(B)	Chest Pain (excludes angina)
7931	(A)	Coin lesion (lung)
4280 4281	(A)	Congestive heart failure - secondary to pulmonary disease - that is with: pulmonary hypertension, 4289 polycythemia or cor pulmonale. EXCLUDED is CHF when associated with: valvular heart disease, ischemic heart disease such as ASCD, ASHD, ASCVD, MI (myocardial infarct) or angina. CHF is not covered when associated with renal failure.
496	(A)	COPD (chronic obstructive pulmonary disease) Acute exacerbation
4150	(A)	Cor pulmonale -acute pulmonary heart disease
483	(A)	Eaton agent - pneumonia
4280 4281 4289	(B)	Edema - pulmonary - CHF
5088 5089	(B)	Edema, pulmonary (other diseases)

DOL'S ACCEPTABLE DIAGNOSIS LIST (ADL) (CONT.)

CODE ICD-9-CM	CATEGORY	DISEASE/CONDITION
4151	(B)	Embolism - pulmonary, covered if associated with polycythemia not covered if post-operative other than lung surgery.
5100 thru 5109	(A)	Empyema
4920	(B)	Emphysema - chronic
4170	(B)	Fistula - pulmonary circulation
487	(A)	FLU (Influenza)
0391	(A)	Fungus - pulmonary infection
7863	(A)	Hemoptysis
11505	(A)	Histoplasmosis, pneumonia
487	(A)	Influenza
7866	(A)	Mass in lung
0310	(A)	Mycobacterium - pulmonary
1622 thru 1629	(A)	Neoplasm - malignant, lung or bronchus
78652	(B)	Painful respiration
5110 thru 5119	(A)	Pleurisy

DOL'S ACCEPTABLE DIAGNOSIS LIST (ADL)(Cont.)

CODE ICD-9-CM	CATEGORY	DISEASE/CONDITION
4810	(A)	Pneumococcal pneumonia
4661	(A)	Pneumonia - capillary
483	(A)	Pneumonia - Eaton agent, Mycoplasma PPLO
4820 thru 4829	(A)	Pneumonia - other bacteria
4840 4860	(A)	Pneumonia - other disease/other organisms
481	(A)	Pneumonia - Pneumococcal
4809	(A)	Pneumonia - viral
5120	(A)	Pneumothorax, non traumatic
483	(A)	PPLO - pneumonia
7931	(A)	Shadow chest x-ray, abnormal
7861	(B)	Stridor
7850	(B)	Tachycardia - unspecified (acceptable when no non-covered conditions are listed)
78609	(B)	Tachypnea, abnormal breathing
0019	(A)	Tuberculosis
4809	(A)	Viral pneumonia

3409.11 DOL's Approved Procedure List.—This list is coded by letter code to assist in identifying the type of service the DOL reimburses. The letters represent the following categories:

CODE A — A major procedure always covered under Black Lung treatment benefits when performed in conjunction with a condition listed on the Acceptable Diagnostic List (ADL).

CODE B	A major procedure covered under the program only when performed for a condition on the Acceptable Diagnostic List (ADL).
CODE C	A routine procedure always covered under Black Lung treatment benefits when performed in conjunction with a condition on the ADL.
CODE D	A routine procedure covered only when performed for a condition on the ADL or considered concomitant care when treating a patient for an ADL condition as an inpatient.

DOL'S APPROVED PROCEDURE LIST

CATEGORY	SURGERY
B	Tracheostomy-incision (only when secondary to pulmonary disease)
B	Tracheostomy-with skin flaps (only when secondary to pulmonary disease)
B	Tracheal puncture for aspiration of mucus
B	Tracheostomy through established incision
B	Thoracentesis
B	Thoracostomy - Tube procedure, pneumothorax, hemothorax
B	Thoracostomy - for empyema with rib resection, open flap drainage
B	Thoracotomy
B	Pleural scarification for repeat pneumothorax
B	Decortication - pulmonary
B	Pleurectomy
B	Decortication and parietal pleurectomy
B	Biopsy pleura
A	Biopsy - Lung
B	Pneumocentesis
A	Pneumonectomy
A	Lobectomy
A	Wedge resection of lung
B	Resection of lung with resection of chest wall

DOL'S APPROVED PROCEDURE LIST (Cont.)

CATEGORY	SURGERY
B	Extra pleural enucleation of empyema
B	Extra pleural enucleation of empyema with lobectomy
B	Thoracostomy exploratory
B	Thoracostomy with biopsy
B	Repair closure of chest wall following open flap drainage for empyema
B	Repair open closure of major bronchial fistula
B	Thoracoplasty
B	Thoracoplasty with closure of broncopleural fistula
B	Exploration for post operative hemorrhage or thrombosis (Sec. to pul. dis. only)
B	Arterial puncture-Withdrawal of blood for diagnosis
A	Mediastinoscopy with or without biopsy
	RADIOLOGY-DIAGNOSTIC
D	Radiologic exam of chest including fluoroscopy
D	Fluoroscopic localization of needle biopsy of intrathorasic lesion
D	Fluoroscopic localization of transbronchial biopsy
D	Bronchography - supervision and interpretation
D	Bronchography - complete
D	Tomography, computerized - thorax
	RADIOLOGY (NUCLEAR MEDICINE)
D	Pulmonary perfusion imaging (particulate gaseous), Pulmonary ventilation imaging (aerosol, gaseous)

CATEGORY	
	RADIOLOGY - RADIOTHERAPY
	PATHOLOGY AND LABORATORY
	(Multichannel tests - automated)
D	SMA: Clinical chemistry tests - various combinations (Diagnosis must justify)
	URINALYSIS
D	Urinalysis - routine
	CHEMISTRY AND TOXICOLOGY
D	Aminophylline
D	Chlorides - blood
D	Dicumarol
D	Digitoxin - blood (digitalis)
D	Fibrinogen - quantitative
C	Blood gases - oxygen saturation, pO_2, pCO_2,pH
D	Glucose, urine
D	Glutamate dehydrogenase, blood
D	Hemoglobin, electrophoresis
D	Hydroxyindolacetic acid, 5-(HIAA), urine
D	Iron, serum
D	Iron binding capacity, serum
D	LDH (lactic dehydrogenase); blood
D	Osmolality; blood
D	Phosphorus (phosphate); blood
D	Potassium; blood
D	Procainamide
D	Protein, total serum
D	Quinidine, blood
D	Serotonin, blood
D	Sodium blood
D	Sulfonamide, blood
D	Theophylline, blood or saliva
D	SGOT (Transaminase, glutamic oxaloacetic blood
D	SGPT (Transaminase, glutamic pyruvic); blood
D	BUN (Blood urea nitrogen)
D	Vitamin K
D	Warfarin
D	Volume, blood - total plasma, total blood cell volume

DOL'S APPROVED PROCEDURE LIST (Cont.)

CATEGORY

IMMUNOLOGY
(Includes serology, immunohematology, blood bank)

D	Antibody, qualitative, quantitative titer not otherwise spec.
D	Drug sensitization, identification (e.g., penicillin) (Antihuman globulin)
D	Antitrypsin, alpha-1 determination
D	Blood cross-match, compete standard technique, includes typing and antibody screening of recipient and donor
D	Blood unit for direct transfusion
D	Complement fixation tests
D	Fibrinogen unit
D	Fluorescent antibody, screen titer
D	Hemagglutination inhibition tests (HAI)
D	Hemolysins and agglutins, auto, screen
D	Immunoelectrophoresis; serum
D	Neutralization test, viral
D	Precipitin determination, gel diffusion (alveolitis cond.)
D	Prothrombin complex
D	Skin test; blastomycosis
D	Skin test; histoplasmosis
D	Skin; psittacosis
C	Skin tests; tuberculosis, patch, intradermal, tine
D	Streptokinase, antibody
D	Tissue culture - typing

MICROBIOLOGY
(Includes bacteriology, mycology, parasitology, virology)

D	Concentration (e.g., tubercle bacillus)
D	Culture - bacterial, aerobic, throat or nose (may include anaerobic screen) identification
D	Culture - bacterial anaerobic - (Acceptable only when from lung)
D	Culture - single organism screening (acceptable only when respiratory)
D	Culture - fungi (Acceptable only when from lung) Identification
D	Culture - myoplasma (acceptable only when from lung)
D	Culture, tubercle or other acid-fast bacilli (Acceptable only when from lung)
D	Culture, typing; fluorescent, gas liquid chromatography, phage method, serology method, precipitin method, other special (acceptable only when applicable to respiratory disease specimen)

DOL'S APPROVED PROCEDURE LIST (Cont.)

CATEGORY	
D	Sensitivity studies; antibiotic tubercle bacillus (TB, AFB)
D	Endotoxin - animal inoculation
D	Endotoxin, chemical analysis
D	Endotoxin - hemogenization, tissue, for culture
D	Sensitivity studies - antibiotic
D	Sensitivity studies - tubercle bacillus (TB, AFB) each drug
D	Smear - primary source, with interpretation; routine stain, for bacteria, fungi; or cell types
D	Smear - special stain for inclusion bodies (parasites not included)
D	Smear - fluorescent and/or acid fast stain for bacteria, fungi, or cell types
D	Wet mount with simple stain and interpretation for bacteria, fungi (parasites not included)
D	Virus, inoculation - embryonated eggs, tissue culture or small animal - observation, etc.
D	Vaccine, autogenous

CYTOPATHOLOGY

D	Cytopathology - fluids, washings or brushings (not cervical or vaginal)
D	Cytopathology - other sources (e.g. sputum)

SURGICAL PATHOLOGY

D	Surgical pathology - gross and microscopic diagnostic
D	Special stains
D	Interpretation, review and consultation on slides and record material
D	Consultation during surgery
D	Immunofluorescent study
D	Electron microscopy - diagnostic, scanning
D	Whole organ sections

MISCELLANEOUS

D	BMR
D	Roll-up codes - These codes include sundry combinations of the following tests/procedures: CBC, urinalysis, serology, blood typing, Rh grouping, cell count (body fluids), CSF
D	Occult blood (not feces)
C	Sputum, obtaining specimen-aeroscol induced

DOL'S APPROVED PROCEDURE LIST (Cont.)

CATEGORY

HOSPITAL MEDICAL SERVICES

D	Inpatient hospital services by physician-examination, diagnosis, treatment, hospital records (ONLY when diagnosis is pulmonary disease.) Physician's services in the emergency room. (Only when primary diagnosis is pulmonary - on the ADL list).

MEDICINE

D	Electrocardiogram, (EKG,ECG) Cardiopulmonary resuscitation (Only when condition due to pulmonary disease)
C	Spirometry - Total and timed vital capacity, flow rate and maximal voluntary ventilation
C	Pulmonary evaluations - specific tests (Must be justified by diagnosis that requires detailed results)
C	Non-pressurized inhalation therapy
C	IPPB treatment, air or oxygen (as an inpatient only)
D	CPAP - (Continuous positive airway pressure ventilation)
D	CNP (Continuous negative pressure ventilation)
C	Aerosal or vapor inhalation therapy for sputum mobilization
C	Percussion, cupping, vibration (Manipulation of chest wall)
C	Arterial Blood Gas study - rest
C	ABG - Rest and exercise (including cannulization)
C	O_2 administration, IPPB, exercise - three or more (IPPB ONLY AS AN INPATIENT)

ANESTHESIA - SPECIAL QUALIFYING CIRCUMSTANCES
(must be for item on APL)

D	Anesthesia for patient - over 70
D	Anesthesia for patient with an incapacitating systemic disease

SPECIAL SERVICES

D	Prolonged physician's services (e.g., operative standby, monitoring blood gases during surgery, etc.)
D	Critical Care - including diagnostic and therapeutic (ONLY FOR PRIMARY LUNG CONDITION - NOT TRAUMA)

NOTE: DOL WILL REIMBURSE FOR A CONSULTATION BY A PULMONARY SPECIALIST EVEN THOUGH A PRIMARY REASON FOR INPATIENT CONFINEMENT IS NOT ON THE ADL (ADDITIONAL CONSULTATIONS MUST BE JUSTIFIED)

3410 PARTY REQUESTS THAT MEDICARE ACCEPT LESS THAN ITS CLAIM

If there is a request that Medicare accept less than the full amount of its claim (see §3407.1F for definition) and less than the full amount of the WC settlement, inform the party that legally Medicare has the right to recover its full claim up to the full amount of the settlement. However, a request for such a reduction will be reviewed provided it is submitted in writing and specifies the reasons why and to what extent the Medicare claim should be reduced.

In addition to the right of direct recovery, §1862(b)(1) of the Social Security Act gives the Medicare program the right of subrogation for any amounts payable to the program under the Medicare Secondary Payer (MSP) provisions. The Federal Claims Collection Act of 1966 (FCCA), as amended by the Debt Collection Act of 1982 and §1870(c) of the Social Security Act give HCFA the right to settle claims for reimbursement.

3410.1 Notification of Other Part A Intermediaries or Part B Carriers.--When investigating the possibility of payment under workers' compensation for items or services for which Medicare benefits are claimed, promptly inform any other carriers or intermediaries concerned with the claim for possible WC involvement. Coordinate your investigation and determination regarding WC coverage with the other carriers or intermediaries for consistency in the determinations concerning the same injury or illness.

3411. MEDICARE MADE PARTY TO WORKERS' COMPENSATION HEARING

If a WC agency has suggested that Medicare be represented at a WC hearing or has named Medicare as a party to a WC claim, or if the government's claim is otherwise in question at a hearing, the lead contractor should represent Medicare's interests at the hearing. In addition, if the lead contractor feels it would be beneficial to the recovery, its attorney can attend a WC hearing at the request of the plaintiff's attorney as long as under the applicable State law such hearing is not considered litigation. However, if the hearing is conducted by a court, whether at the initial or the appellate level (in some States the WC program is administered by a court), consult with the RO as to what action to take. The RO will advise you whether to refer the case to them or whether you should represent the program at the hearing. Take prompt action on such cases to avoid adverse action by the WC agency or court. If the case is referred, include pertinent Medicare claims information.

3412. TIME LIMIT FOR FILING WORKERS' COMPENSATION CLAIM HAS EXPIRED

Most WC plans have time limits within which the employee must notify the employer that he has suffered a work-related injury or illness and file a claim for benefits. If it appears that WC benefits could have been paid for items or services for which benefits have been paid under Medicare, but the time limit for filing a WC claim has expired, refer the case with all pertinent documentation relating to the WC issue to HCFA at the address given in §3417.2 below.

Annotate Item 13 (Remarks) of the Form HCFA-2382 (Intermediary Transmittal of Uncollected Medicare Overpayments) as follows: "Workers' Compensation Case--Referred for Waiver Consideration per §3412 of the Part A Intermediary Manual." Also include in this item the following information: (1) a full explanation of the basis for your determination that WC benefits could have been paid for the items or services and that the time period for filing a WC claim has expired, and (2) the reasons for the beneficiary's delay in filing a WC claim.

3413. BENEFICIARY ACCEPTED COMPROMISE LUMP-SUM SETTLEMENT OF WORKERS' COMPENSATION CLAIM

If you learn that a beneficiary has accepted an award as a compromise settlement of a WC claim, reopen the prior allowance and determine the amount of overpayment in accordance with the instructions in §§3407.7, 3407.8 and 3417. Any Medicare payments made for items or services determined to have also been paid for by the lump-sum settlement should be recovered from the beneficiary in accordance with the instructions in §§3711ff.

3414. INTERMEDIARY ACTIONS WHERE MEDICAID ALSO HAS REQUESTED REFUND

If Medicare and Medicaid have paid for services, and the amount available under a WC plan is not sufficient to satisfy the claims of both programs for reimbursement, notify the WC carrier that Medicare must be reimbursed the full amount of its claim before any other entity, including a State Medicaid agency, may be paid by the WC carrier.

Also where a beneficiary, provider or supplier receives payment from a WC carrier for services which have already been paid by Medicare and Medicaid, and the amount paid by the WC carrier is less than the combined amounts paid by Medicare and Medicaid, inform the beneficiary, provider or supplier that it is obligated to refund the Medicare payment up to the full amount of the WC payment, despite a conflicting claim by a State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary, provider or supplier have the right to reimburse Medicaid or any other entity.

If a WC carrier has reimbursed a State Medicaid agency, or if a beneficiary, after receiving a WC settlement, has reimbursed a State Medicaid agency, request the beneficiary that was paid by the WC carrier to reimburse Medicare from the remainder of the settlement. If the remainder of the settlement is insufficient to reimburse Medicare in full, ask the State agency to reimburse Medicare up to the full amount the agency received. Explain the legal basis for Medicare's right to recover in accordance with §3407.11. If the State refuses to reimburse Medicare in full, refer the case to the RO. The RO's recovery actions may include offset of Medicare's claim against any Federal Financial Participation funds otherwise due the State.

3415. CONDITIONAL MEDICARE PAYMENTS

A. Conditional Medicare Payments.--Conditional Medicare benefits may be paid while a WC claim is being contested. There frequently is a long delay between the occurrence of an injury or illness and the decision by the State WC agency. A denial of Medicare benefits pending the outcome of the appeal would mean that individuals might be required to advance their own funds to pay for expenses which will eventually be borne by either Medicare or by WC. To avoid imposing hardship on Medicare beneficiaries while a decision is being made by the WC agency, conditional Medicare payments may be made pending a final decision on the WC claim.

NOTE: If the injury resulted from an automobile accident, and/or there is indication of primary coverage under an EGHP, the provider bills the automobile medical or no-fault insurer and/or employer plan as appropriate, in accordance with the instructions in §§3489ff, §3490ff, or §3491ff, before requesting conditional Medicare payments. (See §3407.5 and §3408.1.B.)

B. Action by Intermediary Subsequent to Conditional Payment.--Contact the WC carrier at least every 4 months (with a copy to the beneficiary's attorney) to ascertain the status of any claim on which conditional payments have been made. If the carrier is not cooperative, contact the attorney instead.

3416. EFFECT OF LUMP-SUM COMPROMISE SETTLEMENT

Negotiated compromise settlements of WC claims, by their very nature, provide less than full benefits for both income replacement and medical expenses. See §3407.7 for Medicare policy dealing with lump sum settlements.

In general, medical expenses incurred after the date of the final release of a lump sum compromise settlement are reimbursed under Medicare; however, if the settlement agreement allocates certain amounts for future medical expenses, Medicare does not pay for those services until such time as the beneficiary presents medical bills related to the injury totalling the amount of the lump sum settlement allocated to medical treatment. If the lump-sum settlement includes payment for future services, then in order to prevent erroneous payments, retain a copy of the lump-sum agreement and flag any new claims for the same condition for which the beneficiary received the lump-sum payment. Also, whenever you are informed of any lump-sum agreement, notify other contractors that process claims in your area. In addition the Regional Data Exchange System will lend itself to notification within the region. Contractors from other regions can obtain this data upon special request.

If it appears that a settlement represents an attempt to shift to Medicare the responsibility for the payment of medical expenses for the treatment of a work-related condition, it will not be recognized. Settlements of this type may occur, for example, when the parties attempt to maximize the amount of disability benefits paid an injured employee under WC by releasing the WC carrier from liability for a particular course of medical treatment, despite the existence of facts showing a relationship between the work injury and the condition which necessitated the treatment. In such cases, determine that the services could have been paid for under WC and are, therefore, not payable under Medicare.

EXAMPLE 1: A Medicare beneficiary was operated on for a hip fracture received in the course of his employment. Following surgery, the individual went into post-operative shock and suffered a cerebrovascular accident which required hospitalization for an additional 3 months. The total hospital bill was $12,000. Despite the fact that, under these circumstances, the State WC plan would have covered the individual's entire hospital bill, his attorney instructed the hospital to bill the WC carrier only for the expenses incurred through the date of the hip surgery, pending the outcome of the disability settlement which was being negotiated.

The State WC agency subsequently approved a compromise settlement of the claim, under the terms of which the WC carrier admitted liability for the hip fracture but not for the stroke. The settlement provided for payment to the beneficiary of $18,000 plus payment to the hospital of $1,200 for his stay through the date of the surgery. Following the settlement, the beneficiary requested the Medicare intermediary to pay for the 3 months of hospitalization following the surgery, since the settlement did not stipulate that treatment of the stroke was work-related. The intermediary determined that payment under WC for treatment of the stroke could reasonably have been expected if the beneficiary had not agreed to give up his right to such compensation. It, therefore denied the claim. The provider has the right to bill the beneficiary since these services would have been covered by WC and, therefore, are not payable by Medicare.

EXAMPLE 2: A Medicare beneficiary settled a WC claim which stipulated, among other things, that the WC carrier would: (1) pay the individual a lump-sum of $50,000 as compensation for permanent and total disability, (2) pay all of the individual's medical expenses related to his work injury until such time as he became entitled to benefits under Medicare or any other government medical benefit program, and (3) continue to pay, without any time limitation, any portion of his medical expenses for the work injury which was not reimbursable under a government program. The award further stipulated that the employee would seek payment for the medical care related to the work injury from State and Federal Government programs to reduce the obligation of the employer and carrier as much as possible.

Although the compensation order in this case was designed to reduce the obligation of the employer and carrier to pay for medical care by shifting medical expenses to Medicare and other government programs where possible, the agreement recognized the WC carrier's continuing responsibility for the individual's medical care. Since Medicare is not bound by such covenants, benefits were denied for all expenses subsequently incurred by this individual for treatment of the work injury. As in Example 1 above, the Medicare beneficiary may be billed for these services.

EXAMPLE 3: In July, 1980 Mr. Y, age 30, was involved in an accident at work sustaining injury to his neck, back, right arm and legs. Beginning with the date of the accident, the WC carrier paid Mr. Y weekly benefits of $182 for temporary disability and also paid all of his medical expenses.

In 1982, Mr. Y became entitled to Medicare based on disability. In July, 1984, the WC insurer decided to terminate Mr. Y's medical and disability payments based on medical advice that his continuing impairments were not attributable to the work injury. By this time, the insurer has paid a total of $90,000 for Mr. Y's medical care.

Mr. Y contested the termination of his WC benefits, and the case was settled by compromise. A lump sum of $46,000 ($6,000 of which was designated as attorneys' fees) was paid to Mr. Y. As part of the settlement agreement, Mr. Y signed a final release which stipulated that future medical expenses were "in dispute" and that they were to be assumed by Mr. Y "as his sole responsibility."

The fact that Mr. Y accepted, and the State WC agency approved, a relatively small lump sum payment, compared with what Mr. Y would have received had his WC claim been approved in full, indicates that there was doubt as to the compensability of the injury. There was no indication that the lump sum was intended to be payment for future medical expenses, nor do these facts in themselves indicate that the settlement represented an attempt to shift the responsibility for future medical expenses from WC to Medicare.

Therefore, Mr. Y's signing of the final release of all rights under WC makes it possible for medical expenses incurred after the date of settlement to be reimbursed under Medicare.

3416.1 Lump-Sum Payment Which Represents Commutation of Future Benefits.—If an individual is paid a lump sum WC benefit which is intended to compensate the individual for all future medical expenses and disability benefits, and the lump-sum amount is reasonable considering the future medical services that can be anticipated for the medical condition, Medicare benefits are not payable for any future expenses directly related to the work injury for which the lump-sum was paid until such time as the beneficiary presents medical bills related to the injury totalling the amount of the lump sum settlement allocated to medical treatment.

3416.2 Apportionment of a Lump-Sum Compromise Settlement of Contested Workers' Compensation Claim.—If the settlement covers both medical care and disability benefits but does not apportion the sum granted between medical and hospital expenses and income replacement, or does not give reasonable recognition to both medical care and disability, calculate the amount of the award deemed to be payment of medical and hospital expenses as follows:

A. Determine the ratio which the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) bears to the total amount which would have been payable under WC for both medical and hospital expenses (including expenses not covered under Medicare) and income replacement, if the claim had not been settled by compromise.

B. Multiply this ratio by the total medical and hospital expenses incurred as a result of the injury or disease up to the date of the settlement. The product will be deemed to be the amount of WC settlement intended as payment for medical and hospital expenses. The latter amount will be applied to the medical and hospital expenses incurred due to the work-related injury as provided in §3407.7.

In paragraph A. above, the determination of the "total amount that would have been payable under W C had the claim not been settled by compromise" should generally be based on information furnished by the beneficiary's attorney. If you have reason to question the attorney's estimate, base the determination on information from other sources such as the State W C agency.

The first step in making the above determination is to request that the attorney furnish you a statement of the amounts that would have been payable for disability and medical care if the beneficiary were awarded full benefits under the W C law. The attorney's estimate should include an amount for disability based on the anticipated number of months of total disability and an amount for partial disability. Each amount should be based on the specific amounts which the law states are payable for each type of disability. The estimate should also include an amount for medical care based on actual and anticipated medical expenses related to the work injury. The information provided by the attorney should be consistent with the beneficiary's medical condition and the provisions of the applicable W C law. (W C laws require that employers pay all work-related medical expenses, and designate amounts for temporary and permanent disability.)

If you believe there is a discrepancy between the attorney's estimate and what you consider to be the beneficiary's medical situation and the provisions of the law, ask the attorney for additional information and/or an explanation of how the amount was determined. It may also be helpful to consult with the State W C agency to obtain confirmation that the attorney's estimate is consistent with the medical facts and with the law. This agency should also be contacted for the above information if the attorney does not cooperate in furnishing it.

If, after the above development, you are convinced that the attorney has overstated the amount that would have been paid if the claim were not settled by compromise, base your determination of overpayment on a lower amount that you feel is reasonably based on all the facts of the case. In such cases, send the attorney a full explanation of how you determined your estimate with particular attention to those aspects which differ from the attorney's estimate.

EXAMPLE 4: Mr. A suffered a work injury resulting in loss of income and he incurred expenses for hospital and medical services for which the total W C payment would have been $24,000 had the case not been compromised. The expenses totaled $18,000 and included $10,200 in hospital services, which in the absence of W C, would be paid for under Part A; $6,300 in expenses for medical and other health services for which payment would be made under Part B on a reasonable charge basis, and $1,500 in expenses for services not reimbursable under Part A or Part B but reimbursable under W C. The W C carrier made a settlement with the beneficiary under which it paid a total of $8,000. A separate award was made for legal fees.

Since the settlement was for one-third of the amount which would have been payable under W C had the case not been compromised ($8,000/$24,000 = 1/3) the settlement is deemed to have paid for one-third of the total medical and hospital expenses (1/3 x $18,000 = $6,000).

To determine the amount of Medicare benefits payable, the $6,000 of the compromise WC settlement considered as payment for hospital and medical expenses, is applied first to the $1,500 in non-covered expenses. The remaining $4,500 is applied to the $6,300 in Part B covered expenses (without deducting the deductible and coinsurance). The remaining $1,800 of such Part B expenses and all of the $10,200 in expenses for services covered under Part A would be reimbursable under Medicare, subject to the regular deductible and coinsurance requirements. It is assumed in this example that the expenses specified above as incurred by Mr. A are the amounts which would have been paid by the WC for such services. If this is not the case, the services should be charged against the lump-sum payment at the usual WC rate.

EXAMPLE 5: Mr. B worked for a florist. On May 18, 1986, while making a delivery, he fell and broke his hip. He was admitted to the hospital, where it was discovered that, in addition to his fracture, he had a severe infection. He was hospitalized until August 20, 1986. Medicare paid a total of $60,000 toward the medical and hospital expenses.

Mr. B settled his WC claim by accepting a lump sum compromise payment of $50,000, $10,000 of which represented attorney's fees. Medicare submitted a claim to Mr. B's attorney requesting reimbursement for the amount it had paid toward the medical and hospital expenses. The WC lump sum represented a compromise settlement of Mr. B's present and future disability benefits, estimated at $35,000, and past medical expenses (including $48,000 paid under Part A, $12,000 covered under Part B, and $5,000 for expenses not covered under Medicare). Thus, had Mr. B not compromised, the total amount that would have been payable for disability and medical expenses would have been $100,000 ($35,000 for disability and $65,000 for medical). There did not appear to be an attempt to shift the WC liability to Medicare.

The award ($50,000), less attorney fees ($10,000), is 40% of what would have been paid if Mr. B had been awarded full benefits ($100,000). Under the lump sum apportionment formula in subsection A above, it is determined that 40% of $65,000 in total medical expenses, or $26,000, is deemed to have been paid by the WC compromise settlement.

As Mr. B had $5,000 medical expenses for non-covered Medicare services, that amount is deducted from the $26,000, leaving $21,000 to be applied to Mr. B's Medicare covered expenses. The entire $12,000 of Mr. B's Part B expenses (including the deductible and coinsurance) is considered to have been paid for by the WC award and $9,000 of the $48,000 in Part A expenses are considered paid for by the WC award. Medicare's claim is the amount it paid toward the $12,000 in Part B services and $9,000 of the Part A payment. These payments were duplicated by the WC payment.

3417 OVERPAYMENT DUE TO WORKERS' COMPENSATION COVERAGE

You may have paid for services and subsequently learned that the services were job related. However, the mere fact that information is received indicating that a particular injury or illness occurred on the job does not necessarily mean that Medicare payments made for that injury were incorrect. You must consider whether, in view of the factual circumstances, benefits are not payable under the policies in §§3407ff. This generally requires careful development along the lines described in §3409ff. Sometimes, the development will show that there was a legitimate reason for the provider billing the Medicare program. For example, the individual may have exhausted his WC benefits or the particular services may have been for a condition not related for the work injury.

Once it is determined that payment has been made for services covered by WC, initiate efforts to recover the overpayment. Sections 3417.1 and 3417.2 provide guidelines for recovery of Medicare payments in some of the more common situations in which there is an indication that payment was made by Medicare for a work-related injury or illness. However, since the circumstances in which work-related issues arise vary greatly, it is impossible to provide definitive rules which will cover every situation. Therefore, it is essential to use judgment and discretion in applying the guidelines.

3417.1 Duplicate Payment Received by Provider.--If a Medicare payment duplicates a WC payment, recover the Medicare payment from the provider in accordance with the instructions in §§3710ff. Recovery of conditional payments is not subject to the reopening rules nor to the limitation on recovering incorrect Medicare payments discovered later than the third calendar year after the year of payment where a WC plan is primary payer. (See the note in §3708.4.)

3417.2 Medicare Paid for Services Which Should Have Been Paid For by Workers' Compensation.--In any case in which it is clear that Medicare paid for services that should have been paid for by the WC carrier and no payment was made, request that the carrier reimburse the Medicare program for the amounts improperly paid by Medicare.

Include in your notice to the WC carrier, an explanation of the reason you feel that the services should be paid under WC, and the amount that Medicare has paid. In addition, explain that the Medicare law excludes payments for services covered under WC, and requires WC carriers to make direct refund to the Government where Medicare has paid for services that are reimbursable under WC.

If arrangements to refund the amount due are not made by the WC carrier within 30 days after notification, ask the carrier for an explanation for the delay, whether it intends to refund the Medicare overpayment and, if not, why. If the WC carrier's response is negative, and you still feel that the services are clearly covered under WC, refer the case to the RO. If the beneficiary is represented by an attorney, address any correspondence on the WC issue to the attorney. Send copies of all correspondence with the WC carrier and with the beneficiary concerning the WC issue to the State WC agency.

If the carrier either declines to refund the overpayment outright or indicates a long delay will be necessary, refer the file to:

Health Care Financing Administration
Overpayment Section
P. O. Box 120
Baltimore, Maryland 21203

together with a covering letter which fully explains the WC issue and your recommendations for disposition of the case in accordance with the applicable WC and overpayment recovery policies. Include copies of all pertinent documents, including the WC award and your correspondence and reports of contact with the WC carrier, the State WC carrier, the State WC agency, and the beneficiary. HCFA reviews the case and determines what further action should be taken.

Services Reimbursable Under Liability Insurance

3419 GENERAL EFFECT OF LIABILITY INSURANCE ON MEDICARE PAYMENT

A. Statutory Provisions.—Under §1862(b)(1) of the Social Security Act (42 U.S.C. 1395y(b)(1)), payment may not be made under Medicare for covered items or services to the extent that payment has been made, or can reasonably be expected to be made promptly, under a liability insurance policy or plan (including a self-insured plan). All Medicare payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan). Medicare is subrogated to the rights of the beneficiary and may also recover its benefits directly from liability insurance companies and self-insured plans, and from any entity, including the beneficiary, that has been paid by a liability insurer. Medicare's right to recover its benefits from liability insurers and from those who have been paid by liability insurers takes precedence over the claims of any other party, including Medicaid.

"Subrogation" literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary. Medicare can be a party to any claim by a beneficiary or other entity against a liability insurer, can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the liability insurer.

The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to take legal action against a liability insurer that fails to pay primary benefits for services covered by the insurer and to collect double damages.

B. Conflicting Claims by Medicare and Medicaid.—Under the law, Medicare has the right to recover its benefits from a liability insurer before any other entity, including a State Medicaid agency. Also Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by a liability insurer. In other words, Medicare's recovery rights where a liability insurer is primary payer are higher than and take precedence over the rights of any other entity.

The superiority of Medicare's recovery right over that of other entities including Medicaid derives from the Medicare statute, which provides that where Medicare is secondary to another insurer (1) HCFA may recover Medicare benefits from the responsible insurer, (2) HCFA is subrogated to the right of the Medicare beneficiary and the right of any other entity to payment by the responsible insurer, and (3) HCFA may recover its payments from any entity that has been paid by the responsible insurer.

If Medicare and Medicaid both have claims against a liability insurer, Medicare's right to recover its benefits from the liability insurer, or from a beneficiary that has been paid by a liability insurer, is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort and, therefore, doesn't pay its benefits until after Medicare has paid.

Medicare's priority right of recovery from insurance plans that are primary to Medicare, does not violate the concept of Medicaid's being payer of last resort. Under S1862(b) of the Social Security Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by a third party which is primary to Medicare. Where the third party pays right away, Medicare makes no payment to the extent of the third party payment. Delay of third party payment does not change Medicare's ultimate obligation to pay the correct amount regardless of any Medicare payments conditionally made. Thus, where the third party pays less than the charges, Medicare may be responsible to pay secondary benefits. And where the third party pays the charges, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid would have the effect of creating a Medicare payment where none is authorized under the law or improperly increasing the amount of the Medicare secondary payment.

Moreover, the right of Medicaid agencies to recover their benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. Since the beneficiary can assign to the State a right no higher than his own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is higher than that assigned to the State.

Thus, where Medicare and Medicaid have paid for services, and the amount available from a liability insurer is not sufficient to satisfy the claims of both programs for reimbursement, notify the liability insurer and the other parties to the liability claim that Medicare must be reimbursed the full amount of its claim before any other entity, including a State Medicaid agency, may be paid by the liability insurer.

Also, where a beneficiary, attorney, provider or supplier receives payment from a liability insurer for services which have already been paid for by Medicare and by Medicaid, and the amount paid by the liability insurer is less than the combined amounts paid by Medicare and Medicaid, inform the beneficiary, attorney, provider or supplier that it is obligated to refund the Medicare payment up to the full amount of the liability insurance payment, despite a conflicting claim by a State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary, attorney, provider or supplier have the right to reimburse Medicaid or any other entity.

If a liability insurer has reimbursed a State Medicaid agency, or if a beneficiary, after receiving a liability settlement, has reimbursed a State Medicaid agency, request the liability insurer or the beneficiary that was paid by the liability insurer to reimburse Medicare from the remainder of the liability settlement. If the remainder of the liability settlement is insufficient to reimburse Medicare in full, ask the State agency to reimburse Medicare up to the full amount the agency received. Explain the legal basis for Medicare's right to recover. If the State refuses to reimburse Medicare in full, refer the case to the HCFA RO. The RO's recovery actions may include offset of Medicare's claim against any Federal Financial Participation funds otherwise due the State. Explain to the liability insurer that in future cases involving claims by Medicare and Medicaid against a liability settlement, Medicare must be reimbursed first.

3419.1 Effect of Payment by Liability Insurer on Deductibles and Utilization.--

A. Deductibles.--Expenses for which Medicare conditional payments are recovered from liability insurance are not counted toward Part A or Part B deductible amounts.

B. Utilization.--Services for which Medicare conditional payments are recovered from liability insurance are not counted against the number of inpatient care days available to the beneficiary. For instance, if an individual is hospitalized twice in the same benefit period and Medicare recovers its payment for the first hospitalization in full from liability insurance, the first hospitalization would not be charged to the beneficiary's utilization.

3419.2 Definitions.--

A. Liability Insurance.--Insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured and underinsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance and general casualty insurance. It also includes payments under State "wrongful death" statutes that provide payment for medical damages.

B. Self-Insured Plan.--A plan under which an individual or other entity is authorized by State law to carry its own risk instead of taking out insurance with a carrier. "Authorized by State law" means not prohibited by State law. The plan established for the Federal government under the Federal Tort Claims Act is also a self-insured plan.

C. Uninsured Motorist Insurance.--Liability insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law.

D. Underinsured Motorist Insurance.--Optional liability insurance available in some jurisdictions under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the other party's policy or plan.

E. Accident.--Any occurrence or activity that the individual believes resulted in injury or illness for which he or she holds another party liable.

3419.3 Provider Billing Rights and Responsibilities.--

A. Difference Between Liability Insurance and Other Primary Insurers.--Liability insurance differs from the other insurance policies or plans that, under §1862(b) of the Social Security Act, are primary to Medicare. In the case of other types of insurance which are primary to Medicare, i.e., automobile medical and no fault insurance, employer group health plans, and workers' compensation, there is a contractual relationship between the injured party and the third party payer. Thus, the provider has the right to bill the third party payer.

In the case of liability insurance, unlike the other policies or plans, there is no direct or indirect contractual or quasi-contractual relationship between the provider of services and the liability insurer of the alleged tortfeasor. A party alleging injury has a relationship to the liability insurer only through the tortfeasor and must try to prove negligence by the tortfeasor. A provider, in contrast, has no standing to sue the tortfeasor; its relationship is solely to the injured party whom it has furnished Medicare covered services.

best copy available

B. Services Payable By Liability Insurance Are Considered Covered.--The rights and responsibilities of providers regarding services for which liability insurance payments have been made, or can reasonably be expected, are governed by the provisions of §1862(b) (the Medicare secondary provision) and section 1866 (the provider agreement) of the Act. Section 1862(b) is a limitation of payment provision rather than a noncoverage provision. Therefore, when Medicare is secondary under this provision, the services do not lose their identity as Medicare covered services. If the services were not covered, Medicare could not pay secondary benefits for them. In the case of liability insurance, primary Medicare benefits are paid conditionally and then recovered. Payment could not be made for services (even on a conditional basis) if they were not considered covered services.

Section 1866 prohibits providers from charging a beneficiary or any other person for covered services except to collect applicable deductibles and coinsurance. While §1862(b) requires billing third parties that are primary to Medicare, §1866 does not permit such billing where that would take money from the beneficiary, since that would be equivalent to billing the beneficiary for Medicare covered services.

Even without reference to §1866, the right of a provider to bill a liability insurer or to file a lien against a beneficiary's liability settlement is quite limited. Section 1862(b)(1) does not allow billing primary payers unless payment can be expected to be made promptly. Since that would rarely occur in liability insurance cases, because liability settlements are usually made only after protracted negotiations between the injured party and insurer, in the vast majority of cases Medicare payment could not be limited, and the provider would be obliged by its Medicare participation agreement to file a Medicare claim on the beneficiary's behalf. In the rare case where payment could be expected to be made promptly under liability insurance, and Medicare payment might justifiably be limited, it is a violation of §1866 for a provider to bill a liability insurer or to file a lien against a beneficiary's liability insurance proceeds, because either action has the effect of charging the beneficiary for more than the permitted deductibles and coinsurance. It would have that effect because (1) the liability insurer owes nothing to the provider, which itself has no rights against the insured (the tortfeasor) or the company from which he has bought insurance — its only obligation is to the beneficiary that has been harmed by the insured -- and (2) payment to the provider directly reduces the amount the beneficiary recovers from the liability insurer. For the same reasons, a provider may not bill a beneficiary who has received a liability insurance payment, except to collect any applicable deductibles and coinsurance. Thus, if a beneficiary has filed or is contemplating a liability claim, it is immaterial to the provider whether payment under liability insurance could or could not be expected to be made promptly. In either event, the provider's only recourse is to bill Medicare.

In summary, since services for which Medicare is secondary are covered services, the beneficiary is protected by the provider agreement, i.e., a provider of services may not bill an insurer or beneficiary for such services, if the effect would be to reduce the amount the beneficiary can recover. That effect could occur when liability insurance is primary. Payment to a provider by the beneficiary or liability insurer would directly reduce the amount the beneficiary recovers from that insurer.

C. Medicare Must Be Billed.—Although services are needed because of an accident (as defined in §3419.2) or a diagnosis/trauma code listed in §3419.5 is shown, a provider must bill Medicare for conditional primary payments even if it believes that there is a reasonable likelihood that a liability insurer will pay promptly. However, before a provider bills Medicare for primary benefits, it must first attempt to determine whether there are potential primary payers other than a liability insurer, e.g., an automobile no fault insurer or an employer group health plan. Such payers must be billed before Medicare.

D. Prohibition Against Billing Liability Insurer.—Providers may not bill liability insurers instead of Medicare. The criteria for extension of the time limit for filing claims in §3307.3 do not apply, if the late filing of a Medicare claim is due to the provider's not following instructions by billing liability insurance instead of Medicare.

E. Prohibition against Billing Beneficiary.—A provider may not bill a beneficiary for covered services even though the beneficiary has received payment from a liability insurer for the injury or illness for which the services were furnished. This rule applies whether or not the provider has claimed or accepted conditional primary Medicare benefits. Since these are covered services, the beneficiary is protected by the provider agreement, i.e., a provider of services may not bill a beneficiary for such services, except for deductible and coinsurance amounts.

F. Prohibition Against Filing a Lien Against Liability Settlements.—Providers may not file a lien against a beneficiary's liability insurance proceeds. To do so is tantamount to billing the beneficiary and is a violation of the provider agreement.

3419.4 Provider Actions.—

A. Information Obtained from Patient or Representative At Time of Admission or Start of Care.—Medicare providers are instructed to ask Medicare patients, or the patient's representative, at the time of admission or start of care, if the services are for treatment of an injury or illness which resulted from an automobile or other accident, including any that occur on the provider's premises, for which he or she holds another party responsible. The provider obtains the name, address and policy number of any automobile medical, no fault or liability insurance company or any other party that may be responsible for payment of medical expenses that resulted from the accident.

B. Provider Billing.—If a provider learns that an automobile medical or no fault insurance company may pay for otherwise covered services, the provider is instructed to bill the insurance company as primary insurer. See §§3489ff. for instructions on handling claims involving automobile medical or no fault insurance.

If payment cannot reasonably be expected from an automobile medical or no fault insurer (and none of the other Medicare secondary provisions applies), the provider must bill Medicare even though the individual has filed or plans to file a liability insurance claim. When billing Medicare, the provider annotates the bill in accordance with §3680.

3419.5 Identification of Liability Situations.—Use the indicators listed below to identify claims in which there is a possibility that payment can be made by a liability insurer. Develop the possibility of payment by a liability insurer in accordance with §3419.6.

1. You receive information from a provider, a beneficiary, your own operations (e.g., medical or utilization review) or those of your non-Medicare counterpart, another Medicare carrier or intermediary, or any other source, indicating Medicare has been billed for services when there is a possibility of payment by a liability insurer.

2. On Form HCFA-1450 another insurer is shown on line A of item 57. On other billing forms a primary insurer is identified in the "Remarks" portion of the bill.

3. On a HCFA-1450, occurrence code 01 or 03 is shown in items 28-32. On other billing forms the annotation "automobile accident" or "nonautomobile accident" is shown in "Remarks."

4. The billing form shows as complementary insurer an insurance organization that does not issue health insurance.

5. You (or the RO) are asked to endorse a check from another insurer payable to Medicare and the beneficiary.

6. You receive or are informed of a request from an insurance company or from an attorney for copies of bills or medical records.

7. There is indication that a liability insurer previously paid benefits related to the same injury or illness or that a claim for such benefits is pending; e.g., a "Y" trailer containing code "C" or "D" on the query reply. (See §3512.8. and §3535.1) There is no need to investigate this lead, however, if your records show that the services were furnished after the date of a final liability insurance award or settlement for the same injury or illness.

8. You receive from a provider a request from an attorney or insurance company for a copy of a medical record or for a bill concerning a Medicare patient. Providers are instructed to notify you promptly of such requests and to send you a copy of the request or, if it is unavailable, full details of the request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and date(s) of services for which Medicare has been billed or will be billed.

9. The claim reflects one of the diagnosis/trauma codes shown below. The following list consists of selected ICD-9-CM codes which should be used to identify claims which may involve liability insurance. Whenever one of these codes appears on a claim, process the claim as detailed in §3419.6. (You may add to this list any ICD-CM codes which experience indicates are good leads. Based on contractor input, HCFA may later modify this list to reflect actual experience.)

CODE ICD-9-CM	DIAGNOSIS
800.0 - 800.99	Fracture of vault of skull

801.0 - 801.99	Fracture of base of skull
802.0 - 802.99	Fracture of face bone
803.0 - 803.99	Other and unqualified skull fractures
804.0 - 804.99	Multiple fractures involving skull or face with other bones
805.0 - 805.98	Fracture of vertebral column without mention of spinal cord injury
806.0 - 806.99	Fracture of vertebral column with spinal cord injury
807.0 - 807.69	Fractures of rib(s), sternum, larynx, and trachea
810.0 - 810.13	Fracture of clavicle
811.0 - 811.19	Fracture of scapula
828.0 - 828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
839.0 - 839.3, 839.7 - 839.9	Other multiple and ill-defined dislocations
847.0	Sprains and strains of the neck (whiplash)
850.0 - 850.9	Concussion
851.0 - 851.99	Cerebral laceration and contusion
852.0 - 852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury

CODE ICD-9-CM	DIAGNOSIS
853.0 - 853.19	Other and unspecified intracranial hemorrhage following injury
854.0 - 854.19	Intracranial injury of other and unspecified nature
860.0 - 860.5	Traumatic pneumothorax and hemothorax
861.0 - 861.32	Injury to heart and lung
862.8	Injury to multiple and unspecified intrathoracic organs, without mention to open wound into cavity (crushed chest)
863.0 - 863.99	Injury to gastrointestinal tract

864.0 - 864.19	Injury to liver
865.0 - 865.19	Injury to spleen
866.0 - 866.13	Injury to kidney
867.0 - 867.9	Injury to pelvic organs
868.0 - 868.19	Injury to other intra-abdominal organs
869.0 - 869.1	Internal injury to unspecified or ill-defined organs
887.0 - 887.7	Traumatic amputation of arm and hand
896.0 - 896.3	Traumatic amputation of foot
897.0 - 897.7	Traumatic amputation of leg(s)
900.0 - 900.9	Injury to blood vessels of head and neck
925	Crushing injury of face, scalp, and neck
926.8	Crushing injury of trunk (multiple sites)
929.0 - 929.99	Crushing injury of multiple and unspecified sites
958.4	Traumatic shock
958.5	Traumatic anuria
996.0 - 996.5	Complications peculiar to certain specified procedures

3419.6 Development to Ascertain if Liability Claim Has Been or Will Be Filed.--

A. Medicare Benefits Have Not Been Paid.--If there is an indication of possible payment under liability insurance, make a conditional payment and develop with the provider to determine if there was an accident and, if so, if the beneficiary has filed a liability claim or intends to do so. You are not required to develop claims in which the amount payable by Medicare is less than $400. You may set your development tolerance at any dollar level you deem cost effective, but it may not exceed $400.

If the provider indicates that a liability claim is pending, or that the beneficiary intends to file such a claim, or further development is otherwise indicated, develop with the beneficiary and/or his attorney, following the instructions in paragraph B.

B. Medicare Benefits Already Paid.--If a Medicare claim has already been paid and there is an indication of possible payment under liability insurance, develop with the beneficiary and/or his attorney to determine whether a liability claim has been filed or will be filed. You are not required to develop claims in which the amount payable by Medicare is less than $400. You may set your development tolerance at any dollar level you deem cost effective, but it may not exceed $400. The development tolerance applies to development efforts only and does not supersede the overpayment recovery tolerance in §3709.2 if you have enough evidence to determine that an overpayment exists.

Use the Form HCFA-L365, Report to Medicare of Automobile or Liability Insurance Coverage, for this development. Enter necessary identifying information before sending the form. Also ask for the claim number which the insurance company has assigned to the claim. If the beneficiary or attorney does not respond within 30 days, follow up by telephone or letter. If you are unable to obtain the required information from the beneficiary or attorney by letter or by phone, and you determine that further contacts would be unproductive, discontinue further efforts to obtain the information, and institute recovery efforts from the beneficiary in accordance with §§3707ff.

3419.7 Action by Intermediary Where a Liability Claim Is Filed.--

A. Liability Claim Is Pending.—Once you learn that a liability claim is pending, take steps to assure that, in the event a liability insurance payment is made, any conditional primary Medicare payments are refunded for services related to the injury. There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement. However, the entire amount of a settlement is subject to recovery, whether the liability payment is made at the time of settlement, or over a period of time agreed to by the parties in a structured settlement.

B. Recovery From Liability Insurer.—The statute as amended in 1984 gives the Government the right to recover Medicare payments from liability insurers without regard to whether the insurer has already made a liability insurance payment. Always try to recover any Medicare payments directly from the insurer before the proceeds of an award or settlement are disbursed.

C. Liability Insurer Pays Beneficiary.—If a beneficiary is paid by a liability insurer, recover from the beneficiary the lesser of Medicare's payment or the provider's charges, reduced by a proportionate share of the individual's procurement costs, if any.

If, under PPS, Medicare pays a provider more than its charges, Medicare does not recover more than charges from a beneficiary's liability settlement. (Under Medicare regulations, a beneficiary who must refund a Medicare payment made to a provider is liable only to the extent that he or she benefitted from the payment. Since the beneficiary would have had to pay only the provider's charges in the absence of Medicare, the beneficiary is not liable for refunding more than the charges.) In such cases, the provider is not required to refund the excess of the Medicare payment rate over the provider's charges.

Use the following formula to determine the amount of Medicare's claim when there are procurement costs:

1. Determine the ratio which the procurement costs bear to the total amount of the liability insurance payment.

2. Apply this ratio to the Medicare payments.

3. Subtract the amount determined in step 2 from the lower of the amount of the provider's charges or the Medicare payments. The remainder is the amount to be refunded to the Medicare program. (You may round this amount to the nearest dollar.)

Exception: If the Medicare payments equal or exceed the amount of the liability insurance payment, the amount to be recovered is equal to the liability insurance payment less the entire procurement costs.

It is common for insurance companies to settle claims without admitting liability. Therefore, any payment by a liability insurer, except payments under a no fault clause in a non-automobile policy, constitutes a liability insurance payment whether or not there has been a determination of liability. Also, regardless of how amounts may be designated in a liability award or settlement, e.g., loss of consortium, special damages or pain and suffering, Medicare is entitled to be reimbursed for its payments from the proceeds of the award or settlement.

If a negligent party who carries liability insurance decides to pay a liability claim with his own funds rather than submit the claim to his liability insurer, Medicare recovers its benefits from such a payment, because it is deemed to be a liability insurance payment. Medicare benefits are, of course, also subject to recovery from payments by a self-insured party, as defined in §3419.2B.

3419.8 Liability Claim Is Filed and There Is Also Coverage Under Automobile Medical or No Fault Insurance.--If injuries are covered under automobile medical or no fault insurance, and the individual also files a claim against a third party for injuries suffered in the same accident, a claims determination must first be made by the automobile medical or no fault insurer before a claim for Medicare benefits can be paid. Medicare payment may be made to the extent that payment cannot be made under the automobile medical or no fault insurance, subject to recovery if the individual later receives payment from a liability insurer. For example, an individual incurs $20,000 in hospital expenses due to an automobile accident. The individual receives $5,000 in no fault insurance benefits toward his hospital expenses and also has a liability claim pending against the driver of the other car. Medicare will not pay benefits for the $5,000 in expenses paid for by the no fault insurer but will pay benefits based on the additional $15,000 in expenses, subject to recovery when the liability claim is paid.

3419.9 Coordination with Other Part A Intermediaries or Part B Carriers Where There Is a Possibility of Automobile or Liability Insurance Payment.--For consistency in determinations and actions concerning claims arising from the same injury or illness, an intermediary investigating the possibility of payment under automobile or liability insurance coordinates its determination regarding the insurance coverage and/or its recovery efforts with any other intermediaries or carriers that may receive or have received claims for expenses related to the same injury or illness. The intermediary takes the lead in investigating all cases which involve Part A services. If more than one intermediary has paid for expenses related to the condition, the one that has paid the most in benefits conducts the necessary development and pursues recovery on behalf of the others. That intermediary arranges for the beneficiary or insurance company to reimburse each Medicare contractor that has made an overpayment. If the amount of the recovery is not sufficient to repay all contractors, the money is prorated among contractors, giving priority to refunds that restore available benefits, e.g., inpatient hospital days first, then SNF days. Likewise, an insurer's payment to a provider that has furnished both Part A and Part B services is applied first to Part A expenses.

3419.10 EXHIBITS

Exhibit 1--Form HCFA-L365, Report to Medicare of Automobile or Liability Insurance Coverage.

EXHIBIT 1

FORM APPROVED OMB NO. 0938-0283

REPORT TO MEDICARE OF AUTOMOBILE OR LIABILITY INSURANCE COVERAGE

HEALTH INSURANCE CLAIM NUMBER	DATE	SEND COMPLETED FORM TO:
NAME OF PROVIDER, PHYSICIAN, OR SUPPLIER	DATE OF SERVICES FROM: TO:	

NOTE: SEE REVERSE FOR PRIVACY ACT STATEMENT BEFORE COMPLETING FORM.

This refers to the services you received from the provider, physician or supplier named above.

We have received information indicating that these services may be reimbursable under automobile insurance or under liability insurance (including automobile liability insurance). The law excludes Medicare payment for services which have been paid for by such insurance or for which such insurance payment can reasonably be expected. All Medicare payments are made on the condition that the individual is responsible for refunding the amount paid in the event that an automobile or liability insurer makes payment for the same services.

To help us determine whether Medicare covers the above services, we need your responses to the questions listed below. Please return this letter with your answers to these questions in the enclosed self-addressed, postage paid envelope.

A. CAN PAYMENT BE MADE FOR THE ABOVE SERVICES BY AN AUTOMOBILE MEDICAL OR NO FAULT INSURANCE POLICY OR PLAN? ☐YES ☐NO IF YES, GIVE NAME AND ADDRESS OF INSURANCE COMPANY. IF YOU HAVE RECEIVED A NOTICE OF ITS DECISION FROM THE COMPANY, PLEASE SEND US A COPY.	NAME AND ADDRESS OF INSURANCE COMPANY

B. HAVE YOU FILED, OR DO YOU INTEND TO FILE A LIABILITY CLAIM OR LAWSUIT AGAINST ANY PARTY WHO CAUSED THE INJURY FOR WHICH THESE SERVICES WERE FURNISHED, OR DO YOU FEEL YOU HAVE A RIGHT TO BE COMPENSATED BY A PARTY WHO MAY HAVE CAUSED THE INJURY?

☐YES ☐NO

C. IF YOU ANSWERED YES TO QUESTION B., PLEASE FURNISH THE FOLLOWING INFORMATION:

1. DATE OF ACCIDENT WHICH RESULTED IN INJURY OR ILLNESS	2. BRIEF DESCRIPTION OF ACCIDENT OR OTHER CAUSE OF INJURY OR ILLNESS
3. NAME AND ADDRESS OF ATTORNEY IF YOU HAVE ONE	

(CONTINUED ON REVERSE)

FORM HCFA-L365 (12-82)

4. NAME, ADDRESS AND TELEPHONE NUMBER OF ANY PARTY THAT YOU FEEL WAS RESPONSIBLE FOR INJURY OR ILLNESS	5. NAME, ADDRESS AND TELEPHONE NUMBER OF INSURANCE COMPANY OF PERSON YOU FEEL WAS RESPONSIBLE

6. EXPLAIN WHY YOU DID NOT FILE A CLAIM WITH AN AUTOMOBILE OR LIABILITY INSURER PREVIOUSLY EVEN THOUGH YOU WERE ENTITLED TO DO SO

If you have filed or have a right to file a liability claim or lawsuit against another party who you feel was responsible for this injury or illness, Medicare benefits are still payable for the services, pending a decision on your liability claim. If you receive payment from a liability insurer, you will be responsible for reimbursing the Medicare program or arranging for the insurance company to reimburse the Medicare program, the amount of benefits it paid for this injury or illness up to the amount of the award or settlement, less a proportionate share of the cost of procuring the award or settlement. If Medicare is not reimbursed after you receive a liability insurance payment, the amount may be withheld from any social security benefits to which you are entitled.

If you do not presently intend to file a liability claim or lawsuit against any person or insurance company for this injury or illness but later change your mind, you will be responsible for notifying us promptly of your decision.

CERTIFICATION AND AGREEMENT

To the best of my knowledge and belief, the above answers are true. I hereby authorize the Health Care Financing Administration or any of its insurance carriers or intermediaries to pursue my rights against any automobile medical or no fault insurer or any liability insurer that may be responsible to pay for the services and promise to cooperate with the Health Care Financing Administration in such action.

DATE FORM COMPLETED	SIGNATURE OF BENEFICIARY OR REPRESENTATIVE	TELEPHONE NUMBER

PRIVACY ACT STATEMENT

We are authorized to collect this information by sections 205(a) and 1862(b) of the Social Security Act (42 USC 405a and 1395y). The information will be used to determine if the services you received are covered by Medicare or whether an automobile, no-fault, or liability insurer or any other person may be responsible for payment. Section 1877(a)(3) of the Social Security Act (42 USC 1395nn) provides criminal penalties for withholding this information.

FORM HCFA-L365 (12-82)

Utilization Review

3420. UTILIZATION REVIEW PLAN

Hospitals (including psychiatric hospitals) and skilled nursing facilities are required to have in effect a plan for utilization review (UR) which applies to the inpatient services furnished to patients entitled to benefits under the program. The plan must provide for review, on a sample or other basis, of admissions, duration of stays, and professional services furnished; and review of each case of continuous extended duration while the patient is in the facility. See the "Conditions of Participation—Hospitals" and "Conditions of Participation—Skilled Nursing Facilities" for detailed requirements for an acceptable UR plan.

If the facility's UR committee has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. However, the finding of a UR committee in one facility is not binding upon the UR committee in another facility.

The law requires that effective UR be maintained on a continuing basis to assure the medical necessity of the services for which the program pays and promote the most efficient use of available health facilities and services.

3420.1 Physician Members of UR Committee.—A "physician" member of a UR committee must be a doctor of medicine, or a doctor of osteopathy or a doctor of podiatric medicine. (See §3030.)

A doctor of podiatric medicine is considered a "physician" for the purpose of constituting a member of a UR committee, but only if at least two of the other physicians on the committee are doctors of medicine or osteopathy. In addition, the performance of these UR functions by a doctor of podiatric medicine must be: (1) consistent with the policy of the hospital or skilled nursing facility at which the functions are performed and (2) consistent with the scope of professional services provided by a doctor of podiatric medicine as authorized by applicable State law.

Payments made to physicians serving on SNF utilization review committees are considered an allowable cost without regard to whether the facility's plan is applicable solely to Medicare beneficiaries or to all patients of the SNF. However, in the case of hospitals, payments to physicians for such services are considered an allowable hospital cost only if the services are furnished in connection with a UR plan applicable to all of the hospital's inpatients.

3420.2 Definition of Continued Stay—Beneficiary Admitted Before Entitlement.—Guidelines for the review of continued stay cases are explained in the Conditions of Participation—Hospitals, and Conditions of Participation—SNFs.

If an individual is admitted to a hospital before entitlement to hospital insurance benefits (for example, before he reaches age 65), the following applies when he does become entitled. In identifying cases of extended duration for review by the UR committee in those hospitals which provide for the review of beneficiary cases only, the patient will be considered to have been admitted to the hospital on the day he became entitled to hospital insurance benefits. For example, if a hospital has defined continued stay as being 20 days of hospitalization, a patient who becomes entitled to Part A benefits on May 1, but who is admitted prior to that date, would be considered a continued stay case for UR purposes on May 21.

3421. LIMITATIONS ON PAYMENT FOR INPATIENT SERVICES FOLLOWING ADVERSE FINDING BY UTILIZATION REVIEW COMMITTEE

Under the UR requirement, certain limitations on payment for inpatient hospital services have been established. (For purposes of this section "inpatient hospital services" include inpatient hospital services and inpatient psychiatric hospital services.)

A. Payment Limitation.--Program payment can be made for a grace period of up to 3 days of inpatient hospital or extended care services following the date the institution receives notice from a UR committee that further inpatient hospital or extended care services are not medically necessary. This payment limit also extends to a finding by a UR committee, made during the course of a sample or other review of admissions, that admission to the hospital or SNF was not medically necessary. (See §3635.1(B)(3).)

In hospitals paid for inpatient hospital services under the prospective payment system, the payment limit applies only in cases otherwise eligible for outlier payment if the UR committee determines that:

- o excess days of care furnished in the case of a length of stay outlier are not necessary for services covered under Part A; or
- o additional items or services furnished in the case of a high cost outlier are either not covered or not necessary to services covered under Part/A.

Although you should accord great weight to the finding made by the UR committee, the final determination regarding reimbursement under the program rests with you. Accept an adverse utilization review committee finding for claims payment purposes unless there is a clear deficiency in the committee's finding, or the committee fails to follow the procedures prescribed in the law and regulations. For example, you may acquire additional information which was not available to the committee, which clearly indicates that the services were medically necessary.

B. Notification Requirements.--

1. General.--If, after review of an admission or continued stay case and after an opportunity for consultation is given the attending physician, the physician members of the UR committee make a final finding that an admission or further inpatient stay was not medically necessary, written notice must be given to the attending physician, the hospital and the patient (or where appropriate, his next of kin), no later than 2 working days after the review date.

Where the finding is made before the continued stay review date, the notice must be given no later than 2 days after it is made.

While the attending physician may advise the patient of the URC's finding, it is necessary for the committee to give timely notice of its finding to the patient or, where appropriate, to the next of kin. However, failure or omission by the URC to notify the physician, the patient, or the patient's next of kin timely does not justify payment for services (e.g., custodial care) which are specifically excluded by statute.

In the event of an adverse UR finding, the provider is required to show the date of receipt of notice on the billing form. (See S3604, Item 28-32, Code 21.)

2. SNF Notification.--SNFs must give an advance notice to the patient or his/her family that the URC is going to meet and consider whether he/she continues to need a skilled level of care and that Federal regulations require an opportunity be given for the patient's attending physician to present his/her views. The name of the physician the SNF intends to consult with must be included so that the patient or his/her family can verify that the correct physician will be contacted. In a final URC adverse finding concerning SNF care, the written notice must contain the basis for the adverse finding and a statement advising the patient or his/her family that a URC finding is not a Federal decision about Medicare payment, and that the final claims determination will be made when a claim is submitted to you. (See S3730.1.) The notice must clearly state that the beneficiary or his/her representative has the right to request that the SNF file a claim for Medicare benefits for the period the URC believes to be noncovered. The written notice of the finding must not be given later than 3 working days after the review date. The patient or his/her family receives a separate notice from you, and if there is a denial, notice of appeal rights.

C. Relation of Limitation of Liability Provision to Payment Limitation.--The application of the UR payment limitation provision (see subsection A) may be affected by the limitation of liability provision. (See SS3430ff.) Where it is determined that noncovered care was rendered prior to the URC's finding, determine whether the limitation of liability provision applies before making any grace period payment.

Where the institution is notified of an adverse finding by the URC, it can be found liable under the waiver of liability provision for noncovered services it provided to the beneficiary after the expiration of the grace period and up to the date the beneficiary receives written notice of the noncoverage of the services. (See S3440 D.)

EXAMPLE: The institution receives notice from the URC on March 1 that services were not reasonable and necessary beginning February 27, but does not advise the beneficiary until March 4. The patient is discharged on March 5. Where both the beneficiary and the provider meet the requirements for limitation of liability (see §§3430ff.), program payment can be made under §1879 for the noncovered services on February 27, 28 and March 1. Payment can also be made under the limitation of liability provision for the routinely allowed grace day following March 1, the day the provider was notified of the UR finding. (See §§3441ff.) In addition, if you determine that more than 1 day was needed to arrange for post-discharge care, grace period payment may be made for 1 more day. However, payment for March 4 would not be made, and the beneficiary would not be be responsible for the charges since he did not receive notice until that date.

3421.1 Availability and Appropriateness of Other Facilities and Services.—In determining whether further inpatient hospital stay is medically necessary, UR committees take into account the availability and appropriateness of other facilities and services. The following guidelines are used by URCs.

A. Determining Required Level of Care.—If the URC believes that the patient no longer requires hospital care but could receive proper treatment at the SNF level of care, it determines whether there is a bed available in a participating SNF or swing bed hospital in the area. (See subsections C and E.) If a bed is available, the committee finds that further care at the hospital level of care is not medically necessary.

If the URC determines that an extended care bed is not available in a participating swing bed hospital or SNF, it finds that continued stay in the hospital is medically necessary. The basis for the finding is documented in the committee's record. The committee advises the attending physician that its finding is based on the lack of availability of a bed in a participating SNF or swing bed facility; and that it is his responsibility to attempt on a continuing basis, (with the assistance of the hospital's social worker, etc.) to place the patient in a participating extended care bed as soon as a bed becomes available.

If the URC determines that the patient requires services other than inpatient hospital or extended care services (such as custodial, outpatient, or home health care), it finds, without regard to the availability of such kinds of care, that further inpatient hospital stay is not medically necessary. Covered inpatient hospital or extended care services are not considered alternatives to noncovered or noninstitutional services.

B. Home Health Care as an Alternative to Institutionalization.—A patient who needs either hospital or extended care services continually requires a level of care and a scope of services that can only be provided in an institutional setting. Only those institutions which met the conditions of participation for hospitals and skilled nursing facilities are qualified to provide them.

A patient who needs home health services requires a minimal level of services which does not call for the patient to be institutionalized. For example, an individual may only require a single service, such as physical therapy. A utilization review committee which finds that an individual only requires home health services should not recommend continued inpatient stay, even though the required services are not available to the individual because there is no agency in the community which can provide the services, or there is an agency but the individual has no home to which he can be discharged.

C. Location of Alternative Facilities.-- A utilization review committee will consider what facilities are available in the community or local geographic area in deciding whether the patient can be cared for effectively elsewhere. It is not possible to define community or local geographic area with any precision. However, as a general rule, a community or local geographic area should not be defined in such a way as to require a patient to be taken away from his family and transported over great distances.

D. Patient's Financial Status and Personal Preference.--A utilization review committee should not take into account a patient's ability to pay for services or his coverage or lack of coverage under the health insurance program in deciding whether continued hospital stay is medically necessary.

A patient's preference for one SNF over another (such as a preference for a sectarian facility over a nonsectarian facility) should not be taken into account by the committee. If SNF's are available but the patient's preferred facility is filled, the committee should find that further inpatient stay is not medically necessary.

E. Sources of Information on Available Participating Skilled Nursing Facilities.--Hospitals have been advised that the intermediary or local social security office can supply the names and addresses of participating SNF's in the local area; and that medical social workers, public health nurses, religious counselors, etc., can provide information about bed availability in such facilities.

3421.2 Failure to Make Timely Review of Cases.--If the Health Care Financing Administration determines on the basis of information obtained by a State agency or by an intermediary during the course of its ongoing review of utilization practices, that a hospital or SNF has substantially failed to make timely review of long-stay cases, it may in lieu of terminating the agreement with the provider, decide that no payment may be made on behalf of patients for more than a continuous period of 20 days of inpatient hospital services or a continuous period of 20 days of posthospital extended care services. For cases paid under PPS, the 20-day payment limitation will only affect the outlier portion of any prospective payment.

HCFA will determine the effective date of this limitation, which will be applicable to services rendered to individuals admitted after that date. The decision may be made effective only after notice is given to the hospital or SNF and to the hospital(s) with which the SNF has transfer agreement(s), and to the public.

HCFA will notify the intermediary of the identity of any hospital or SNF subject to this limitation and of the effective date of HCFA's decision. The limitation will be removed when HCFA determines that timely review of long-stay cases has been restored and there is reasonable assurance that the deficiency will not recur.

3422. ASSURING PROPER UTILIZATION IN SHORT STAY CASES

Because so much emphasis has been placed on looking at long stay cases for possible improper utilization, there has been less attention given to short stays which may also reflect improper utilization of inpatient services. The intermediary's claims review system should be capable of identifying provider stays of short duration which may not meet the test of medically necessary inpatient care. Particular attention should be given to the screening and review of one-day stays. Listed below are examples of short stays that may not be medically necessary. (Note: In situations where PSROs are conducting binding review, § 3422.1 is applicable.)

1. Provision of Diagnostic or Therapeutic Services on an Inpatient Basis Which Could Have Been Safely and Effectively Delivered in An Outpatient Setting.--The provision of diagnostic tests or therapies during a short inpatient stay which can normally be performed on an outpatient basis should alert intermediaries to the possibility that the inpatient stay may not be medically necessary. Absent other medical indications which would necessitate the delivery of services on an inpatient basis, intermediaries should consider such hospital stays to be noncovered under Part A. (See § 3422.1 regarding PSRO involvement and § 3605.6 regarding waiver processing.)

2. One-day Preoperative Stay Prior to Performance of Essentially Outpatient Surgical Techniques.--Some providers may admit patients the day before surgery for preoperative services when the actual surgical procedure does not normally require an overnight postoperative stay. Where both the preoperative and surgical procedures could safely and effectively be conducted on an outpatient basis, claims for preoperative overnight stays should be considered noncovered.

3. One-day Stay for Psychiatric and Alcoholism Patients.-- A pattern of improper utilization often exists where providers routinely claim one-day

inpatient stays for patients with a psychiatric and/or alcoholism diagnosis. Intermediaries should carefully evaluate such cases (unless the record indicates that the patient was discharged against medical advice) to insure that there was a medical need for and intention to provide acute, inpatient hospital services. Reimbursement should not be made for care if hospitals are inappropriately providing overnight room and board for these patients.

4. Billing An Inpatient Stay Where The Patient Has Not Been Admitted as An Inpatient.--If a patient does not actually stay overnight in a provider, Medicare does not permit an "admission" to be billed as an inpatient stay, unless the patient was formally admitted as an inpatient with a reasonable expectation that he or she would remain overnight and was unexpectedly discharged earlier (see § 3101 and 3611).

Intermediaries should be particularly alert to situations in which providers submit a significant number of one-day inpatient stay claims. If, upon investigation, it is determined that an inpatient stay has not occurred in a particular instance, instruct the provider to bill the stay correctly, and delete the item from inpatient statistics. The argument that the "reasonable expectation" of overnight stay applies to all patients (in for example, a "walk-in surgery" service), is not acceptable, since each case must be considered individually.

3422.1 RELATIONSHIP OF PSROs TO THE ASSURANCE OF PROPER UTILIZATION IN SHORT STAY CASES

In situations where a PSRO has assumed binding review authority, the PSRO is responsible for certifying the medical necessity of admissions, including short stay cases. Because PSROs have typically concentrated review activity on extended stays, it is particularly important that intermediaries alert the PSRO to questionable utilization patterns in short stay cases even after formal intermediary monitoring of PSRO decisions has ceased. The PSRO, of course, retains binding authority to make medical necessity decisions on such cases but may wish to conduct a special review of short stay cases. Their binding authority extends to the situations described in subsections 1, 2, and 3 of 3422, above. In situations, however, where erroneous or inappropriate billing practices are involved (see subsection 4, above), intermediaries are responsible for taking action. The decision as to whether inpatient or outpatient services were rendered is a factual determination, which does not require the medical judgment of the PSRO.

Limitation on Liability of Beneficiary and Provider Where Medicare Claims Are Disallowed

3430. LIMITATION OF LIABILITY FOR PROVIDER CLAIMS UNDER PARTS A AND B OF MEDICARE PROGRAM.

Section 1879 of the Act provides relief for a beneficiary who acted in good faith in accepting services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. The provision also applies to denials of home health services beginning July 1, 1987 and ending September 30, 1989, where the beneficiary is not homebound or does not or did not need skilled nursing care on an intermittent basis. In such situations, the beneficiary is not liable for the charges for the services. The provider is liable if it is determined the provider knew, or could reasonably have been expected to know, that the items or services provided were not covered under Medicare. However, the Medicare program accepts liability, i.e., makes payment to a provider even though a noncovered service is involved, if neither the beneficiary nor the provider knew, or could reasonably be expected to have known, that the services were not covered.

This provision does not apply to any services rendered by a provider prior to the date on which its Medicare agreement is accepted by the Secretary, even though the effective date of the agreement may be earlier. This is so because a beneficiary entering a nonparticipating provider could not reasonably have expected Medicare coverage.

Section 1879 permits a provider to appeal a determination that services were not reasonable or necessary or constituted custodial care when it is determined that liability rests entirely with the provider, or when the beneficiary is partially or completely liable for the noncovered items or services and it has been determined that the beneficiary is not exercising his appeal rights. (See §3781.4.) Section 1879 also provides that the Medicare program will indemnify (i.e., make direct payment to) the beneficiary or other person(s), subject to the deductible and coinsurance amounts, for any payments made by the beneficiary or other persons to a liable provider that are not refunded or credited, for items or services which have been determined to be noncovered, as specified in §3431. Any payments made as indemnification are treated as overpayments to such provider and withheld from future Medicare benefits due that provider. (See §3446.8.)

NOTE: Sections 3431 through 3442 discuss specific procedures for implementing this provision with regard to provider claims for inpatient Part A services generally billed on form HCFA-1450, in addition to Part A and Part B HHA claims billed on form HCFA 1450. Section 3444 discusses procedures for processing ancillary and outpatient provider services payable under Part B usually billed on form HCFA-1450.

3431. APPLICABILITY OF LIMITATION OF LIABILITY TO ITEMS OR SERVICES FURNISHED BY PROVIDERS OF SERVICES PAYABLE UNDER PART A.

A. The limitation of liability provision applies to claims denied for the following reasons:

- Items or services that are not reasonable and necessary for the diagnosis or treatment of illness, injury, or to improve the functioning of a malformed body member (excluded by §1862(a)(1)(A); see §3151); or in the case of hospice care, are not reasonable and necessary for the palliation or management of terminal illness (excluded by § 1862(a)(1)(C)).

- Items or services that constitute custodial care (excluded by §1862(a)(9); see §3159), i.e., are not a covered level of care.

- Under OBRA (Pub. L. 99-509) for denials processed on or after July 1, 1987, and through September 30, 1989, those HHA services denied under §1814(a)(2)(C) or §1835(a)(2)(A) because the patient: is not or was not confined to his/her home, or does not or did not need skilled nursing care on intermittent basis, are subject to application of the limitation of liability provisions under §1879 of the Act.

NOTE: Limitation of liability applies to both the services which were denied directly for the reasons shown, and the dependent services which may be denied as an indirect result of denials for the reasons listed. For example, where the services of a home health aide were denied because the beneficiary failed to meet the statutory requirement of needing skilled nursing care on an intermittent basis, limitation of liability also applies to the home health aide services which are denied as an indirect result of the denial of the skilled nursing care.

This limitation of liability provision does not apply to claims denied for any other reason. (See §3707 concerning liability for overpayments arising from other causes.)

B. The following examples illustrate types of denials which cannot involve the limitation of liability provision and for which no payment can be made. (These examples are not all inclusive.):

- Inpatient hospital services for cosmetic surgery, or excluded foot care services.

- Services payable under State or Federal workers' compensation.

- SNF stay not preceded by the required 3-day hospital stay. (See §3431.1A.)

- The beneficiary did not meet the requirement for transfer to an SNF and for receiving covered services within 30 days after discharge from the hospital nor were the special requirements met for extension of the 30 days. (See §§3431.1 and 3431.3.)

- o Denial of payment of charges for private room accommodations. (See § 3101.1ff.)
- o Home health visits denied because they were not ordered on a plan of treatment or subsequent amendment.

3431.1 Prior Hospitalization and Transfer Requirements for SNF Coverage as Related to Limitation of Liability.-- In order to qualify for posthospital extended care services, the individual must meet the prior hospitalization and transfer requirements discussed in §§ 3131-3131.3. The following sections discuss the relationship of these requirements to the limitation of liability provision.

A. Three-Day Prior Hospitalization.-- Before Medicare payment can be made for posthospital extended care services, it is necessary to determine whether the beneficiary had a prior qualifying hospital stay of at least 3 consecutive calendar days. When a beneficiary's liability for a hospital stay is waived, the hospital days to which the limitation of liability applies cannot be used to satisfy the 3-day prior hospitalization requirement, since the services rendered during the days in question were found noncovered because they were not considered reasonable and necessary or because they constituted custodial care. (See § 3131.1 for instructions on determining whether the 3-day prior hospitalization requirement is met.) If a beneficiary's hospital stay was partially covered, consider the covered portion of the stay in determining whether the SNF prior hospitalization requirement is met.

B. Transfer Requirements.--

1. Transfer Period.-- The limitation of liability provision may be applied where you determine that all the SNF care received during the period serving to satisfy the transfer requirements described in §§ 3131.3A and 3131.3B1 either constituted custodial care or was not reasonable and necessary. Where you determine that only the beneficiary's liability can be waived, the limitation of liability applies through the date of the notice to the beneficiary including any inpatient days beyond the transfer period. If the provider is also entitled to limitation of liability and program payment is possible under the limitation of liability provision, such payment is appropriate through the date of the notice and if you determine that additional time is needed to arrange for postdischarge care, for up to 24 hours after the date of notice to the provider or the beneficiary, whichever is earlier. If you determine that even more time is needed to arrange postdischarge care, up to 24 additional hours may be paid for. (See § 3441.)

Where a beneficiary entitled to limitation of liability starts to require and receives reasonable and necessary or noncustodial services only after the expiration of the SNF transfer period, he may nevertheless have his liability waived for days where such services were rendered, in addition to those days waived during the noncovered transfer period but only through the date of notice to the beneficiary. If the provider is also entitled to limitation of liability, program payment may be made under the limitation of liability provision through the date of notice of noncoverage, and if you determine that additional time is needed to arrange for postdischarge care, for a "grace period" of 1 day thereafter. If you determine that even more time is needed to arrange postdischarge care, 1 additional "grace period" day may be paid for. (See § 3441.) This payment is made because it is inequitable to waive liability for noncovered services rendered during the transfer period but not for a period thereafter (prior to notice) during which the beneficiary needed and received an otherwise covered level of care.

2. Delayed Transfer Due to Medical Appropriateness.-- The law also provides for an extension of the usual 30-day time limit for transfer where the patient's condition makes it medically appropriate. (See § 3131.3B2.) However, if you determine that such an extension is not allowable because an interval of more than 30 days for transfer to an SNF was not medically appropriate, the SNF services are to be denied because the transfer requirement was not met. The limitation of liability provision is not applicable in such a case.

3431.3 Application of Limitation of Liability to SNF and Hospital Claims for Services Furnished in Non-Certified or Inappropriately Certified Beds.—

A. General.—Payment for SNF and hospital claims may not be denied solely on the basis of a beneficiary's placement in a non-certified bed of a participating SNF or hospital. When requested to by the beneficiary or his representative, a provider must submit a claim to you for services rendered in a non-certified bed. When you review a claim for services rendered in a non-certified bed, you must first determine whether the beneficiary consented to the placement. (See § 3431.3C.) If you find that the beneficiary consented, the claim must be denied. If you find that the beneficiary did not consent, you must determine whether there are any other reasons for denying the claim. (See § 3431.3D.) If there is another reason for denying the claim, it must be denied. However, if none of the reasons for denial exist, beneficiary liability must be waived as provided under § 1879(e) and a further determination must be made as to whether the provider, rather than the Medicare program, must accept liability for the services in question. (See § 3431.4.)

B. Provider Notice Requirements.—When an SNF or hospital places a patient in a non-certified or inappropriately certified portion of its facility because it believes the patient does not require a covered level of care, or for any other reason, it must notify the patient (or person acting on behalf of the patient) in writing that services in a non-certified or inappropriately certified bed are not covered. The written notices should make it clear that the beneficiary has the right to request that the provider file a claim for Medicare benefits if he/she believes a covered level of services is required, such as:

> "We are placing you in a part of this facility which is not appropriately certified by Medicare because (you do not require a level of care that will qualify as skilled nursing care/or covered hospital services under Medicare)/(or state any other reasons for the non-certified bed placement). Nonqualifying services furnished a patient in a non-certified or inappropriately certified bed are not payable by Medicare. However, you (or someone acting on your behalf) may request us to file a claim for Medicare benefits. Based on this claim, Medicare will make a formal determination and advise whether any benefits are payable to you."

If the beneficiary requests that the provider submit a claim for Medicare payment, the provider must do so. The provider should point out that the claim is being submitted at the beneficiary's request and explain why it considers the care to be noncovered.

C. Determining Beneficiary Consent.—Effective for services provided on or after February 1, 1983, providers may submit evidence to rebut the presumption that the beneficiary did not consent to the placement in a non-certified bed. However, under this policy, beneficiaries will still not be viewed as having given their consent to placement in a non-certified bed if their consent is based on erroneous or incomplete information. In other words, if the beneficiary consents on the basis of an incorrect statement from the provider's admissions office, the Utilization Review Committee, or any other entity on which the beneficary could reasonably be expected to rely, that he does not require a covered level of care, then the consent is determined to have been invalid, and program payment may be made (assuming, of course, that there exists no other basis on which to deny the claim). On the other hand, a beneficiary may knowingly and voluntarily consent to placement in a non-certified bed—because he only requires a short stay, because he wishes to be placed in a facility that is near a close relative, because he believes the care will be paid for by a third party payor (other than Medicare), or for any other reason. In such a situation, program payment is not to be made, even though the beneficiary may have needed and received an otherwise covered level of care.

In order to rebut the presumption of non-consent, the provider must submit to you a valid consent statement attached to any request for payment for care received in non-certified beds. Moreover, in any case in which a Medicare beneficiary gives his or her consent to placement in a non-certified bed, the provider must submit a consent statement to you, and you are to determine its validity. In order to be considered valid, the consent statement must include language to the effect that the beneficiary understands that his or her voluntary placement in a non-certified portion of the facility disqualifies the beneficiary from eligibility for Medicare payments for services received while in the non-certified bed. The statement must assert that the beneficiary's consent to being placed in a non-certified bed is given freely. The consent statement must be signed by the beneficiary (provided he or she is competent to give such consent) or by the beneficiary's legal representative, and must be accompanied by a physician's statement attesting to the beneficiary's competence or incompetence. If any of these requirements is not met, a consent statement is automatically determined to be invalid.

When you receive requests for payment with consent statements attached, determine whether the consent statement is valid, that there is no evidence of coercion, and that it is not based on erroneous information. If the consent is found to be valid, deny the claim and notify the beneficiary (see Sample Letter No. 5) that §1879 limitation of liability cannot be applied because of his or her valid consent to be cared for in a non-certified or inappropriately certified bed. If the consent is found to be invalid process the claim further in accordance with the instructions in §§ 3431.3D and 3431.4.

Review consent statements that do not accompany requests for payment. If you determine that the consent statement is invalid, notify the provider and the beneficiary that payment may be made to the extent that all other requirements are met.

D. Determining Whether Other Requirements for Payment are Met.—Denials still are appropriate for any of the following reasons and you should undertake the development needed to permit a determination as to whether:

o The patient did not receive or require otherwise covered hospital services or a covered level of SNF care;

o The benefits are exhausted;

o The physician's certification requirement is not met;

o There was no qualifying 3-day hospital stay (applicable to SNF's only); or

o Transfer from the hospital to the SNF was not made on a timely basis. (However, if transfer to an institution which contains a participating SNF is made on a timely basis, a claim cannot be denied solely on the grounds that the transfer requirement is not met because the bed in which the beneficiary is placed is not a certified SNF bed.)

Deny cases falling within these categories under existing procedures. Also, if the beneficiary receives care in a totally nonparticipating institution, denial on the grounds that he was not in a participating SNF or hospital is still appropriate.

E. Intermediary Notices to Advise Beneficiary of Claim Development.—Upon receipt of a claim for services furnished in a non-certified or inappropriately certified bed, review it to see if it should be denied for any of the reasons listed in subsections B, C or D. If so, send appropriate denial letters. If not, immediately send the beneficiary an acknowledgement modeled after Sample Letter No. 1. Undertake development as needed and make a determination as to whether the beneficiary required and received otherwise covered hospital or SNF services. (If claims are subject to PRO review, request the PRO to prepare a determination as to whether the patient was furnished otherwise covered SNF or hospital services in the noncertified portion of the facility.) If you determine that the beneficiary did not require and receive otherwise covered services, send a denial letter modeled after Sample Letter No. 2 (for SNF claims) and Sample Letter No. 3 (for hospital claims). If you found that the beneficiary required and received services equivalent to a covered level of SNF or hospital care, send a letter modeled after Sample Letter No. 4.

SAMPLE LETTER NO. 1

ACKNOWLEDGEMENT LETTER TO BENEFICIARY

This is to let you know that we are reviewing the claim that was submitted for you by (name of SNF) for services you received at the nursing home between (dates).

In order for us to make a determination on that claim, we need more information from the nursing home about your medical condition, the services you received, and why you were placed in a part of the nursing home that is not certified to provide Medicare services.

It may take us a few weeks to get the information we need and to make a determination. You may submit medical evidence such as statements from your treating physicians, or treatment records to show that you required and received skilled nursing services at the (name of SNF) between (dates).

We will notify you of our determination on this claim as soon as we can.

SAMPLE LETTER NO. 2

DENIAL LETTER - BENEFICIARY DID NOT RECEIVE REQUIRED SNF LEVEL OF CARE

This is in response to the Medicare claim submitted in your behalf by (name of SNF) for services you received as a patient at the nursing home between (dates). After a careful review of the facts, we have denied the claim.

Normally, Medicare payments can only be made for services furnished in a nursing home, or in a part of a nursing home, that has been certified as qualified to participate in the Medicare program. However, Medicare policy now permits payment for otherwise covered services furnished in noncertified parts of participating nursing homes, under the following circumstances:

Payments may be made for individuals who need and receive skilled nursing care or skilled rehabilitation services on a daily basis for the continued treatment of a condition for which they received inpatient hospital care. Skilled care is the type of care which must be furnished by or under the supervision of skilled personnel to assure the safety of the patient and to achieve the medically desired result.

However, when individuals in a nursing home do not require such skilled services on a daily basis, or do require such care but do not receive it, the services they do receive are not payable under the Medicare law. Since we have determined that your stay in (name of SNF) was not covered because (you did not need or receive skilled nursing care or skilled rehabilitation services on a daily basis,) no Medicare benefits can be paid on your behalf.

If you have any questions about this determination, you should first get an explanation from your local Social Security Office. If you still believe the determination is not correct, you may file a request for reconsideration within 60 days from the date of this notice. You may make the request through your Social Security Office.

SAMPLE LETTER NO. 3

DENIAL LETTER - BENEFICIARY DID NOT RECEIVE OTHERWISE COVERED HOSPITAL SERVICES

This is in response to the Medicare claim submitted in your behalf by (name of hospital) for services you received as a patient at the hospital between (dates). After a careful review of the facts, we have denied the claim.

Normally, Medicare payments can only be made for services furnished in a hospital, or in a part of a hospital that has been certified as qualified to participate in the Medicare program. However, Medicare policy permits payment for otherwise covered services furnished in noncertified or inappropriately certified parts of participating hospitals, under certain circumstances.

Payment for inpatient hospital care may be made if such care is reasonable and necessary for the treatment or diagnosis of the patient's condition and can be furnished only in an inpatient hospital setting.

However, when individuals in a hospital do not require the type of care described above, the services furnished are not covered under the Medicare law. Since we have determined that the services you received were not covered because you did not require or did not receive a level of care that could be furnished only in an inpatient hospital setting, no Medicare benefits can be paid on your behalf.

If you have any questions about this determination, you should first get an explanation from your local Social Security Office. If you still believe the determination is not correct, you may file a request for reconsideration within 60 days from the date of this notice. You may make the request through your Social Security Office.

SAMPLE LETTER NO. 4

NOTICE OF DECISION TO BE ISSUED TO BENEFICIARY WHERE OTHERWISE COVERED SERVICES WERE FURNISHED IN A NONCERTIFIED OR INAPPROPRIATELY CERTIFIED BED

This is in response to the Medicare claim submitted in your behalf by (name of facility) for services you received as a patient at the facility between (dates). These services are not covered under Medicare, because they were furnished in a part of the facility that was not appropriately certified for Medicare purposes. However, since you received needed services that would have been covered under Medicare if furnished in an appropriately certified part of the facility, we have decided that you will not have to pay the facility for anything more than the standard Medicare coinsurance, and charges for certain items Medicare does not pay for, such as telephones and TV rentals. The days you spent in the facility will be counted in figuring the number of Medicare benefit days that you have used, and the number still available to you.

You need not pay any bills you have received or may receive from the facility for these services except for bills covering the standard Medicare coinsurance and noncovered items. If you have already paid a bill, or if you have any questions about whether to pay a bill, please contact this office or your local Social Security Office within 6 months and furnish the following documents: a copy of this notice, the bill(s) received for services, receipts, or other evidence of payments to the provider.

If you have any questions about this determination, you should first get an explanation from your local Social Security Office. If you still believe this determination is not correct, you may request a reconsideration within 60 days from the date of this notice. You may make the request through your Social Security Office.

SAMPLE LETTER NO. 5

DENIAL LETTER - BENEFICIARY CONSENTING TO PLACEMENT IN NONCERTIFIED OR INAPPROPRIATELY CERTIFIED BED LATER FILES CLAIM

This is in response to the Medicare claim submitted in your behalf by (name of facility) for services you received as a patient at the facility between (dates). These services are not covered under Medicare, because they were furnished in a part of the facility that was not appropriately certified for Medicare reimbursement.

There is a provision that permits Medicare payment where a patient who otherwise qualifies for Medicare reimbursement is inadvertently or erroneously placed in a noncertified or inappropriately certified bed. However, this provision does not apply where the beneficiary consents in writing to placement in such a bed and is fully knowledgeable of the consequences.

The attached statement shows that you gave written consent to placement in the inappropriately certified bed at the (name of facility) and that you understood that the charges for the services furnished you would not be reimbursed by Medicare since you did not intend to claim such Medicare reimbursement. Therefore, we have determined that no Medicare benefits can be paid on your behalf.

If you disagree or have any questions about this determination, you should contact this office for an explanation. If you still believe the determination is not correct, you may file a request for reconsideration within 60-days from the date of this notice. You may also make the request through your Social Security Office.

Attachment

3431.4 Determining Liability For Services Furnished in a Non-Certified SNF or Hospital Bed.—

A. Beneficiary Liability.—If you determine that the beneficiary did not consent to placement in the non-certified bed within the participating facility (see § 3431.3C), and that no other basis for denial of the claim exists (see § 3431.3D), find the beneficiary not liable under § 1879 of the Act.

B. Provider Liability.—If the beneficiary is found not liable under § 1879, liability may rest with the provider, or with the program. Liability rests with the Medicare program, unless any of the following conditions exist, in which case the provider is liable for the services.

o The provider did not give timely written notice to the beneficiary of the implications of receiving care in a non-certified or inappropriately certified bed as discussed in § 3431.3B.

o The provider failed to attempt to obtain a valid consent statement from the beneficiary. (See § 3431.3C.)

o You determined from medical records in your claims files that it is clear that the beneficiary required and received services equivalent to a covered level of SNF care, or that constituted covered hospital services, and the provider had no reasonable basis for placing the beneficiary in a non-certified bed. Following are examples of situations in which it would be found that the provider did in fact have a reasonable basis to place a beneficiary in a non-certified bed:

EXAMPLES:

— You, a PRO, or Utilization Review Committee had advised the provider that the beneficiary did not require a covered level of SNF care or covered hospital services;

— The beneficiary's attending physician specifically advised the provider (verified by documentation in the medical record) that the beneficiary no longer required a covered level of care or services;

— A beneficiary not requiring covered services had a change in his condition that later required a covered level of care or services and the provider had no certified bed available (of course, the SNF transfer requirement must be met, see § 3131.3ff.);

— The provider itself decided that the beneficiary did not require a covered level of care, unless you determined that in more than 5 percent of these SNF placements or 2.5 percent of hospital placements in a calendar quarter, the beneficiary required and received services equivalent to a covered level of SNF care or covered hospital services. (The provider may, of course, still attempt to show in any individual case that it had a reasonable basis for deciding that covered care was not required); or

— You have other sufficient evidence to determine that the provider acted in good faith but inadvertently placed the beneficiary in a non-certified bed.

3432. DETERMINING LIABILITY FOR PROVIDER CLAIMS UNDER SECTION 1879—

Ordinarily a finding is made that the beneficiary did not know nor could reasonably have been expected to know that the items or services were not covered by Medicare, unless there is evidence as discussed in § 3432.1. The procedures for determining whether the provider knew or could reasonably have been expected to know of the noncoverage of services are discussed in § 3432.2.

3432.1 Determining Beneficiary's Liability.--For the beneficiary, the presumption is made that he did not know that services are not covered unless the evidence indicates that written notice was given to the beneficiary. In some cases, the beneficiary may have been given notice in a previous claim that a type of care is not covered. More commonly, the provider or its utilization review committee gives notice to the beneficiary that a particular stay or course of treatment is not covered or that coverage ended at a particular time. (See § 3440 regarding when a beneficiary is on notice of noncoverage.)

A. Beneficiary Determined to Be Liable--Right to Appeal.--When you determine that the beneficiary is liable, the beneficiary is held responsible for the payment of expenses incurred for items or services determined to be noncovered under Medicare. However, the beneficiary can appeal both your determination holding him liable for the cost of the noncovered care and the coverage issue. (See § 3781.3.)

B. Beneficiary Determined to Be Without Liability.--Unless evidence indicates that the beneficiary knew or had reason to know that the items or services he received were noncovered because they were not reasonable or necessary or constituted custodial care, presume that the beneficiary did not know that the services are not covered.

When the beneficiary's liability is waived, all days or HHA visits for which he received benefit of limitation of liability (whether Medicare payment is made) are charged to the beneficiary's utilization record of hospice and SNF days and HHA visits, as though covered under Medicare.

Such days and visits are shown as having been used on the utilization notice, form HCFA-1533. This requirement includes days for which the beneficiary's liability has been waived but for which the provider is liable. (See § 3610.9.)

3432.2 Determining Provider Liability.--

A. General.-- Hold the provider liable for noncovered services if it is determined that the provider:

- o had actual knowledge of the noncoverage of services in a particular case, or
- o could reasonably have been expected to have such knowledge.

B. The Favorable Presumption Provision. —Prior to March 24, 1986, a provider that was found to make all reasonable efforts to assure that its Medicare coverage decisions were correct and demonstrated the ability to make accurate Medicare coverage decisions, was presumed not to have had knowledge of noncoverage. As a means of determining whether the provider could be entitled to such a "favorable presumption" under the limitation of liability provision, a denial rate criterion was established which was intended to indicate whether the provider could make accurate judgments concerning the coverage or noncoverage of services in most cases. If the provider did not meet the denial rate criterion, it could not be considered to have taken all reasonable measures to obtain knowledge of noncoverage and therefore could not be granted a favorable presumption.

The application of § 1879 limitation of liability provisions was revised by a final rule published in the Federal Register on February 21, 1986. That final rule had no provision for the use of the favorable presumption for providers (hospitals, SNFs, HHAs, and additional entities included in § 3444) effective for services furnished on or after March 24, 1986. However, use of the favorable presumption was extended for limited periods by subsequent legislation. See subsection C below.

C. Time-Limited Extension of Favorable Presumption by Legislation.—

1. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), enacted April 7, 1986, provided for the use of the favorable presumption for SNFs and HHAs for designated periods:

a. The favorable presumption applies for 30 months after the month of enactment for SNFs who meet a 5 percent denial rate criterion; that is, to denials processed through October 31, 1988.

b. The favorable presumption applies for medically reasonable and necessary denials of HHAs who meet a 2.5 percent denial rate criterion until one year after the date on which the 10 regional home health intermediaries have begun operations to service HHAs. It has been determined that the favorable presumption will apply to such denials of services processed through August 31, 1988.

Extension of the favorable presumption also applies to ancillary and outpatient services furnished by an SNF and to outpatient services (e.g., physical therapy (PT) and speech pathology (SP)) furnished by an HHA in its capacity as a rehabilitation agency, as long as the HHA has only one provider number. The statutory provision for use of the favorable presumption extends to all services provided by SNFs and HHAs, including those which are payable under Part B discussed in §3444ff.

Since a hospital when it provides swing-bed care can be considered to function as an SNF, the favorable presumption does apply in accordance with the aforementioned COBRA provisions, where a hospital files for reimbursement for SNF services furnished in one of its swing beds.

2. The Omnibus Budget Reconciliation Act of 1986 (OBRA), enacted October 21, 1986, provided for the use of the favorable presumption for hospices and for technical denials of HHA claims for designated periods:

a. Hospice.—OBRA provided for the use of the favorable presumption for denials of hospice services furnished on or after May 1, 1987 through October 31, 1988. The favorable presumption applies for hospices with denial rates of 2.5 percent or less for services denied under §1862(a)(1)(C) (i.e., hospice services which are not reasonable and necessary for the palliation or management of terminal illness).

b. Home Health Technical Denials.--For claims processed on or after July 1, 1987 and through September 30, 1989, OBRA provides for application of limitation of liability and use of the favorable presumption for denials of home health services where the beneficiary does not meet the requirements under §1814(a)(2)(C) or under § 1835(a)(2)(A) of being homebound or of needing skilled nursing care on an intermittent basis. A favorable presumption regarding the limitation of liability for such denials is available for HHAs which (1) comply with requirements respecting timely submittal of bills for payment and medical documentation, (2) promptly notify patients, and their physicians, where it is determined that a patient is being or will be furnished items or services which are excluded from coverage, and (3) have not more than 2.5 percent of claims submitted during the previous quarter (based on visits billed) denied on the bases of home bound or intermittent nursing care requirements. Ordinarily (1) and (2) will be deemed to have been met where the HHA meets the 2.5 percent denial rate requirements for such denials. Limitation of liability will not apply to these technical denials after September 30, 1989.

D. Effect of Favorable Presumption. —Where an SNF, HHA or hospice meets the denial rate criteron for any particular category of denials in §3432.2 C, all of its claims for services for the particular category of denials are to be processed under the favorable presumption that the provider of the services has no knowledge of noncoverage, unless the evidence in the particular case shows that, in fact, the provider has or could reasonably have been expected to have had knowledge of noncoverage. (See §3439ff.) When the denial rate criterion is not met for any of the categories of denials in §3432.2 C, a favorable presumption cannot be extended for any of those denials. However, even though a favorable presumption cannot be extended to its claims, the SNF, HHA or hospice may allege that, in an individual claim, it did not know and could not reasonably have been expected to know that the services were not covered. In such situations, you must consider the evidence submitted in support of the provider's allegation. These situations will generally arise during the reconsideration process. In order for a provider to qualify for limitation of liability, the evidence must show that, even though the SNF, HHA or hospice has not qualified for a favorable presumption in the particular denial, it still did not know or could not reasonably have been expected to know that the care was not covered.

Each category of denials discussed under subsection C. will be subject to a favorable presumption. Thus, an SNF in C.1.a. could qualify for a favorable presumption based on its medical necessity denials under §§1862(a)(1) or (9). A hospice under subsection C.2.a. also could qualify for a favorable presumption based on its hospice medical necessity denials under §1862(a)(1)(C). An HHA, however, could qualify for two separate favorable presumptions, one based on its medical necessity denials §1862(a)(1) or (9) as discussed in subsection C.1.b, and another based on its technical denials §§1814(a)(2)(C) and 1835(a)(2)(A) as discussed in subsection C.2.b.

Even though an SNF, HHA or hospice meets the requirements for a favorable presumption, if any such provider has been advised either by your bulletins or by denial of a prior claim that a specific modality of services that it rendered was not covered, claims for that specific modality of services can not be entitled to the favorable presumption for limitation of liability purposes. (See §3439ff.) See §3444ff. for a discussion of limitation of liability for ancillary and outpatient services payable under Part B.

E. Provider Is Determined to Be Liable--Right to Appeal. -- A provider which is determined liable for all or a portion of the charges for noncovered items and services furnished a beneficiary may appeal such a decision by you under certain conditions. If a beneficiary is partially liable for the noncovered items or services, you must first establish that the beneficiary will not exercise his appeal rights. (See §3781.4.) If the beneficiary chooses not to appeal, the provider has the right to appeal both the coverage and limitation of liability decisions. However, a provider does not have a right to appeal when neither the beneficiary nor the provider is liable, e.g., when the entire noncovered portion of the stay is paid under §1879.

NOTE: The limitation of liability provision does not apply to third party payors except liability insurers. Therefore, a provider that you determine liable may seek payment from a third party payor other than a liability insurer without being subject to recovery action that could occur if it sought payment from the beneficiary.

F. Provider and Beneficiary Determined to Be Without Liability.-- If you determine that neither the provider nor the beneficiary knew or had reason to know that the services provided the beneficiary were not covered, the Medicare program will accept liability and make payment. (See §3441.)

3433. CRITERIA FOR PRESUMING THAT SNF, HHA OR HOSPICE MEETS LIMITATION OF LIABILITY REQUIREMENTS.

To determine whether an SNF, HHA or hospice has knowledge of Medicare coverage rules and can apply them, collect statistics to ascertain whether denial rates exceed 5 percent for SNFs and 2.5 percent for hospices and HHAs (the HHAs' 2.5 percent criterion applies to each favorable presumption calculation, that is, separately for medical necessity denials and technical denials). (See § 3434ff. for determining denial rates.)

Because compliance with the denial rate criterion is difficult without an effective URC, timely notification of noncoverage to patients, and timely and meaningful completion of physician certifications, these activities need not be separately evaluated for purposes of determining a provider's qualification for a favorable presumption.

For purposes of determining favorable presumption, compliance with the following criteria are deemed met if the SNF, HHA, or hospice meets its applicable denial rate: (1) all UR standards; (2) the certification/recertification requirements in 90 percent of the cases reviewed; (3) procedures that assure that bills and medical documentation are submitted in a timely manner; and (4) procedures which assure timely notice to beneficiaries.

3433.1 Newly Participating SNF, HHA or Hospice.--When denial rate statistics are not available for a newly participating SNF, HHA, or hospice, it is deemed to meet the requirement for an initial period not to exceed 60 days. During this period, monitor the provider's performance and evaluate the data being accumulated on an ongoing basis. The denial rate for the initial period determines whether the provider qualifies for the favorable presumption for the following quarter.

3433.2 SNF, HHA or Hospice Changing Intermediaries.--An SNF, HHA, or hospice changing intermediaries retains the favorable presumption received from its prior intermediary for a 60-day period from the date of the change, during which the new intermediary accumulates denial rate data. However, if in the judgment of the new intermediary, sufficient data have been accumulated prior to the end of the 60-day period to support a finding that the provider is, or is no longer, complying with this criterion, continue or withdraw favorable presumption accordingly. (See § 3434.9 with regard to low utilization providers.)

3433.3 Reevaluating Favorable Presumption.-- Each SNF, HHA, and hospice must be reevaluated at least every 3 months to determine whether it is entitled to a favorable presumption (or presumptions, in the case of HHAs). (See § 3434.7.) A shorter time span may be set for reevaluation in special situations where there is a drastic fluctuation in denial rates.

Notify the provider in writing when there is a change in its qualification for favorable presumption. Explain not only what this means in terms of limitation of liability determinations as discussed in § 3432.2, but also what a favorable presumption means to the provider in terms of its giving notice of noncoverage to beneficiaries as discussed in § 3440. If the denial rate criterion is not met, the reason must be clearly explained. Work with such providers to assist them in meeting the criterion. Even though a determination that the denial rate criterion is not met is not subject to appeal, document the reason for such decisions and assist the SNF or HHA in meeting the criterion.

3433.4 Notifying ROs of Excessive Denial Rates.--Advise your RO of SNFs, HHAs or hospices that continue to submit bills resulting in an excessive rate of denials. A denial rate for two successive quarters higher than 5 percent for HHAs and hospices and 10 percent for SNFs is excessive, and may indicate potential program abuse.

3433.5 Reevaluating Favorable Presumption for Prior Period.--Occasionally, new information may indicate that an earlier determination that an SNF, HHA or hospice qualified for favorable presumption was erroneous. In such a situation, you may retrospectively reevaluate and redetermine the provider's previous qualification for favorable presumption.

If the reevaluation establishes that the provider did not qualify for the favorable presumption, determine that the provider had, or could reasonably have been expected to have had, knowledge of the noncoverage of the services for claims denied as not being medically reasonable and necessary or for custodial care, or as technical denials, in the case of HHAs, unless the provider can demonstrate through objective evidence that, even if it had had a favorable presumption, it would not have known that the services were noncovered. Such a reevaluation and redetermination is made only after careful and well-documented examination of the facts and issues.

Even though the provider was determined to be in compliance with the appropriate denial rate criterion, upon reevaluation, the favorable presumption may be rebutted in any individual case in which the evidence is clear that the provider should have known at the time that the services furnished were not covered. (See § 3439.)

3434. DETERMINING DENIAL RATE FOR FAVORABLE PRESUMPTION.

Specified data must be recorded for each SNF, HHA or hospice for those cases in which a Medicare beneficiary receives services as an inpatient of a participating SNF or receives services from a participating HHA or hospice prior to an event terminating program coverage. Terminating events include: (1) provider notice; (2) URC notice; (3) intermediary notice; (4) exhaustion of benefits; (5) transfer to a non-certified bed; (6) discharge; and (7) death.

Denial rates are calculated on the basis of the formula B/A, in which "B" - the number of denials (the numerator) is divided by "A" - the number of claims submitted (the denominator). The denominator is always either (1) the entire universe of claims (days or visits) billed as covered and incurred before a terminating event, or (2) all claims (days or visits) included in a statistically valid random sample. The numerator is the number of denials (days or visits) within either the entire universe of claims or the random sample, as appropriate. Due to medical review requirements, the use of the random sampling option for calculating denial rates is inappropriate for all HHA claims, for all hospice claims, and for hospital based SNF claims, and "A" must be the entire universe of claims. Random sampling may be used for freestanding SNF claims. In any case where selection of a statistically valid random sample is not possible, "A" must be the entire universe of claims.

3434.1 SNF Denial Rate Calculation.--The following data must be recorded:

A. All days (excluding "grace" days under §1879) that the SNF billed as covered and which were incurred prior to a terminating event, that is, all such days in the universe of claims or in the random sample. (Random sampling may be used only for freestanding SNFs.)

B. All days that the SNF billed as covered but that you determined to be noncovered because the services provided were not medically necessary and reasonable or constituted custodial care, that is, all such days in the universe of claims or in the random sample.

- Days denied for reasons other than those noted in B above are not to be included in B.

To calculate the denial rate, divide "A" into "B." For the denial rate criterion to be met, the number of days in "B" must not exceed 5 percent of the number of days in "A."

Examples of Denial Rate Calculation for SNFs

EXAMPLE 1: Standard Billing:

> A patient was admitted to an SNF on 1/1 and discharged on 1/31. A claim for payment was submitted to the intermediary for the period 1/1 to 1/31. The intermediary determined that covered care ended on 1/20 and noncovered care began on 1/21. The data collected on this case shows A = 30; B = 10.

EXAMPLE 2: Interim Billing:

> Patient was admitted to an SNF on 1/1 and was still an inpatient on 1/31. An interim bill for the period 1/1 to 1/31 was submitted to the intermediary. The intermediary reviewed the claim on 2/10 (beneficiary was still an inpatient on that date), determined that covered care ended on 1/20 and noncovered care began 1/21. Based only on the days billed in the interim bill, the intermediary compiles the data for the number of days actually billed as covered and the number of days determined to be noncovered (A = 31, B = 11). If the SNF submits a payment bill to Medicare for the subsequent period, the additional data would be compiled (A = 10 (2/1 - 2/10); B = 10 (2/1 - 2/10)).

3434.2 HHA Denial Rate Calculation.--The following data must be recorded:

A. All visits (excluding "grace" visits under §1879) that the HHA billed as covered and which were incurred prior to a terminating event.

B. All visits the HHA billed as covered but that you determined to be noncovered because (1) the services provided were not medically necessary and reasonable or constituted custodial care; or (2) because the beneficiary was not homebound or did not need skilled nursing care on an intermittent basis.

- Visits denied for reasons other than those noted in B above are not to be included in B.

To calculate the denial rates, divide "A" into "B(1)" and "B(2)." For the denial rate criterion to be met in either case, the number of visits in "B(1)" or "B(2)" must not exceed 2.5 percent of the number of visits in "A."

Calculate HHA Denial Rates by Breaking Out Medical Necessity Denials and Technical Denials:

During the statutorily established periods that the favorable presumption may be applied to medical necessity denials (i.e., not medically reasonable and necessary or custodial care, § 1862(a)(1) or (9) exclusions) and technical denials (i.e., not homebound or not needing skilled nursing care on an intermittent basis, §1814(a)(2)(C) or § 1835(a)(2)(A) exclusions), it is necessary to establish that an HHA separately meets the denial rate criterion for each of these two categories of denials. Make two separate denial rate calculations for each HHA. As a result, an HHA potentially could qualify for 2 favorable presumptions, one favorable presumption based on its medical necessity denials and another based on its technical denials. It is also possible that an HHA might qualify for only one favorable presumption, depending on its meeting the denial rate criterion for only one category of denials (either medical necessity denials or technical denials). There is the possibility that an HHA may not qualify for a favorable presumption for any of its denied services because it did not meet the denial rate criterion for either category of denials .

When calculating the two denial rates for an HHA, the same factor A is used when determining the HHA's qualification for a favorable presumption for its: 1) medical necessity denials and 2) technical denials.

Thus, A is divided into B(1), when B(1) represents the total number of visits billed as covered by the HHA which you deny for medical necessity reasons, to determine the HHA's denial rate for medical necessity denials. The same A is divided into B(2), when B(2) represents the total number of visits billed as covered by the HHA which are denied for technical reasons, to determine the HHA's denial rate for technical denials.

The following are examples of how denials are categorized for purposes of their inclusion in the proper denial rate:

Reasonable and Necessary Denials:

o Denials of services which were not needed.

o Denial of services because they were to administer treatments which are not demonstrated to be safe and effective (e.g., experimental drugs).

o Denials of visits because the services could have been provided in the course of fewer visits (e.g., one aide visit in a day to bathe, and a second visit that day to wash hair).

o Denials of dependent services (e.g., home health aide, medical social services, occupational therapists) because the patient ceased to need skilled care. (If the patient continued to need skilled care, but a few skilled visits were denied as not being necessary, there would be no denial of the dependent services since the patient would continue to qualify notwithstanding the denial of some skilled care).

Technical Denials

- Denials of all services after the patient ceased to be (or was never) confined to the home.

- Denials of skilled nursing care because the patient needed skilled nursing care which did not meet the definition of "intermittent."

- Denials of dependent services (e.g., home health aide, medical social worker) because the patient did not need skilled nursing care on "intermittent" basis.

Examples of Denial Rate Calculations for HHAs

- Reasonable and Necessary Denial Rate:

EXAMPLE 1: The HHA billed for 16 skilled nursing visits and 16 home health aide visits a patient for the first month after start of care (no other skilled services were needed). The intermediary determined that no further skilled nursing care was needed after the 8th skilled nursing visit. Therefore the intermediary denied the 8 skilled nursing visits and the 7 home health aide visits which were provided after the date of the last medically necessary skilled nursing visit. In this case A=32, and B(1)=15.

EXAMPLE 2: The HHA billed for 10 skilled nursing visits and 16 home health aide visits for a month. The intermediary determined that 5 of the skilled nursing visits were not reasonable and necessary, but that the patient, nevertheless, continued to need skilled nursing care on an intermittent basis for care of an indwelling catheter. The intermediary denied the 5 skilled nursing visits, but paid the home health aide services since the patient continued to qualify for Medicare coverage of the services. In this case, A=26, and B(1)=5.

- Technical Denial Rate:

EXAMPLE 3: The HHA billed for 31 skilled nursing visits and 31 home health aide visits for a month. The intermediary determined that the patient needed skilled nursing care on other than an intermittent basis, and denied all of the visits. In this case, A=62, and B(2)=62.

EXAMPLE 4: The HHA billed for 12 skilled nursing visits and 16 home health aide visits for a patient for a month. The intermediary determined that the patient ceased to be confined to the home in the middle of the month. The intermediary then denied the 5 skilled nursing visits and the 6 home health aide visits which were provided after the patient ceased to be confined to the home. In this case, A=28, and B(2)=11.

- Interim Billing:

EXAMPLE 5: The patient received home health services beginning 3/1 and remained a patient on 3/31. The intermediary received a bill from the HHA for 20 home health visits rendered during March. On 4/10, the intermediary reviewed the bill and determined that only the first 18 visits were covered. When the intermediary notified the HHA of the noncoverage of the remaining 2 visits, the HHA advised that still another 5 visits had been furnished to the patient during the period 4/1 -4/10.

Based only on the visits billed (during 3/1 - 3/31) in the interim bill, the intermediary compiles the data for the number of visits actually billed as covered and the number of those billed visits determined to be noncovered. In this case, A=20, B(1)=2. If the HHA submits a payment bill to Medicare for the visits furnished in the subsequent period (4/1 - 4/10), the additional data would be compiled. In this case, A=5, B(1)=5.

3434.3 Hospice Denial Rate Calculation.—The following data must be recorded:

A. All days (excluding "grace" days under §1879) that the hospice billed as covered and which were incurred prior to a terminating event, that is, all such days in the universe of claims.

B. All days that the hospice billed as covered but that you determined not to be covered at the billed level of care because the services provided were not reasonable and necessary for the palliation or management of terminal illness, that is, all such days in the universe of claims . Where one or more hours of continuous home care are denied for a day billed as a continuous home care day, that entire day is to be counted as a denied day.

- Days denied for reasons other than the above are not to be included in B.

To calculate the denial rate, divide "A" into "B." For the denial rate criterion to be met, the number of days in "B" must not exceed 2.5 percent of the number of days in "A."

Examples of Denial Rate Calculations for Hospices

EXAMPLE 1: The hospice billed for continuous home care provided to a patient for 12 days of a 30 day month. The other 18 days were billed at the routine home care rate. The intermediary determined that the patient did not need any continuous home care for 5 of the 12 days billed for continuous home care and, hence, denied payment at the continuous home care rate and paid for these days at the routine home care rate. In this case, A=30, and B=5.

EXAMPLE 2: The hospice billed for 5 days general inpatient care, 10 days continuous home care, and 16 days routine home care provided to a patient during a 31 day month. The intermediary denied 2 of the general inpatient care days, and 2 of the continuous home care days and paid for these 4 days at the routine home care rate. In this case, A=31, and B=4.

EXAMPLE 3: During a patient's stay, in a 30 day month, a hospice billed for 18 hours of continuous home care on 1 continuous home care day and billed for routine home care for the other 29 days. The intermediary determined that only 15 hours of the care provided on the continuous home care day was covered as continuous home care, and it denied payment for the 3 remaining hours. In this case, A=30, and B=1 (B=1 whether only 1 hour or all 18 hours on that day are denied).

3434.4 Random Sample Size.--When a random sample review is used to evaluate whether a provider qualifies for a favorable presumption, the sample size must be representative of the provider's universe of claims. The following table identifies the minimum sample size required to calculate a provider's denial rate. In the case of an inadequate sample size, sampling is not used and the entire universe of claims is used for the denominator of the denial rate calculation.

Claims Processed Quarterly	Sample Size
1-14	8
15-20	14
21-30	19
31-40	24
41-50	28
51-70	34
71-100	43
101-200	61
201-400	85
401-600	107
601-1000	136
1001-1500	167
1501-2000	200
2001-3000	243
3001+	370

3434.5 Favorable Presumption Sampling Guidelines.--The objective of sampling is to allow us to economically measure the percentage of denied visits or days of service for a given provider. This measurement then allows for determinations regarding a provider's eligibility to retain its favorable presumption. Sampling, assuming proper design and execution, allows us to measure the tolerance percentages with a known degree of accuracy for a fraction of the cost of a full universe review. The ability to make concise and accurate statements regarding the projection of sample findings assumes the following:

- The sample was randomly selected from the appropriate universe,
- The sample size is large enough to ensure a good representation of the universe, and
- The review findings for the sampled services are appropriate.

The sample size and review quality of limitation of liability sampling are established by existing policy and are assumed to be appropriate. The random selection of a sample from an appropriate universe requires a further understanding of the principles of random sampling.

A. General Principles of Sampling.--In order to ensure that sample findings represent the universe within the laws of probability, it is necessary to ensure that the sample selection process does not introduce any non-random misrepresentation, or bias. The first step in selecting an appropriate sample is to ensure that the list to be sampled (the sampling frame) corresponds to the universe of interest. The sampling frame must contain ALL units appropriately included in the universe of interest and exclude all units not in the universe of interest (sampled units not in the universe of interest can be replaced with appropriate units but this practice is avoided). The sampling frame must be complete and as clean as possible in regard to such determinants as time frames, claim types, etc. It is critical that the definition of the sample unit on the sampling frame be consistent with the desired statistical conclusions. In most situations the sample unit for limitation of liability determinations is the claim. The use of any other sample unit requires an evaluation by a statistician to ensure the acceptability of the resulting statistics.

The application of sampling techniques to the established sampling frame must not introduce any over or underrepresentation of universe subgroups. Simply stated, each unit on the complete sampling frame must have an equal chance of being included in the sample. Targeted sampling on error prone or prescreened units must be avoided at the risk of invalidating sample projections.

The basic methods used in selection of a random sample are simple random sampling and systematic sampling. In simple random sampling, each unit on the sampling frame is assigned a unique number and the sample is identified through random generation of corresponding numbers. This random number generation can be obtained through a computer software package or from a published table of random numbers. Random numbers are generated sequentially until the sample size requirement is satisfied. Systematic sampling involves the computation of a sampling interval which is equal to the sampling frame size divided by the required sample size. The sample is selected by taking a random unit between the first unit and the interval size and then every subsequent unit corresponding to the interval. For example, with an interval of 20 and on initial random selection of unit 12, the sample includes units 12, 32, 52, 72, etc, until the sampling frame is exhausted.

There are a number of more sophisticated variations on either of these methods, including stratifying the sampling frame into subgroups and sampling by groups (or clusters). Although these techniques may allow for somewhat improved cost effectiveness or reliability of the sample findings, use of these techniques is discouraged due to the inherent increase in computational complexity and the likelihood of bias due to misapplication of the techniques.

Regardless of the technique used to identify the sample unit, it is critical that only those units identified by the established methodology be included. Use of human "judgment" to change the selection process or to supplement the sample violates the integrity of the sample. Supplementation of the sample, should it prove necessary, must be accomplished through the reapplication of either simple random or systematic sampling methodologies.

B. Application of Sampling for Favorable Presumption Determination.--The following is a hypothetical example for application of sampling under typical circumstances. Although variations can result in acceptable samples, it is assumed that this example provides an illustration of a sampling application which is feasible for most providers/intermediaries.

EXAMPLE: Provider X typically submits 245 claims for services for the quarter under review. Based on the sample size chart in §3434.2, a universe of 245 claims corresponds to a minimum sample of 85 claims. Select a systematic sample using the following steps:

1. Compute a sampling interval = 245/85 = 2.88 which is truncated (not rounded) to one decimal place (2.8).

2. From a table of random numbers select a random start integer between 1 and the interval size (in this case 2.8 rounded to 3). In our example, the random start selected was 2.

3. Select the second claim in the sampling frame and every 2.8th claim thereafter, as illustrated in the following table

	Interval	Cumulative Interval	Claim Selected
Random start equals	2	2	2
	+2.8	4.8	5(4.8 rounded)
	+2.8	7.6	8
	+2.8	10.4	10
	.	.	.
	.	.	.
	.	.	.
	.	.	.
	.	.	.
	+2.8	240.8	241
	+2.8	243.6	244

Based on the universe of 245, and a sampling interval of 2.8, the resulting sample size was 87. The sample size exceeded the 85 minimum by a small margin due to the truncation of the sampling interval from 2.88 to 2.8. If the sample exceeds the minimum by a substantial margin, the excess claims may be RANDOMLY deleted. The easiest way to accomplish this is to select numbers from a random numbers table and to delete the corresponding claims from the sample. These claims are then deleted from the sample, regardless of review status, until the proper sample size is reached.

Once the sample is established, all claims selected are reviewed to determine the number of denials and the total number of days. The number of total days reviewed exceeds the claim sample size due to the large number of average days per claim. It is these totals for denied days and total days that determine the denial rate used for the favorable presumption determination.

For example, when we randomly reduced our sample from 87 to 85, the following performance was observed.

(a) Number of Sample Claims	(b) Total Number of Sample Days	(c) Number of Days Denied	(c)/(b)x100 Percentage of Denied Days
85	680	16	2.4%

This provider retains a favorable presumption due to the 2.4 percent denial rate. A denial rate above the tolerance level results in loss of the favorable presumption.

3434.6 Precision of Favorable Presumption Determination.—When sampling is used to measure the provider's performance, you must be capable of computing the degree of precision to be applied to the estimate. Make this computation only when all of the following criteria are met:

- o The point estimate of the provider's denial rate exceeds the favorable presumption tolerance;
- o You intend to withdraw the provider's favorable presumption; and
- o The provider specifically requests the contractor to compute the precision level of the sample estimate.

The determination of qualification for a favorable presumption is based on the simple ratio of denials to service units in the sample. However, the universe characteristics and sample sizes correspond to an implied degree of variability of this ratio around the true value. The expected variation of the sample denial rate around the true universe denial rate is referred to as the precision of the sample estimate. The degree of precision resulting from a sample largely determines the amount of risk HCFA assumes that the sample estimate is above or below the favorable presumption tolerance.

In order to evaluate the degree of variation risk due to sampling, the precision limits from a sample may be computed after the sample findings are available. Assuming a standard confidence factor of 95 percent, the limits of a sample estimate may be computed as explained below. Note the lower limit of the estimate, which is the lowest realistic possible value of the true universe denial rate, based on a given sample. While the sample denial rate is the best estimate of the true value, the lower limit provides valuable insight into the degree of sampling risk. The following calculations assume that a random or systematic sample of claims was selected and the denial rate computed as the ratio of sample denials to sample service units. These instructions, when applied to a provider's sample findings, yield the lower limit of this sample denial rate. Keep in mind the distinction between claims and service units (i.e., visits or days).

1. Compute the sample denial rate as the sample number of denied service units (Y) divided by the sample number of total services (X). (DO NOT CONVERT THIS NUMBER TO A PERCENTAGE). R=________________ $\frac{\Sigma Y}{\Sigma X} = \frac{\bar{Y}}{\bar{X}}$

2. Compute the sample fraction as the claim sample size(n) divided by the claim universe size (N) f=________________ $\frac{n}{N}$

3. Compute the average number of service units per claim in the sample as the total sample service units divided by the number of sample claims x=________________ $\bar{X} = \frac{\sum X}{n}$

4. Compute the square root of the sample size NSQR=______________ $\sqrt{n}$

5. Compute factor one as the square root of 1 minus f divided by NSQR times X Fl=________________ $\frac{\sqrt{1-f}}{\sqrt{n}\;\bar{X}}$ Rev.

6. Square the number of denied service units on **EACH CLAIM,** then sum the squared numbers Y2=________________ $\sum Y^2$

7. Square the number of total service units on **EACH CLAIM,** then sum the squared numbers X2=________________ $\sum X^2$

8. Square the denial rate (R) and multiply the result times the **SUM OF SQUARED SERVICES UNITS** (X2) R2X2=______________ $\hat{R}^2\sum X^2$

9. Multiply the number of denials times the total service units on **EACH CLAIM,** then sum these products XY=____________ $\sum XY$

10. Multiply the result (XY) by 2 and multiply this result by the denial rate (R) 2RXY=__________ $2\hat{R}\sum XY$

11. Compute factor two as (Y2) plus (R2X2), minus (2RXY), the result divided by (n-l), where n-l is the number of sample claims minus one. Take the square root of the final result. F2=____________

$$\sqrt{\frac{\sum Y^2+\hat{R}^2\sum X^2-2\hat{R}\sum XY}{n-1}}$$

12. The standard error of the sample denial rate is (Fl) time (F2). SE=____________

$$\frac{\sqrt{1-f}}{\sqrt{n}\;\bar{X}}\sqrt{\frac{\sum Y^2-2\hat{R}\sum XY+R^2\sum X^2}{n-1}}$$

13. The lower confidence limit of the denial rate is computed as (R) minus 2 times (SE) $\hat{R}-2S(R)$

Lower Limits=__________

NOTE: If desired, the denial rate (R) and the Lower Limit may be converted to percentages after all precision calculations are completed by multiplying each number by 100.

If the above lower limit is below the tolerance level and the standard error (Step 12) exceeds the denial rate (Step 1), the precision of the sample denial rate is suspect. In this instance, the contractor, at the provider's request, selects a supplemental sample to augment the initial sample. This supplemental sample is based on the same universe as the original sample and equals to the original sample size up to the review of the entire universe.

3434.7 Time Period for Calculating Denial Rate.--Each calendar quarter, calculate each SNF's, HHA's, or hospice's denial rate based on the data collected for that provider during the preceding calendar quarter. Calculate the denial rate by the end of the month following the end of the quarter.

For example, data compiled during 1/1 through 3/31 is used to calculate the denial rate. This calculation is to be made by 4/30. If shorter times, e.g., 1 or 2 month periods, are used, adapt the instructions above to the shorter times. (HHA technical denials rates are calculated on a quarterly basis only.)

3434.8 Effect of Change in Favorable Presumption.--Advise an SNF, HHA, or hospice of any change in its favorable presumption (i.e., gain or loss of the favorable presumption) by the end of the month following the end of the quarter for which the denial rate was calculated.

For example, if there is a loss of favorable presumption based on data compiled from 1/1 through 3/31, favorable presumption is retained for services rendered from 1/1 through 3/31 and up to the date of your notice of change of favorable presumption, but no later than the last day of the month following the end of the quarter (in this case 4/30).

All claims processed for services furnished on or after the date of notice are processed under the new favorable presumption determination.

3434.9 Low Utilization Providers.--A SNF, HHA, or hospice that submits payment claims for fewer than 10 admissions during a 6-month period generally does not generate sufficient data for a valid analysis of its ability to make coverage determinations. However, if you believe that such a provider should be granted a favorable presumption, discuss the case with the RO which may approve a favorable presumption for a low utilization SNF, HHA, or hospice.

3434.10 Treatment of Day or Visit Determinations Later Reversed.--Where an initial payment or denial of payment determination which was included in the denial rate calculation is reversed as a result of reconsideration, hearing, reopening or other review (e.g., a Coverage Compliance Review), it is necessary to adjust the number of denied Medicare days and visits (no adjustment is necessary to the total number of days or visits). In the case of days or visits initially denied, but later determined to be covered, subtract such days or visits from the denied Medicare days or visits. Days or visits initially found to be covered, but later determined to be noncovered, are to be added to the denied Medicare days or visits. (Where the review merely affirms the initial payment or denial of payment decision, no adjustment action is necessary.) The subtraction or addition of such days or visits is to be applied to the period during which the intermediary took action on the reversal, that is, to the current denial rate calculation.

NOTE: Days and visits payable only under the limitation of liability provision are considered noncovered days and visits and are not counted as covered in the denial rate calculations.

3439. DETERMINING WHETHER PROVIDER HAD KNOWLEDGE OF NONCOVERAGE OF SERVICES

A provider is considered not to have had knowledge of noncoverage of services in a particular claim unless there is evidence to the contrary. Such evidence to the contrary may include the following:

A. Limitation of Liability Criterion.-- In the case of SNFs, HHAs, and hospices, the provider did not meet the criterion for a favorable presumption;

NOTE: Where a provider does not meet the criterion for favorable presumption, it may qualify for payment, under limitation of liability, of the noncovered services in a denial only where it can demonstrate through objective evidence that, even if it had had a favorable presumption, it would not have known that the services were noncovered.

Where a provider meets the criterion for a favorable presumption, it qualifies thereby for payment, under limitation of liability, of the noncovered services in the case of a denial where there is a reasonable doubt as to whether any of the conditions listed in the following subsections B. through G. is met; that is, the provider receives the benefit of the doubt in this regard. However, the favorable presumption is rebutted and no payment is made where it is clear and obvious in a denial that any one of the conditions listed in the following subsections B. through G. is met.

B. Provider Notices.--

o The provider's utilization review committee informed the provider in writing that the services were not covered;

o The provider submitted a no-payment claim, or submitted a claim for payment only at the request of the beneficiary; or

o The provider issued a written notice of noncoverage to the beneficiary.

C. HCFA Notices to Provider.--HCFA has informed the provider in writing of the noncoverage of a particular service or category of services. All participating providers are issued instructions which discuss and define coverage and noncoverage of specified services under Medicare.

For example, instructions in §232ff. of the HHA Manual, §280.9 of the SNF Manual, and §230ff. of the Hospice Manual define covered care and provide examples of unskilled services excluded from Medicare coverage. Where it is clear and obvious from review of a particular medical record that the patient received only excluded services described in the SNF, HHA, or Hospice Manuals and in §§3132.6 and 3159 of this manual, the provider is expected to have knowledge of noncoverage. In such cases, where the provider has a favorable presumption, rebut the provider's favorable presumption. Clear-cut decisions as to noncovered care may not be possible in many cases since patients may require a combination of skilled and unskilled services during a SNF stay or when receiving services at home.

D. Intermediary Notices.--

o A one-time written notice to the provider that a particular item or service is not covered (e.g., acupuncture) is sufficient notice for all subsequent claims involving that service and similar or reasonably comparable services.

o The provider was notified by telephone and/or in writing that the care is not covered or that covered care has ended. If the beneficiary is still an inpatient, give notice by telephone and annotate your record to show that telephone notice was given and the date of the notice. The date of the telephone notice is the effective date of notification to the provider.

o A general bulletin or newsletter was issued to providers advising that a specific item or service is not considered reasonable and necessary.

E. PRO.--A PRO notified the provider that services are not covered. This includes notification of PRO screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical procedures subject to preadmission review by the PRO. Instructions for application of limitation of liability to PRO determinations are in the PRO Manual.

F. Medical Information.--

1. A physician clearly indicated in the patient's medical record that the patient no longer needed the services or the level of care provided. The provider is accountable for information found in the patient's medical records, such as the patient's medical chart, attending physicians' notes, or similar records, since these are provider records. A provider's favorable presumption may be rebutted on the date the evidence based upon medical records, such as that described below, clearly indicates noncoverage of services:

o A physician indicated the patient could be discharged; or

o The attending physician refused to certify or recertify the patient's need for a level of care covered by Medicare because he determined that the patient does not require a covered level of care.

2. You requested additional medical evidence after a certain number of days to determine whether continued coverage is warranted. However, the provider did not submit the evidence within the stipulated time.

EXAMPLE: Based on an admission notice and medical information, it was conditionally projected that coverage was likely to extend for 12 days. The SNF must submit additional evidence of coverage within the 12 days. If the SNF failed to do so, its liability can be waived only through the 12th day of the stay, if you later determine the services were not covered under §1862(a)(1) or (9).

3. Follow the established procedure for requesting additional evidence needed in a particular case to permit a decision on coverage. Where the beneficiary is still an inpatient at the SNF, advise the SNF that the additional information must be submitted (i.e., postmarked), within 5 work days of a telephone request, or if a telephone request is not feasible, postmarked within 7 work days of the date of a written request.

If this requirement is met, and the SNF has a favorable presumption, it is protected from liability under the limitation of liability provision through the date you made the coverage determination based on the requested additional evidence and notified the SNF. If the evidence is not submitted within the required 5 to 7 days, the SNF is protected from liability only through the date the additional evidence was requested, even though the SNF otherwise has a favorable presumption.

G. Patently Unnecessary Services.-Make an immediate finding of liability in fraud and abuse, as well as in other situations where a provider furnishes and claims payment for services that are so patently unnecessary that all providers could reasonably be expected to know that they are not covered. Generally, this would be the case where abuse has been identified in a particular claim.

As defined in §3454.1B, abuse exists when a provider furnishes services that are inconsistent with accepted sound medical practices, are clearly not within the concept of reasonable and necessary as defined by law or regulations, and, if paid for, would result in an unnecessary financial loss to the program.

3439.1 Notifying Patient of Noncoverage.—Where a provider is aware that the services to be furnished to a patient will not be covered, it advises the patient or his representative in writing (see §§3440ff.) at or before admission/start of care or when the type of care changes during a stay/course of care, that the services are not paid for by Medicare, the basis for this belief, and that no claim for Medicare reimbursement will be submitted or that a claim will be submitted for only the covered portion of the stay. The notice must clearly state that the beneficiary has the right to request the provider to file a claim for a Medicare coverage decision. The SNF provides a copy of the noncovered notice to the beneficiary. If the beneficiary requests it, the SNF submits a noncovered claim and copy of the beneficiary notice to Medicare.

EXAMPLE: If an SNF intends to place a patient in a noncertified portion of its facility because it believes the patient does not require a covered level of care, it must notify the patient in writing. If the beneficiary requests that the SNF submit a claim, the SNF indicates that the bill is being submitted at the beneficiary's request, and why it considers the care to be noncovered. The no-payment billing procedure is used. In such a case, neither the beneficiary nor the SNF (or HHA if appropriate) is entitled to payment under limitation of liability. Do not count such denials in determining denial rates for SNFs, hospices, and HHAs. (See §§3434ff.)

3439.2 Verifying Provider Notification Procedure.—To make sure that nonhospital providers have an established procedure for notifying beneficiaries and physicians promptly when a decision of noncoverage is made, obtain a written description of the procedure from them. The procedure should provide for a written notice of noncoverage to the beneficiary or person acting on his behalf, on the day of admission or start of care, on the day the care is found to be noncovered, or on the same day you advise the provider of noncoverage. SNFs are required to use the appropriate denial notices found in §3730.1.

Verify, at least annually that non-SNF providers follow their notification procedures. For SNFs, refer to §3630.4.

3439.3 Improper Coverage Decisions.--A provider must submit, at the request of the beneficiary or the beneficiary's representative, claims for services the provider believes are not covered because the services are not medically reasonable and necessary, or constitute custodial care or, in the case of HHAs, are technical denials . Review these claims to assure that the provider is not improperly indicating that no Medicare payment should be made where some or all of the services are covered. You may infer that a provider which is submitting an excessive number of such claims does not know the standards for coverage and thus is not in a position to give effective notices of noncoverage. If you find that an HHA or hospice is improperly submitting no-payment claims in excess of 5 percent of its total claims, or that an SNF is improperly submitting no-payment claims in excess of 10 percent, deny the provider a favorable presumption even if it meets the criteria in §§3434ff.

3440. ESTABLISHING WHEN BENEFICIARY IS ON NOTICE OF NONCOVERAGE

A beneficiary informed by written notice that specific services were noncovered, following a prior stay or prior receipt of home health services, is liable for payment for the same or similar services furnished under the same or similar conditions, if it is clear that the beneficiary or the person acting on his behalf should have known that the services were not covered.

The beneficiary is presumed not to have known or not to have been expected to know that care would not be covered, unless or until one of the following occurs:

A. Provider Is Source of Notice.--

- A provider advised the beneficiary or the person acting on his behalf in writing on or before the day of admission that the care is noncovered.

- During the course of the patient's stay, you advised the provider that covered care had ceased and the provider notified the beneficiary or the person acting on his behalf in writing of your determination.

- During the patient's stay, a provider advised the patient or the person acting on his behalf in writing that the patient no longer required covered care.

NOTE: See §§3730ff. for provider notices.

B. PRO Is Source of Notice.--A PRO notified the beneficiary or the person acting on his behalf in writing that covered care is not required or is no longer required.

C. Intermediary Is Source of Notice.--The beneficiary received his first notice of noncoverage from you (e.g., an intermediary denial notice).

D. Utilization Review Entity Is the Source of Notice.—The group or committee responsible for utilization review for the provider that furnished the services advised the patient or the person acting on his behalf in writing that the patient no longer required covered care.

3440.1 Determining Date of Notice.--

A. For Beneficiaries.—In determining when the beneficiary received notice of noncoverage, use the date the written notice was given to the beneficiary when the beneficiary is an inpatient and is capable of handling his own affairs (i.e., is able to sign and negotiate checks).

Providers which must furnish notice to the beneficiary who is incapable of managing his own affairs telephone the person who is acting on the beneficiary's behalf or has assumed financial responsibility for the beneficiary on the same day the provider knows the services are not covered. The provider confirms the telephone contact by written notice mailed on that same date, to protect itself from liability. A written notice is mailed on the same day even if a telephone contact cannot be made. The provider places a dated copy of the notice in the incapable patient's medical file.

HHAs which are unable to deliver notice of noncoverage personally to a beneficiary are instructed to give notice by telephone, and on the same day to mail a written confirmation of the telephone notice. The date of the telephone call is considered the date the beneficiary received notice of noncoverage.

B. For Providers-- When notifying a provider of noncoverage, use the date of notice annotated in your records, in accordance with § 3439D2.

Where a URC notifies a provider of noncoverage, use the date of notice shown by the provider in Item 21 of the billing form HCFA-1450, unless you have evidence of an earlier notification.

Where the provider itself determines that covered care is no longer required, use the date of the provider's written notice of noncoverage to the beneficiary, as indicated in subsection A. Be alert to the possibility that the provider may have had earlier knowledge of noncoverage. (See § 3439).

3440.2 Documentation of Notice.-- Make every effort to assure that providers understand the importance of notice for them and for beneficiaries. (See § 3439.1.)

Providers retain copies of all notices of noncoverage given to beneficiaries because the date of notice to the beneficiary may be important in the event of an appeal on the issue of provider liability.

3441. PAYMENT UNDER LIMITATION OF LIABILITY.

When it is determined during the course of a beneficiary's inpatient stay or during his course of home health visits that the care is not covered but both the beneficiary and the provider of services are entitled to limitation of liability, the Medicare program may make payment for the noncovered services up to the date of notice and, if you determine that additional time is needed to arrange for post-discharge care, also for a "grace period" of 1 day after the date of notice to the provider or to the beneficiary, whichever is earlier. If it is determined that even more time is required in order to arrange post-discharge care, 1 additional "grace period" day may be paid for. (See §§ 3439 and 3440 for definition of notice.)

When the provider is given notice as described in § 3440.1, it is required to advise the beneficiary in writing of the determination on the same date it received your notice. Where the provider fails to give the beneficiary such timely notice, the beneficiary is protected from liability until he receives the notice.

For example, if an SNF received your notice of noncoverage on February 15 but failed to advise the beneficiary until February 19, the beneficiary is protected from liability through February 19--the date on which he first received notice. However, the SNF is entitled to program payment only through the date--February 15--on which it received notice, and for whatever "grace period" is allowed thereafter. In a case in which an SNF received your notice on February 15 but failed to give the beneficiary notice until the next day--February 16--the beneficiary and provider, if you determine that additional time is needed to arrange post-discharge care, would be protected from liability under the "grace period" only for the additional day--February 16-- unless it is determined that even more time is required to arrange postdischarge care, in which case 1 additional "grace period" day may be paid for.

NOTE: The "grace period" is applicable only where circumstances have permitted program payment under § 1879 of the Act, i.e., limitation of liability was applicable both to the beneficiary and the provider of services. Where you concur with a URC's decision that covered care has ended, any payments made during the "grace period" after the URC's notice are made under the authority of that statutory provision (§ 1814 of the Act) rather than under § 1879. (See § 3420ff.)

3442. WHEN TO MAKE LIMITATION OF LIABILITY DECISIONS.

A. Initial Claims.-- In implementing the limitation of liability provision, make a coverage decision before making a limitation of liability decision. It is not intended that you pay all claims submitted by providers which have been granted a favorable presumption on the basis that limitation of liability would allow payment anyway. Such action would be contrary to the requirements of § 1879, which provides that limitation of liability can be allowed only in cases:

"Where -- (1) a determination is made that, by reason of §1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services...." (Section 1879(a)(1) of the Social Security Act.)

NOTE: Subsection (g) refers to home health service technical denials under §§ 1814(a)(2)(C) and 1835(a)(2)(A).

Only after you make a decision that care is not reasonable or necessary, is custodial, is not reasonable and necessary for the palliation or management of terminal illness in hospice denials, or does not meet the homebound or intermittent nursing care requirements in home health service denials, should a determination be made regarding limitation of liability. In every such case there will be two parts to the limitation of liability determination: (1) whether and when the beneficiary knew or should have known that the services were noncovered, and (2) whether and when the provider knew or should have known that the services were noncovered.

B. Reconsideration.-- At the reconsideration level, again first make a determination on the coverage issue. Consider the question of limitation of liability, if applicable, only if the initial adverse coverage decision is wholly or partially affirmed. (See § 3780ff. for discussion of the appeals process.)

3443. PREPARATION OF DENIAL NOTICES.

The provider and beneficiary notification procedures discussed in § 3439 and § 3440 for determining liability do not change the instructions for the preparation and issuance of denial notices in §§ 3717, 3719, 3721 and 3722ff.

Accordingly, in cases where the services are found to be custodial care or not reasonable and necessary or in the case of HHA services, are denied for technical reasons under § 1814(a)(2)(C) or § 1835(a)(2)(A):

A. A denial notice is sent to the beneficiary in cases where only the beneficiary is entitled to limitation of liability for any part of the noncovered stay. The notice advises the beneficiary of his entitlement to indemnification (see § 3446ff.) in the event the provider seeks payment from him for the noncovered services. (See § 3446.9, Exhibit 1.)

B. All denial notices explain any decision regarding limitation of liability for either the provider or the beneficiary. (See § 3721, Exhibits 2 and 2A and § 3722.5).

C. All denial notices, where either the beneficiary or provider has been found liable, must state that the provider has a right to reconsideration when it has been determined that the beneficiary will not exercise his appeal rights, or when the beneficiary's liability has been entirely waived but the provider is fully or partially liable. A copy of the beneficiary's denial notice is sent to the provider with the covering letter. (See § 3721, Exhibits 2 and 2A and § 3722.5.)

3444. APPLICABILITY OF THE LIMITATION OF LIABILITY PROVISION TO CLAIMS FOR ANCILLARY, OUTPATIENT PROVIDER AND RURAL HEALTH CLINIC SERVICES PAYABLE UNDER PART B.

The following sections discuss how the limitation of liability provision is applied to claims involving ancillary, outpatient and rural health clinic services billed on form HCFA-1450 (Provider Billing for Medical and Other Health Services), where reimbursement is sought under Part B. Determine whether limitation of liability applies to these categories of claims when the basis for the denial is that the services were not reasonable and necessary (under § 1862(a)(1) of the Act).

3444.1 Determining Beneficiary Liability in Claims for Ancillary and Outpatient Services.-- A presumption will be made that the beneficiary did not know that items or services are not covered unless there is evidence to the contrary. Indication in the claims file that the beneficiary received notice before receiving the noncovered ancillary, outpatient, or rural health clinic services is evidence to the contrary which rebuts the presumption in the beneficiary's favor. The definitions of "notice" to the beneficiary are set forth in § 3440.

3444.2 Determining Provider Liability in Claims for Ancillary and Outpatient Services.-- The application of the limitation of liability provision to ancillary and outpatient services depends upon whether a favorable waiver presumption applies .

A. SNF or HHA Entitled to Favorable Presumption.-- Where an SNF or HHA is entitled to a favorable presumption for its inpatient SNF services payable under Part A or for HHA visits (based on its medically unnecessary denial rate), the presumption is extended to its claims for ancillary and outpatient services payable under Part B. Process that SNF's or HHA's claims under the presumption that the SNF or HHA did not know that these services were not covered. If you determine that the SNF or HHA is submitting an excessive number of noncovered claims for its ancillary and outpatient services and the noncovered claims relate to a particular service, such as laboratory tests or physical therapy services, the favorable presumption must be withdrawn for that type of service rather than for all ancillary or outpatient services. The withdrawal of the favorable presumption for ancillary and outpatient services does not affect the SNF's or HHA's favorable presumption with respect to its claims for Part A services.

B. Providers Not Entitled to Favorable Presumption.-- The procedures in §3439 apply for determining liability for providers when they do not or are not able to qualify for a favorable presumption. A provider may have its liability waived in an individual claim if it can establish that it did not know and could not have been expected to know that the items or services would not be covered.

3445. BILL PROCESSING AND WORKLOAD REPORTING.

A. Bill Processing.-- Where payment is made under the limitation of liability provision, the usual deductible and coinsurance amounts apply.

When payment under limitation of liability is made for noncovered services, the bill is to be processed in the same manner as any payment bill for covered services. The number of days or visits paid for under the limitation of liability provision is charged to the beneficiary's utilization record. (See § 3620.)

The no-payment procedures in § 3624 for inpatient stays and in § 3638.2 for home health visits are to be followed in the following cases:

o Either the beneficiary or the provider, or both, knew or should have known that services were not covered.

o The provider knew or should have known that the services were not covered even though the beneficiary did not know. In these cases, the notice to the beneficiary will have informed him that, even though no Medicare payment is being made, he is not liable for the cost of the services and that he may be indemnified if he has made improper payments to the provider.

Where no Medicare payment is being made because limitation of liability does not apply or where payment ceases because of notice in a noncovered case, the normal provisions for no-payment situations apply.

For ancillary and outpatient services billed on form HCFA-1450, the provider follows the instructions in § 3626ff. for hospitals, §3630 for SNFs and §3638 for HHAs to process bills for these types of claims. Further, where ancillary services may not be paid for under Part A because they were rendered in connection with a noncovered inpatient stay, the provider may still bill under Part B for ancillary services that may be covered under § 1861(s)(3)-(9) of the Act.

B. Workload Reporting.-- See § 3862 for information to be included in the remarks section of intermediary workload reports where payment is made under the limitation of liability provision.

Indemnification Procedures under Limitation of Liability

3446. INDEMNIFICATION PROCEDURES FOR CLAIMS FALLING WITHIN THE LIMITATION OF LIABILITY PROVISION.

Section 1879(b) of the Act provides that when a provider is held liable for the payment of expenses incurred by a beneficiary for noncovered items or services and such provider requests and receives payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program indemnifies the beneficiary or other person(s) less the applicable deductible and coinsurance amounts. Further, any such indemnification payments are considered overpayments to the provider.

The limitation of liability provision does not apply to third party payors, such as Medicaid. A provider who is determined liable may, therefore, seek payment from a third party payor if one exists.

3446.1 Intermediary and Social Security Office Responsibility in Indemnification Claims.-- Requests or inquiries concerning indemnification may be received by the intermediary, SSO, RO, or central office. However, a beneficiary or person(s) who made payment on behalf of the beneficiary to a liable provider, in most cases, visits their nearest SSO or deals directly with the intermediary to file a request for indemnification.

Those offices are responsible for assisting beneficiaries or any person(s) in filing claims for indemnification.

3446.2 Conditions for Indemnification.-- A beneficiary or any person(s) who assumed financial responsibility for payment is indemnified for claims filed if all of the following conditions are met:

o You have determined that the beneficiary is without liability under authority of section 1879 of the Act for items and services furnished by a provider; and o You have determined that the provider is liable under section 1879 for the items and services furnished to the beneficiary;

o The requester for indemnification has paid the provider all or some of the charges for items and services for which the beneficiary's liability has been waived under §1879 of the Act; and

o The requester seeks indemnification by filing a written statement prior to the end of the sixth month following:

— The month in which payment was made to the provider; or

— The month in which you advised the beneficiary that he was not liable for the noncovered items or services, whichever is later.

The time limit may be extended if good cause is shown. (In determining good cause, use the principles for reconsideration requests outlined in § 3781.3.)

3446.3 Development and Documentation of Indemnification Requests.-- When you receive a request or inquiry concerning indemnification directly from the beneficiary or other person(s) on his behalf; obtain the following information and documentation:

o Identifying information sufficient for you to locate the claim(s) for noncovered items or services for which payment has been made to the provider by the beneficiary or other person and for which the liability of the beneficiary was limited. Ordinarily, the initial denial letter or reconsideration determination suffices.

o A statement on Form SSA-795, Statement of Claimant or Other Person, (see § 3446.9, Exhibit 4) to the effect that the requester paid the provider all or some of the charges for the noncovered items or services for which the beneficiary's liability was limited. The statement must specify the amount the requester has paid the provider. If the requester submits this information in a letter, the letter serves as the signed statement.

o Proof of payment. The following types of documentation are sufficient to establish that payment was made in the amount alleged:

— An itemized bill from the provider which reflects the items and services for which the provider has been found liable and has received payment along with the payor's cancelled check, or money order receipt, or statement of receipt from the provider;

— A summary bill from the provider which pertains to the items and services for which the provider has been found liable and has collected from the beneficiary or other person along with the payor's cancelled check, or money order receipt, or a statement of receipt from the provider showing the same total amount;

-- The payor's cancelled check, or money order receipt, or the statement of receipt from the provider if your records reflect the provider's charges for the items and services for which the provider has been found liable and these equal the total of the amount paid; or

-- If the requester alleges that the provider did not furnish an itemized bill or a receipted statement and no other proof of payment is available, a statement to this effect is obtained on form SSA-795 from all parties involved, including the provider if possible. The circumstances, such as the manner of payment, are to be described and the reasons for not obtaining a receipt or any proof of payment should be provided. If there were any witnesses to the payment, their statement also is to be obtained on form SSA-795. Any questions as to the acceptability of proof of payment should be referred to the RO.

When the beneficiary or other person on behalf of the beneficiary initially contacts the SSO, send the statements and evidence relevant to the indemnification claim to the appropriate intermediary. If future contact with the beneficiary or other person is necessary, proceed with a direct contact unless the assistance of the SSO is needed.

3446.4 Beneficiary Requests Indemnification, But Had No Financial Interest in the Claim.-- If a request for indemnification is received from the beneficiary but he did not have full financial interest in the claim, then any other person(s) who made full or partial payment to the provider must be contacted to ascertain if he wishes to file for indemnification.

If the individual declines to file for the indemnification payment, the SSO or your staff should assist in preparing a statement to that effect for the individual's signature. No payment is made in this instance, and you are to notify all parties involved.

If more than one person helped pay the bill; e.g., sons and daughters of the beneficiary got together and each paid a portion of the bill, you must determine the indemnification amount for each payor unless they all agree in writing that payment is to be made to one person. The deductible and coinsurance amounts, as appropriate, are deducted from the total indemnification amount and the remaining amount due paid proportionately. Explain this to the requester for indemnification.

3446.5 Questionable Indemnification Requests Procedure.-- If you receive a request for indemnification that does not appear to meet the conditions outlined in § 3446.2, and there is some uncertainty concerning the indemnification claim, undertake development to resolve the issues. If the issues cannot be adequately resolved, obtain the opinion of the RO.

3446.6 Determining the Amount of Indemnification.-- In accordance with § 1879(b) of the Act, the beneficiary or other person(s) is indemnified for actual charges paid to a provider, rather than the usual allowable charges as might be determined by the Medicare program, PPS amounts, or established per diem rates that apply to certain providers. The beneficiary is still responsible for any unmet deductible or coinsurance for the items or services for which the provider has been held liable.

In determining the beneficiary's deductible and coinsurance liability:

o Determine if any deductible is met. If any deductible remains unmet in the particular benefit period, the beneficiary is liable for that amount; and

o Determine the coinsurance amounts for days for which the beneficiary's liability has been limited and the provider has been held liable in the same manner as if the days had been covered days.

When you have determined the deductibles and coinsurance amounts the applicable amounts are deducted from the indemnification amount before payment is made.

3446.7 Notifying the Provider.-- After you have reviewed the claim for indemnification and the indemnification amount has been determined, notify the provider of the proposed indemnification action. (A sample letter for these situations is contained in § 3446.9, Exhibit 1A.) The essential elements of this written notice are:

o An explanation of the items and services for which the provider is liable with reference to the original notice to the provider.

o A statement of the provision of § 1879 which allows the program to indemnify the beneficiary and recover an overpayment from the provider;

o An explanation of the amount determined payable to the requester for indemnification;

o A statement that the amount you have determined to be payable is paid to the requester and that it constitutes an overpayment to the provider which is to be recovered from future Medicare payments made to it;

o A statement encouraging the provider to refund any amount(s) already collected; and o The opportunity for the provider to question the amount you have determined payable, in writing, within 15 days.

If the provider does not respond to this notice within 15 days, make payment to the requester in accordance with § 3446.8. If the provider disputes the indemnification or the amount to be paid, resolve any discrepancies before making payment. The payment process takes place even if the provider might appeal your initial determination which held it liable and that appeal is still pending at the time payment of the indemnification amount is to take place. If the appeal decision reverses the initial determination, then adjustments are to be made at that time in your and the provider's records. In all cases, encourage the provider to refund any and all amounts collected to this point. If the provider chooses to refund any money collected, less deductible and coinsurance amounts, verify that such a refund has actually been made to the requester.

3446.8 Making Payment Under Indemnification.-- If the provider does not make refund, the indemnification payment is made. Take action then to recover this amount as an overpayment from the provider. Also issue a letter of explanation to the requester for indemnification. (See § 3446.9, Exhibits 2 and 3.) Send a copy of this notice to the provider. The fundamental points of the notice include:

o Name of the provider and dates the services in question were rendered; and

o The amount of the indemnification check that the requester is to receive including an explanation of the deductible and coinsurance amounts.

3446.9 Exhibits.--

1. Guide Language to Beneficiary or His Representative Explaining Limitation of Liability and Possible Right to Indemnification

1A. Letter to Provider.

2. Letter to Beneficiary Who Requests Indemnification.

3. Letter to Someone Other Than Beneficiary Who Requests Indemnification.

4. Form SSA-795, Statement of Claimant or Other Person.

EXHIBIT 1

GUIDE LANGUAGE TO BENEFICIARY OR HIS REPRESENTATIVE EXPLAINING LIMITATION OF LIABILITY AND POSSIBLE RIGHT TO INDEMNIFICATION (See 3443A)

A determination has been made that you (the beneficiary) had no knowledge or any way of knowing that the services you (he/she) received during (dates of services for which beneficiary's liability has been waived) would not be covered under the Medicare law.

It has therefore been determined that you (the beneficiary) are (is) not responsible for the charges billed by the (provider's name) for the period (__________) except for deductible and coinsurance amounts that might apply or any charges for services or items not covered by Medicare. If you (the beneficiary) have (has) paid (provider's name) for the services at issue, reimbursement can be made to you (the beneficiary) for the amounts charged, less any applicable deductible or coinsurance amounts. To obtain this reimbursement, please advise this office and enclose the following documents:

1. A copy of this notice;

2. The bill you received for the services; and

3. The payment receipt from the (provider's name), or any other evidence showing that you (the beneficiary) have (has) already paid the (provider's name) for the services at issue.

You should file your written request for reimbursement within 6 months of the date of this notice.

EXHIBIT 1A

LETTER TO PROVIDER

To: Provider

Dear Administrator:

Under section 1879 of the Social Security Act, a Medicare beneficiary is relieved of the liability for certain noncovered services if the beneficiary did not know and could not reasonably have been expected to know that the items or services were not covered. Further, the law provides that the provider is liable if it is found that the provider knew or could reasonably have been expected to know that the items or services were not covered by Medicare.

On (date of limitation of liability notice), your facility was notified that the services provided to (beneficiary's name) during the period _______________ to _______________ were not covered under Medicare and that you were liable for these items and services.

(Requester's name) has submitted evidence which establishes that he paid your facility (amount paid) for the services received by (beneficiary's name). Because your facility has collected payment from (requester's name) after being determined liable for these services, section 1879(b) of the Act requires that the Medicare program make direct payment (indemnification) to him for this amount, less any unmet deductible and coinsurance amounts for which (beneficiary's name) is still responsible.

A check in the amount of (amount of check) is being sent to (requester's name). This indemnification payment represents an overpayment to your facility and it will be withheld from future Medicare payments due you unless you advise this office that refund of the incorrect amount(s) has been made to (requester's name).

If you do not agree with the amount determined to have been paid you, please contact this office in writing within 15 days of the date of this letter.

Sincerely yours,

EXHIBIT 2

LETTER TO BENEFICIARY WHO REQUESTS INDEMNIFICATION

Dear (Beneficiary's Name):

Your request for refund of improper payment under section 1879 of the Social Security Act (the limitation of liability provision) for the noncovered services provided you at (name of provider) from (date to (date) has been received.

The evidence submitted establishes that, even though you were not responsible for the services you received, you paid (provider's name) (amount paid) for the services. Your refund for these payments to (name of provider) has been calculated to be (indemnification amount). This figure represents full repayment for the charges you paid, less the deductible and coinsurance amounts which apply to this claim and for which you are responsible.

Since you are responsible for the deductible and coinsurance amounts, your record will be credited with these payments. In addition, your Medicare utilization record will be charged where noncovered services were provided to you and you were determined not liable.

If you have any questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer to visit your local social security office, please take this letter with you.

Sincerely yours,

EXHIBIT 3

LETTER TO SOMEONE OTHER THAN BENEFICIARY WHO REQUESTS INDEMNIFICATION

Dear (Person's Name):

Your request for refund of improper payment under Section 1879 of the Social Security Act (limitation of liability provision) for the noncovered services provided (beneficiary's name) at (name of provider) from __(date)__ to __(date)__ has been received.

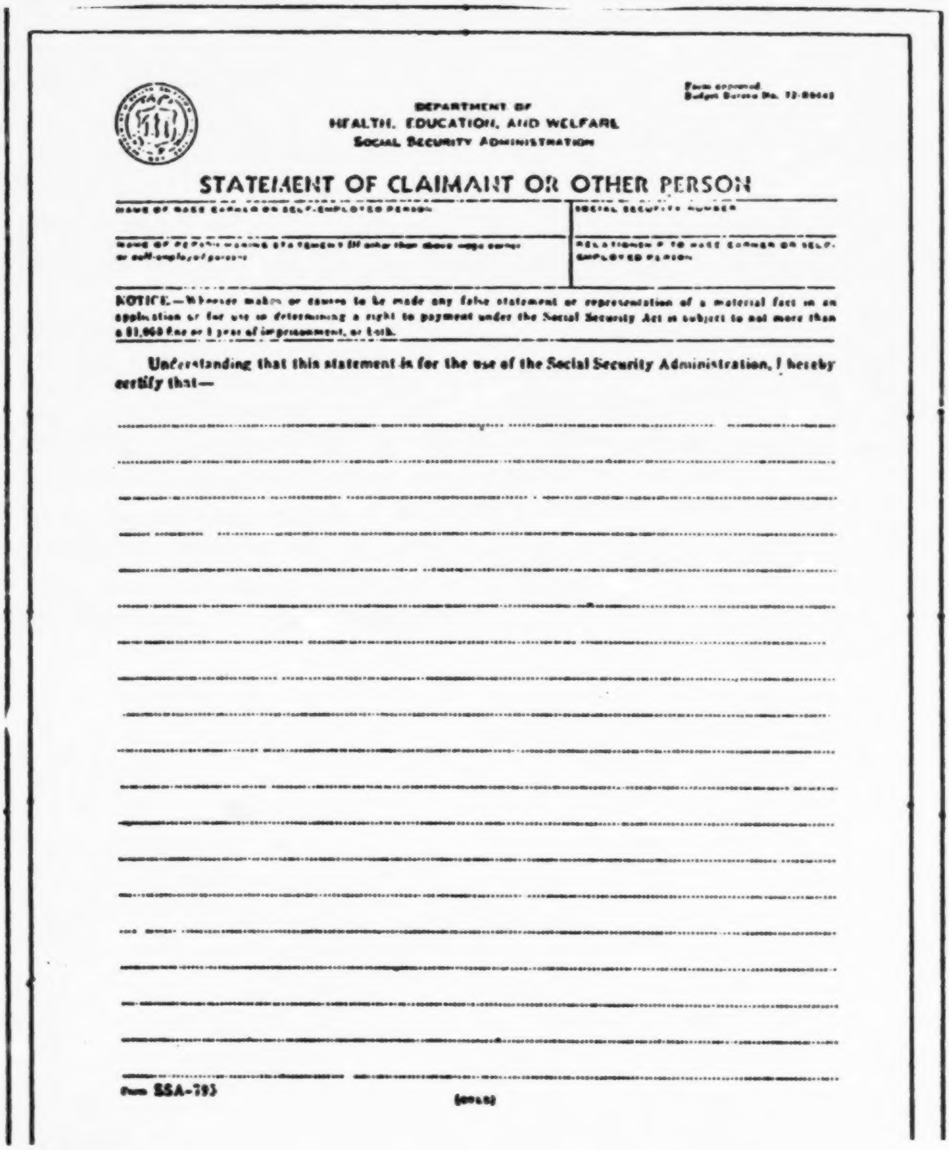
It was determined that (beneficiary's name) was not liable for the services except for the applicable deductible and coinsurance. The evidence you submitted establishes that you paid (provider) (amount paid) for the services provided (beneficiary's name). Your refund has been calculated to be (indemnification amount). This figure represents full repayment based on the expenses incurred by (beneficiary's name) in the amount of $ _____, less the deductible and coinsurance amounts of $ _____.

If you have any questions concerning the matters discussed in this letter or the amount of the check enclosed, please call this office. If you prefer, you may visit the local social security office. If you do, take this letter with you.

Sincerely yours,

EXHIBIT 4

STATEMENT OF CLAIMANT OR OTHER PERSON



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

STATEMENT OF CLAIMANT OR OTHER PERSON

NOTICE.—Whoever makes or causes to be made any false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act is subject to not more than a $1,000 fine or 1 year of imprisonment, or both.

Understanding that this statement is for the use of the Social Security Administration, I hereby certify that—

Form SSA-795

(over)

Program Integrity

3450. MEDICARE PROGRAM INTEGRITY--GENERAL

The potential for fraud and abuse in Medicare is heightened by the sheer magnitude of the program, which affects millions of beneficiaries, involves thousands of doctors and health care institutions, and which depends on many private health insurance organizations for proper claims review and payment. Medicare was designed not to impose an onerous Federal superstructure on the nation's existing health care system. Reimbursement principles, both for physicians and institutions, were rather broadly designed to accommodate, to the extent possible, established ways of doing business and to allow reimbursement of actual costs and charges. Every effort was made to respect the traditional doctor-patient relationship and to permit doctors to retain discretion in determining what services are necessary for the care of their patients, and to give patients ready access to the broad array of medical services which are available. Only those quality standards were imposed that were believed necessary to protect the health and safety of beneficiaries.

Medicare, therefore, utilizes established health care systems as the means for providing and paying for the health care services received by program beneficiaries. Within a program of such complexity and magnitude yet which provides flexibility and room for variation, opportunities for fraud and abuse are considerable. The problem is to carry out the legislative intent and at the same time detect and prevent fraud and abuse. To do this successfully requires the cooperation and concerted efforts of different SSA components, and of intermediaries and carriers.

3452. PROGRAM INTEGRITY DEFINED

The Medicare program presents a somewhat different situation in respect to identifying and preventing fraud and other abuses compared to cash benefit programs. This is true in terms of the kinds and scope of the problems encountered as well as some of the methods and procedures used to dispose of individual cases and to correct problems in general.

The suspects in Medicare fraud cases are seldom beneficiaries. Most often the suspects are physicians or suppliers, ambulance companies, proprietary hospitals, SNF's, or HHA's. Beneficiaries are most often the witnesses in Medicare suspected fraud cases and their age and health are important factors in developing cases of fraud. Although claims under Medicare are not for continuing benefits and, therefore, are for lesser amounts when considered individually, Medicare fraud cases in the aggregate involve huge sums of money.

Medicare also introduced a new concept of "program abuse." Not all incidents of abuse are considered violations in a legal sense and are usually disposed of by corrective and preventive actions taken by intermediaries and carriers rather than by SSA.

3454. MEDICARE FRAUD DISTINGUISHED FROM ABUSE

Fraud in Medicare usually takes the form of false claims for payment submitted to carriers and intermediaries for medical or health services which were in fact not rendered. Another form of fraud is the representation on the claim form of more complicated, and hence more costly, procedures than those actually rendered. Still another form of fraud in Medicare results from "kickback" arrangements between providers of services and their suppliers. Briefly, a provider purchases items reimbursable under Medicare for a stated price but the seller "kicksback" a discount amount. If the provider claims the stated price as his reimbursable cost under Medicare knowing it to be false, the act constitutes fraud. Allegations of this kind of fraud are usually made by third parties, possibly employees of either the provider or supplier.

The term "abuse" is used to describe incidents and practices which, although not considered fraudulent acts, may directly or indirectly cause financial losses to the Medicare program or to beneficiaries and their families. The type of abuse to which Medicare is most vulnerable is overutilization of medical and health care services. The Medicare law expressly excludes from coverage any services that are not reasonable and necessary for the diagnosis or treatment of illness or injury. Overutilization can occur when a patient requests and receives services that are medically unnecessary, or when a physician or a provider of services renders services that are medically unnecessary.

The most frequent incident of abuse, however, is breach of the Part B assignment whereby a physician agrees to bill on behalf of a beneficiary and to accept as his full charge the amount determined by a carrier to be the reasonable charge (as defined by law and regulations). Violation of the agreement occurs when the carrier reduces the physician's charge because it exceeds the reasonable charge and the physician, in violation of his agreement, requests the patient to pay the amount of the difference.

3454.1 Definition of Key Terms.—

A. Intent to Defraud.—The terms "with intent to defraud" and "fraudulently" are synonymous. They refer to an intentional deception or misrepresentation which the individual knows to be false and which the individual makes knowing that his deception could result in some unauthorized benefit to himself or some other person. The requisite intent is present if the representation was either knowingly false or fraudulent, or made in reckless disregard of what the facts might be.

Since fraudulent intent, as a subjective element of crime, is difficult to prove by direct evidence, it may be inferred from circumstances and from patterns of actions.

Intent to defraud may be imputed to a corporation if an agent of the corporation who committed the act had such intent. Thus, there is no legal obstacle to successful prosecution of a corporation provided that: (1) the guilt of the individual acting on behalf of the corporation can be established; and, (2) the act of the individual was commited within the scope of his employment by the corporation.

It is important to remember that the question of "criminal intent" is a question of fact and one ultimately decided by a court. The responsibility of those developing cases is to accumulate facts that demonstrate the existence of such intent. However, it is not their responsibility to decide this question, and they should guard against the tendency to prejudge and close cases on the basis of facts accumulated.

B. Abuse: Those practices wherein providers, physicians, or other suppliers of medical services operate in a manner inconsistent with accepted sound fiscal business or medical practices in such a way that these practices result in an unnecessary financial loss to the Medicare or Medicaid programs and are not within the concept of reasonable and necessary services as defined in the Medicare or Medicaid laws.

Examples:
1. Unnecessary services
2. Breach of assignment agreement
3. Gang visits
4. Improper billing practices

C. Integrity Review: The initial screening of complaints, inquiries, incidents, issues, etc., associated with abusive practices perpetrated against the Medicaid/Medicare program. Such review may consist of a limited review of other beneficiaries, assessment of information at hand, etc. The "normal" Medicare/Medicaid claims processing and prepayment operations should not be included as integrity reviews. The integrity review is resolved with one of two decisions:

1. No abuse is demonstrable and the issue is closed; or,

2. Abuse has been demonstrated sufficiently to warrant a full scale investigation.

Postpayment medical review (overutilization, upcoding, etc.) and abuse related complaint activity should be reported as integrity reviews or full scale investigations as appropriate.

D. Material.--The term "material" as applied to a false statement, false representation, or deceitful withholding of information where there is a duty to disclose the truth, means that the deceit must relate to a matter that is of significance and would tend to influence an intermediary to pay benefits not authorized by the Act; permit a beneficiary to keep benefits previously paid to him which were not authorized by the Act; or otherwise influence HCFA in determining rights to payment.

E. Knowingly.--The term "knowingly" as used in a criminal statute generally means that state of mind which exists when the accused person is aware that a particular act would constitute a deception or misrepresentation, but nevertheless proceeds to do it. It is intended to exclude unwitting or unconscious actions contrary to the law, such as mistakes of fact or accidents.

F. Willfully.--The term "willfully" means voluntarily, purposefully, deliberately, and intentionally as opposed to accidently, inadvertently, or carelessly. It involves actual knowledge of and intent to commit a particular act.

For example, to establish a violation under section 1877 (42 USC 1395nn), it is necessary to prove that a person or persons made a false statement by filing false claims or cost reports, for reimbursement, knowingly and willfully. The mere fact that an incorrect claim was filed is not in itself sufficient. It must be shown that the act was done intentionally with knowledge that such an act constituted a deception or misrepresentation to satisfy the knowingly and willfully aspects.

G. Full Scale Investigation.--Once the integrity review has been conducted and a decision is made to expand the investigation due to the belief that abuse exists, a full scale investigation is initiated. This decision will result in the preparation of an abuse form (HCFA-51).

H. Overpayment Established.--An overpayment will be considered as having been determined when the intermediary has completed its review and determined a specific figure. This determination could be based on either a sample or 100 percent review of bills. It should represent the amount the intermediary has presented, or will present, to a provider of services as the amount due in abuse cases.

3455 REPORTING TITLE 18 REQUIREMENTS FOR ABUSE CASES

Intermediaries that perform full scale abuse investigations are required to prepare Medicare, Medicaid Abuse Report forms which are intended to achieve 2 major goals:

(1) Create an integrated Medicare/Medicaid workload report; and

(2) Establish a comprehensive reporting system to provide sufficient information to meet the needs of the Administration, Congress, and the public

All intermediaries will summarize data concerning the number of Integrity Reviews (see § 3455.1) acted upon during the calendar quarter and will enter the required data into the appropriate section of the Postpayment Medical Review (Abuse Cases) Summary Report--Medicare (HCFA-60). The other data requested on this form may be obtained by summarizing the data on the HCFA-51.

Preparation and Distribution of Workload Reporting Forms

Form	Prepared by	Copies Prepared/ When	Sent to OPI RO	Sent to MAB RO	Sent to OPI CO by RO
Medicare/Medicaid Abuse Report HCFA-51	Medicare Contractor	3 copies on a Flow Basis	2 copies		1 copy
Postpayment Medical Review (Abuse Cases) Summary Report (Medicare)--HCFA-60	Medicare Contractors	4 copies Quarterly	2 copies	1 copy	1 copy

Department of Health, Education, and Welfare
Health Care Financing Administration

FORM APPROVED
OMB NO 66-RO 119

OFFICE OF PROGRAM INTEGRITY ABUSE REPORT

☐ MEDICARE ☐ MEDICAID

OPI RO	CARRIER/INTERMEDIARY NAME
STATE	CARRIER/INTERMEDIARY NUMBER
DATE RECEIVED	DATE INVESTIGATION INITIATED

A SUSPECT INDIVIDUAL OR ORGANIZATION	NAME	STREET ADDRESS, CITY, STATE	CASE NUMBER
	CROSS REFERENCE NAME	STREET ADDRESS, CITY, STATE	CASE NUMBER

B
CLASSIFICATION OF SUSPECT CIRCLE ONE

01 MD	05 Hospital	09 Clinic	13 Drug Supplier	17 ICF
02 DO	06 SNF	10 DME	14 Renal Facility	18 Transportation Co.
03 Podiatrist	07 HHA	11 Laboratory	15 Chiropractor	99 Other, Explain
04 Dentist	08 Therapist	12 Ambulance	16 Optometrist	______

C
NATURE OF POTENTIAL ABUSE COMPLAINT

AREA UNDER REVIEW

01 Breach of Assignment/Contract Violation
02 Excessive Services
03 Services Not Medically Necessary
04 Gang Visits
05 Improper Billing Practices, Specify: ______
99 Other: ______

06 Dollar Volume Related To Area Under Review		07 Total Dollar Volume Paid for Vendor's Services During Most Recent 12 Month Period	
$	Time Period	Period	$

D
SOURCE OF COMPLAINT

01 Postpayment Review System	08 Other Government Source (Identify) ______
02 State Fraud Unit	
03 Prepayment Review System	09 Medical Society
04 PSRO	10 Recipient Beneficiary
05 HEW Project Integrity	11 Media
06 PARE	99 Other, Explain: ______
07 OPI RO	

E
CORRECTIVE ACTION

	Date
01 Refer for Inhouse Medical Review	______
02 Refer for Peer Review (PSRO)	______
03 Refer for Peer Review (Medical Society)	______
04 Refer for Peer Review (Other Identify) ______	______
99 Other (Describe) ______	______

DISPOSITION

	Date
01 Closed No Abuse Determined	______
02 Overpayment Established $ ______	______
03 Pre/Post Payment Monitoring Established	______
04 Educational Contact/Warning Letter	______
05 Referred to Licensing or Professional Conduct Authority	______
06 Referred for Termination/Exclusion	______
07 Suspended/Terminated	______
08 Administrative Penalty (Medicaid Only) $ ______	______
99 Other (Describe) ______	______

Form HCFA-61 (8-78)

3455.1 Medicare/Medicaid Abuse Report Form (HCFA-51).--

A. Submission of Form.--The intermediary will prepare a Medicare, Medicaid Report Form (HCFA-51) in triplicate when a full scale abuse investigation is initiated. Retain one copy (the original) with the case file and forward two (2) copies (batch and mail them each Wednesday and Friday) to their designated OPI regional office. The HCFA-51 will be completed twice: once when the full scale investigation is opened (the heading and categories A through D are completed); and again when the case is closed (categories E through F should be annotated on the original form and copies of this form will then be forwarded to the OPI RO).

B. When to Complete Form.--The Medicaid, Medicare Abuse Report Form will be completed in all instances where the intermediary has determined that a situation warrants a full scale abuse investigation. The opening of a full scale abuse investigation and the initiating of an abuse form is appropriate only when the postpayment medical review of the physician's (provider's) practice pattern is beyond the level of initial screening and development (integrity Review) for possible abuse, and an overpayment recovery and/or other administrative action (e.g., 100 percent prepayment monitoring) should be undertaken. For example, the postpayment edits generate 1,000 cases for screening that result in 50 cases (Integrity Review) which warrant further review. Of these 50 cases, 20 (full scale investigation) must have additional medical review (nurse/physician) or concurrence for recovery and other administrative action.

An abuse form will be prepared if the physician or provider were the subject of a closed criminal investigation where additional administrative recovery or sanction action should be pursued.

C. Instructions for Completion of Form.--

1. Heading:

The intermediary will insert the organization name and number. Ordinarily, the intermediary will complete the Medicare block. However, if appropriate, both the Medicare and Medicaid block should be checked. Finally, the appropriate dates should be entered as follows:

a. Date Received: Is the date the Integrity Review was initiated (e.g., the date the complaint for inquiry was received, the date of the computer run, etc.)

b. Date Investigation Initiated: Is the date the reviewer determined that a full scale abuse investigation was warranted and initiated the abuse report form.

2. Block A - Suspect Individual or Organization:

This block will identify the name and address of the provider of service, physician, or other supplier under suspicion. Enter the full name of the subject in CAPITAL letters. If the subject is an individual, enter the surname first. The case number may be utilized by the intermediary. At this time, it is not intended to be utilized by the OPI central office.

(1) Cross Reference Name: Identify the name and address of the primary case under investigation to which the suspect indicated on this form has been associated or connected.

3. Block B - Classification of Suspect:

Circle only the code number of the appropriate classification. It is imperative that the name of the classifications be indicated, otherwise the tabulation will be distorted. The following is a list of codes and explanations.

Code	Explanation
01	All categories of approved, licensed medical doctors
02	Osteopath
03	Podiatrist, Chiropodist
04	Dentist
05	All types of hospitals
06	All types of skilled nursing facilities and nursing homes
07	All types of home health agencies
08	Facilities or individuals specializing in therapeutic treatment (Includes speech, physical, inhalation, occupational therapy)
09	Clinic, per se, or two or more doctors operating as a group
10	Supplier of equipment
11	Independent laboratory
12	Ambulance facility
13	Supplier of drugs, medications, etc.
14	Chronic renal disease facility
15	Chiropractor
16	Optometrist
17	Intermediate Care Facility
18	Transportation other than an ambulance
99	None of the above, explain

4. Block C - Nature of Potential Abuse Complaint:

This block identifies the potential problem. Area under review: Select the appropriate code 01-05 or 99 that best describes the area under review.

Code	Explanation
02	Excessive Services would be utilized to indicate items such as 10 office visits for a minor illness that would ordinarily require a maximum of only 2 visits
03	Services Not Medically Necessary would be utilized to report items such as EKG's and Chest X-rays reported on a patient treated for a fractured arm.
06	Dollar Volume, refers to the total dollars involved for the services that are under review. Indicate the time period reviewed to determine the amount. For example, if it is suspected that there is a problem in the rendering of laboratory services, the vendor's dollar volume for those services should be shown in this block. It is recognized that all intermediaries may not have the capacity to retrieve this information readily. Where this is the case,"unknown" should be shown in block 06.
07	Total Dollar Volume Paid should be completed where information on the total dollar volume of the suspect vendor for the most recent 12-month period is available.
99	Other. If this code is selected state the appropriate area.

5. Block D - Source of Complaint:

The information in this block will show how potential abuse became unknown.

01	This category encompasses the review of all bills that have been paid (postpayment review). It is anticipated that this code will be the most frequent method by which potential abuse situations are identified.
02	Refers to those situations which were potentially identified as fraud, but could not be litigated. In those instances where files are returned to the RO for administrative action this code should be circled.
03	Refers to cases identified before payment has been made and which indicates a potential for abuse,
04	A Professional Standard Review Organization
05	A Project Integrity case
06	A Payment Review case
07	A case referred from the OPI regional office.
08	Refers to any government source other than Federal and State
09, 10 and 11	Self-explanatory
99	Should be utilized when none of the above apply and an explanation should be provided.

6. Block E - Corrective Action:

This block provides information on the course of action taken to resolve the abuse situation. Quite often, abuse equates with unnecessary services or overutilization and professional medical judgment is needed to finally adjudicate the matter. Therefore, it is anticipated that an abuse case may often have to be referred for medical or peer review. If a course other than medical or peer review is taken, code 99 should be circled and an explanation included. More than one response may be necessary in this section. Also, it is possible that more than one code may be circled in this section, e.g., a case was referred for in-house review and subsequently referred to a PSRO (02) or Medical Society (03).

Code	Explanation
01	In-House Review: For the purposes of initiating an abuse form and for opening a full scale investigation, an "in-house review" is warranted only when the issues require an unusual or extraordinary review by medical or paramedical personnel. For example: a medical issue routinely reviewed by paramedical/medical personnel would not meet the criteria to qualify as an in-house review.

7. Block F - Disposition:

This block provides information concerning the action taken in closing the case. It is especially important for an overpayment established that the dollar amount be identified in block 02 (round figures to the nearest dollar). Code 08 is intended to be used when the State agency imposes a financial penalty. The dollar amount of such penalty should be shown. Code 99 will be used when none of the above are applicable. When this code is used an explanation is required. More than one action may be indicated in this section, e.g., an overpayment (02) may be established as well as pre-or postpayment monitoring (03) initiated. When an action code is shown, the date of the action must be included. Update the form and send two copies to the OPI RO when all actions in Blocks E and F are completed.

OFFICE OF PROGRAM INTEGRITY (HCFA)
POSTPAYMENT MEDICAL REVIEW (ABUSE CASES) SUMMARY REPORT — MEDICARE

MEDICARE CONTRACTOR REPORTING	REPORTING PERIOD

	OPEN PENDING	RECEIVED IN THIS QUARTER	CLEARED IN THIS QUARTER	$ O/P ESTABLISHED	CLOSE PENDING
Integrity Reviews					
Assignment Agreement and Provider Agreement Violations					

		OPEN PENDING	RECEIVED IN THIS QUARTER	CLEARED IN THIS QUARTER	CLOSE PENDING
Full Scale Investigations	Institutional				
	Non-Institutional				

		NUMBER PLACED ON PREPAYMENT MONITORING	OVERPAYMENT ESTABLISHED	
			# OF PROVIDERS SUPPLIERS	$ O/P ESTABLISHED
Administrative Actions	Institutional			
	Non-Institutional			

			OPEN PENDING	RECEIPTS	CLOSED
PARE Reviews	Part A				
	Part B	1978			
		1977			
		1976			
		Others			

SIGNATURE	DATE

Form HCFA-60 (8-78)

3455.2 Postpayment Medical Review (Abuse Cases) Summary Report--Medicare (HCFA-60)

The intermediary will prepare 4 copies of the Postpayment Medical Review (Abuse Cases) Summary Report and submit 2 copies to the OPI regional office within 10 calendar days after the end of each calendar quarter. One copy should be sent to the Medicare Bureau regional office.

This summary will be utilized to capture data concerning integrity reviews, full scale investigations, overpayment, and other administrative actions of the intermediary. The name and number of the intermediary and the reporting period should be identified in the heading.

To avoid duplication of reporting, the component (intermediary or regional office) with primary responsibility for the resolution of the integrity review or full scale abuse investigation case should report the activity, e.g., a complaint received by the RO would be tabulated by the RO as an integrity review. If a full scale abuse investigation is warranted (a HCFA-51 opened) and the case is referred to the intermediary for resolution, the intermediary would report it as a full scale abuse case on the HCFA-60.

A. Integrity Reviews. The total number of integrity reviews, including assignment agreement violations (AAV) and provider agreement violations (PAV), should be reported. A separate count of the reviews which are assignment or provider agreement violations should be annotated on the appropriate line. (See § 3454.1.)

B. Full Scale Investigations. Report the total number of cases (Form HCFA-51) under each of the appropriate column headings. Further, the totals must be shown appropriately as "Institutional" or "Non-Institutional." For the purposes of this report, an institution includes the following: Hospital 05, SNF 06, HHA 07, Renal Facility 14, and ICF 17. (See § 3454.1.)

C. Administrative Action. For each reporting period, information entered in the column titled "Number Placed on Prepayment Monitoring" indicates the number of providers/suppliers warranting such action because of intermediary postpayment review activity resulting from a full scale investigation which has been closed. Information entered in the column titled "Overpayment Established" (see § 3454.1H) indicates the total number of providers/suppliers and their related aggregate total dollars where an overpayment has been identified during this reporting period.

D. Reviews. Data entered should summarize the PARE activity of the intermediary.

E. Signature. Each quarterly report should be signed and dated by the intermediary employee who is regularly responsible for the reports.

3456. STAGES IN THE DEVELOPMENTAL PROCESS

There are four general stages in the development of fraud cases in the Medicare program. These are:

A. Identification.—Potential fraud or potential abuse situations first must be recognized and reported. Identification of these cases can come from a variety of sources such as claims review activities, reports from beneficiaries to carriers or intermediaries, etc. At this stage all allegations should be clear and precise and reported to the RO for control or additional direction. See §§ 3458 and 3464.

B. Development.—Once a potential case or situation has been reported to the RO. case development is usually required to determine if in fact fraud or abuse is a real possibility. During this stage one or more contacts may be needed to ascertain the correctness of the suspect's billings, etc. These contacts would normally be with individual beneficiaries or providers and would not involve contact with any potential suspects. Such contacts should normally only be made at the request of the RO.

C. Interview with Subject.—This is a direct contact with the "suspect" and usually comes only after validation interviews suggest that fraud is a real possibility. These contacts will be with physicians, suppliers, providers, beneficiaries, etc. and normally will be made by or at the request of the RO.

D. Prosecution.—This is the final stage in processing fraud cases. This stage includes the decision on whether to recommend prosecution, preparation of the case for referral ultimately to a U.S. Attorney and any appropriate post referral development required by the U.S. Attorney.

3458. ROLE OF INTERMEDIARIES

The first responsibility of intermediaries is to refer to the RO cases of suspected fraud or abuse that come to their attention as a result of their claims review activities or through any other device. Thereafter, the extent of their involvement in the development and disposition of cases depends on the nature of the cases.

An intermediary will usually become aware of a possible violation through an allegation by the beneficiary (or his representative) or through its review process. When the intermediary is the first to receive the complaint, it follows the procedure outlined in § 3464, without awaiting RO instructions. If the intermediary can resolve the discrepancy through a review of in-house material there is no need to advise the RO. However, if the issue cannot be resolved in this manner, the RO should be advised.

The participation of intermediaries in the development of suspected fraud cases is usually limited to furnishing information about claims and payments. In abuse cases the role of intermediaries is greater because correction and prevention of abuse is basically their responsibility.

It should be noted that intermediaries are prohibited from contracting with third parties to undertake development of potential fraud cases. Program integrity investigations are to be conducted solely by authorized intermediary personnel in concert with the RO. This function may not be delegated to an organization, corporation, or individual not otherwise participating directly in the administration of the Medicare program.

3459. PROGRAM INTEGRITY COMPLAINTS RESOLVED BY INTERMEDIARIES

In some instances an intermediary may become aware of potential fraud or abuse situations which it is able under § 3464A to resolve without referral to the regional office. In the past the intermediary reported to the regional office information on all such cases by preparing and submitting a Part A Quarterly Report of Program Integrity Complaints. As a result of modifications to the reporting requirements for Title XIX abuse cases, this form should not be submitted to the regional office. The intermediary should, however, maintain the same information on such cases in the same manner as they have in the past. This information should be available for regional office review as part of the CIEP review process or upon request of the regional office. This will enable the regional office to compile useful statistical data as to the types and frequency of violations, variances by States within the regions, identification of violators, etc. After analyzing the data, the regional office will be able to discuss trends and remedial actions with each intermediary. At the same time, "repeaters" will be readily identified and aberrant patterns detected at an early stage.

3459.1 Information Required on Program Integrity Complaints.--All information which was previously reported by the intermediary on the Part A Quarterly Report of Program Integrity Complaints should continue to be maintained by intermediaries. In addition, to foster consistency of information and ease of review by regional office personnel, intermediaries should maintain the information in the same manner as it has in the past.

3459.2 Explanation of Information Required on Complaints.--

SOURCE OF COMPLAINT: Show the name of the individual or organization which notified the intermediary of the alleged program fraud or abuse.

PROVIDER NAME, ADDRESS AND I.D. NUMBER: This information is necessary to identify the provider involved in the alleged fraud or abuse.

NATURE OF COMPLAINT: Fully describe the nature of the alleged fraud or abuse, i.e., "provider billed for services not rendered," "beneficiary alleged provider billed for more than deductible and coinsurance," etc.

DATE RECEIVED: Show the date the complaint was received by the intermediary.

ACTION TAKEN: Fully describe the remedial action taken to close out the complaint. For example, "reviewed provider records and substantiated amounts billed beneficiary." It is important that this item provides sufficient information to enable the regional office to understand the reason for the closeout of this item.

DATE CLOSED: Show the date the closeout occurred.

NUMBER OF COMPLAINTS: List the number of complaints received concerning this provider including the present complaint. This information is useful in determining which providers are involved in an unduly frequent number of complaints.

PART A QUARTERLY REPORT OF PROGRAM INTEGRITY COMPLAINTS

Intermediary I.D.

Period Covered by Report

Source of Complaint	Provider's Name, Address and I.D. Number	Nature of Complaint	Date Received	Action Taken	Date Closed	Number of Complaints

3460. FRAUD IN CONNECTION WITH CLAIMS

A. Fraud.—Section 208 of the Social Security Act provides penalties for obtaining or attempting to obtain services or payments by fraudulent means. When Medicare was enacted, Congress specifically extended these penalties to the health insurance program by section 1872 of Title XVIII of the Social Security Act. In addition, portions of the U.S. Criminal Code regarding conspiracy, submittal of false or altered documents, and making false claims against the Government apply to Medicare requests for payments. Upon conviction, penalties can range up to $10,000 or up to 5 years in prison.

With the passage of Public Law 92-603 on October 30, 1972, specific penalty provisions have been added to Title XVIII of the Social Security Act. These penalty provisions are contained in Section 1877 of the Act and apply to any acts, statements or representations under Medicare that occurred on or after October 30, 1972. Therefore, title II penalties set forth in section 208, and made applicable to title XVIII by section 1872, do not apply to Medicare as of October 30, 1972. The applicable section of the United States Code is 42 U.S.C. 1395nn. The following penalties are effective on and after October 30, 1972.

1. Penalty for False Statements, Misuse, Bribes, Kickbacks, or Rebates.—Whoever:

a. knowingly and willfully makes or causes to be made any false statement or representation of a material fact, in an application for a Medicare benefit or payment, or for use in determining the right to any such benefit or payment, or

b. has knowledge of any event affecting his right to receive a benefit or affecting the right of another individual in whose behalf he receives such benefit, and fails to disclose such event with the intent to fraudulently secure either a greater amount or quantity than is due or to receive benefits when none is due, or

c. receives benefits in behalf of another person and knowingly and willfully puts them to a use other than for the benefit or that person, or

d. furnishes items or services and solicits, offers, or receives a kickback, bribe, or rebate of a fee,

shall be guilty of a misdemeanor and upon conviction shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

2. Penalty for False Statement to Qualify as Provider.—Whoever knowingly and willfully makes or causes to be made a false statement

or representation of a material fact in order that an institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, or home health agency shall be guilty of a misdemeanor and upon conviction shall be fined not more than $2,000 or imprisoned for not more than 6 months, or both.

While the number of such cases is expected to be relatively small, bringing them to light and making every possible effort to ascertain whether or not a criminal violation of the Act has occurred is of great importance in maintaining the program's overall integrity and effectiveness. Prompt and decisive action in handling these cases also acts as a deterrent to other potential offenders.

B. Abuse.—In the performance of its contractual duties, Part A intermediaries are in the best position to detect activities which are not criminal offenses but rather represent abuses of the health insurance program. To maintain the Medicare program's fiscal integrity and retain the public's confidence in its administration, the Part A intermediary should establish sufficient controls to promptly detect and act upon these cases.

C. Intermediary Responsibilities.—To fulfill its responsibility to prevent, promptly detect, and act upon Medicare fraud or abuse situations the intermediary should:

1. Carefully evaluate completed provider billing forms;

2. Devote sufficient administrative, fiscal and paramedical personnel and work time to detecting and dealing with fraud or abuse situations;

3. Conduct special reviews to determine the appropriateness of payments. Such reviews should include:

a. Checking a particular organization's bills for accuracy;

b. Making onsite inspections to validate claims by comparing medical records with billing forms;

c. Contacting beneficiaries to verify services; or

d. Initiating other methods that authenticate proper payments.

4. Conduct investigations as requested, of:

a. Complaints or tips received by mail, telephone, or in person;

b. Cases referred by the BHI regional office;

c. Situations brought to light by the intermediary's special reviews, internal controls, or proper audits or inspections;

d. Providers selected by analysis of the provider statistical and reimbursement report; and

e. Referrals from other agencies or sources of information.

5. Promptly report instances of possible fraud or abuse to the HI regional office and supply that office with whatever data or documentation it possesses or obtains concerning the matter;

6. Recognize situations where suspension of payments is in order and discuss such action with the HI regional office;

7. Assist the HI regional office in obtaining additional information and documentation regarding the problem and its demensions. This includes but is not limited to validating the services rendered, checking prior records, and compiling provider payment and statistical data;

8. Maintain controls and records of all potential fraud and abuse situations whether investigated and closed out by the intermediary or whether referred to the HI regional office;

9. Send corrected bills to SSA central office in all cases where a change is made. See § 3816.

10. Take precautions, because of evidentiary requirements, to insure that all documents are kept free of any annotations or underlining, bracketing, or other emphasizing pencil, pen, or similar marks.

3462. IDENTIFYING POTENTIAL FRAUD SITUATIONS

The kind of fraud violation which the intermediary is apt to encounter would arise from a false statement or misrepresentation made, or caused to be made, which is material to entitlement or payment under the program. Such violation may come to the intermediary's attention as a result of a beneficiary complaint, bill processing, provider audit, special review, analysis of the PS&R report, or claims validation. Some violations may be referrals from the BHI regional office, or from other public or private agencies. The perpetrator of the violation may be a participating provider, supplier, nonparticipating emergency hospital, or related organization, as well as an employee of the above. The perpetrator in some situations may be a Medicare beneficiary. See Part A Intermediary Manual, Part 2, § 2060.5, for guidelines where the appearance of fraud or abuse is encountered during an audit.

Situations which could suggest the possible existence of fraud would include:

1. Billings for services, supplies or equipment which were not rendered to, or used for, Medicare beneficiaries;

2. Billings for supplies or equipment which are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;

3. Flagrant and persistent overutilization of medical or paramedical services with little or no regard for results, the patient's ailments, condition, medical needs or the doctor's orders;

4. Claiming of costs for noncovered or nonchargeable services, supplies or equipment disguised as covered items;

5. Material misrepresentations of dates and descriptions of services rendered, or of the identity of the recipient or the individual who rendered the services;

6. Duplicate billing which appears to be deliberate. This includes billing the Medicare program twice for the same services or billing both Medicare and the beneficiary for the same services;

7. Arrangements by providers with employees, independent contractors, suppliers and others which appear to be designed primarily to overcharge the health insurance program with various devices (commissions, fee splittings) used to siphon off or conceal illegal profits;

8. Charging to the health insurance program, by subterfuge, costs not incurred or which were attributable to nonprogram activities, other enterprises or personal expenses of principals;

9. Deliberately providing, or receiving health insurance benefits on the Medicare account of another individual;

10. Persistently and deliberately billing beneficiaries rather than Medicare for covered services;

11. Providers concealing business activities which would prevent them from complying with the provisions of the Provider Agreement (SSA-1561);-

12. Falsifying provider records in order to meet or continue to meet the Conditions of Participation. The regional office will report this situation to the State agency for an appropriate action regarding the provider's certification;

13. Soliciting, offering, or receiving a kickback, bribe or rebate.

3464. PRELIMINARY INTERMEDIARY ACTION IN POTENTIAL FRAUD OR ABUSE CASES

A. Initial Action.—The intermediary will immediately ascertain whether the cause was a clerical or similar error, a misunderstanding, etc. If an explanation is obtained reflecting that it was a clerical or similar error and the intermediary is satisfied that it has the true explanation it should close out its investigation, take whatever steps are necessary to correct the situation, and send an appropriate explanation to any complainant (subject to the disclosure of information guidelines contained in §§ 3760ff.) with a copy to the health insurance regional office. If the complaint was initially a referral from the health insurance regional office, the intermediary should forward a completed report to that office which then has the responsibility of notifying the complainant.

See § 3472 for a discussion of records to be kept by the intermediary when a case is resolved as a clerical error or misunderstanding, and § 3816 for instructions on submitting corrected bills to SSA.

B. Action in Cases Not Immediately or Satisfactorily Resolved.--Where the situation cannot be resolved as an error or misunderstanding, etc., the intermediary will immediately notify the HI regional office, transmitting all pertinent information and correspondence to that office. The intermediary should also advise the regional office of any prior problems or complaints it has had relating to the provider or other suspect. The intermediary should alert the regional office to any congressional or press interest or of any particular public relations problem which may be associated with the case. All such communications should be directed to the attention of the HI regional office program integrity specialist. Local offices of intermediaries will report potential violations directly to the nearest HI regional office and work directly with them in developing these cases.

The HI regional office has responsibility for directing and coordinating the development of potential fraud and abuse cases. If additional information is needed, the regional office may request assistance from a social security office and from the intermediary. Where potential violations are detected in one facility of a chain operation, all intermediaries dealing with any member of the chain will be alerted to the situation by the regional offices servicing them.

3466. WITHHOLDING PAYMENT WHEN THERE IS A STRONG INDICATION OF FRAUD OR ABUSE

A. Regional Office Direction.--The HI regional office may direct the intermediary to suspend payments in situations discovered by the intermediary as well as in situations uncovered by other sources.

In a situation where the intermediary believes there is a strong indication of fraud or abuse, it will seek the concurrence of the HI regional office to withhold future payment to the suspect until the matter is clarified.

In a case where the suspected fraud or abuse problem is first uncovered by the HI regional office, that office may direct the intermediary to stop payment at the time of the referral.

Note that there can be no suspension of payments without prior approval by the HI regional office.

If the potential fraud or abuse is limited to a particular type of ancillary service (e.g., physical therapy), it may sometimes be considered sufficient by the regional office to withhold payments only for this type of service unless the suspect is a PIP hospital or a provider reimbursed on a per diem basis. In most situations all payments will be suspended.

B. Notification of Suspension Action.--After consultation with the HI regional office, the suspect should be notified by the intermediary that payments will be withheld until the investigation of the matter is completed. The notice should be worded in such a way as not to make any accusation of fraud or misrepresentation since the allegations or suspicions of fraud will at that point be unsubstantiated. A copy of the notice should be sent to the HI regional office.

3468. OVERPAYMENTS IN FRAUD AND ABUSE CASES

3468.1 Fraud.--

A. Likelihood of Fraud Exists.--Where the preliminary investigation described in § 3464 establishes strong likelihood of fraud, the intermediary should not attempt recovery of the overpayment unless requested to do so by the HI regional office in accordance with § 3466. Note that no final cost settlement can be made with a provider suspected of fraud. This is because the case may ultimately be referred to the Department of Justice for possible criminal prosecution and also for consideration of instituting legal proceedings to recover the indebtedness under the provisions of 31 U.S.C. 231-233, 235, the False Claims Act. Any amounts voluntarily and unconditionally remitted should be accepted unconditionally and placed in escrow. Any amounts otherwise due the suspect under the Medicare program should be accounted for to the HI regional office and retained by the intermediary until final disposition of the case. The HI regional office will advise the intermediary of any overpayment information needed to be furnished to the Department of Justice.

B. Active Fraud Investigation.--When the HI regional office begins an active fraud investigation in a particular case, the intermediary should not request a refund and all unsolicited funds remitted to the intermediary before final disposition of the criminal and civil aspects of the case should be placed in escrow. The intermediary should immediately notify the HI regional office by telephone when funds are placed in escrow. The intermediary should then follow the instructions of the regional office on the proper disposition of remitted funds. After notification from the intermediary, the HI regional office will make all necessary contacts and advise the intermediary regarding proper disposition of the funds. Once the case has been forwarded to the United States Attorney for legal action (criminal and civil), that office has complete control over the case and the disposition of the remitted funds. In some instances, the U.S. Attorney may want the monies forwarded to his office. Under no circumstances should the intermediary place such monies into its Medicare trust fund or private medical insurance accounts.

In addition, all contacts with the intermediary by the suspect or his legal representative (personal, letter, or telephone), should be referred to the HI regional office. This applies to all contacts after the intermediary has been advised that the regional office has instituted an active fraud investigation involving a particular provider including when the case has been referred to the Regional Attorney or the U.S. Attorney.

C. Exception Where Provider Furnishes Services "Under Arrangements".--An exception to A and B above may be made where a provider furnishes services "under arrangements" with suppliers of services who are independent practitioners. Such suppliers would include, but not be limited to physical therapists, inhalation therapists, and speech therapists. If the supplier is under investigation for alleged fraudulent practices and it is definitely determined that there is no complicity on the part of the provider, the intermediary may proceed to final settlement on the provider's cost report including recoupment of any overpayments determined by audit. In this situation, the recovery of overpayments involving services rendered by the supplier would not be damaging to the prospects of a successful criminal or civil action against him. (Questions concerning arrangements of this type should be directed to the regional office.)

3468.2 Abuse.--There will be situations investigated by the intermediary under the direction of the HI regional office in which the elements of criminal fraud are not present or, if present, not prosecutable but which nevertheless constitute irregular financial practices or patterns or rendering care which abuse the Medicare program. In those cases no referral to the Department of Justice for possible criminal prosecution is usually made. The intermediary, at the conclusion of the investigation, will determine the amount of the overpayment and recover the overpayment in accordance with §§ 3707ff.

3470. RESUMPTION OF PAYMENT TO A SUPPLIER OR PROVIDER--CONTINUED SURVEILLANCE AFTER DETECTION OF FRAUD OR ABUSE

When payments to a supplier or provider have been suspended due to strong indications of fraud, serious misrepresentation, or abuse, payments may not be resumed until the fraud or abuse investigation has been completed. (See § 3466.) After completion of the investigation and appropriate legal action, all determined overpayments must be recouped by the intermediary either by direct refund or offset against claims being held in suspense.

Once recoupment action has been completed, the RO will advise the intermediary by letter that future claims, bills, and related actions of the supplier or provider are subject to a continuing and careful surveillance for at least 6 months to assure the propriety of future payments. In addition to internal screening of the claims, if previous experience or the future billing volume warrant, the RO will instruct the intermediary to periodically interview a sampling of the supplier's or provider's patients to verify that billed services were actually rendered. Subject to the above, the intermediary may be instructed to resume payment on the claims and to release any monies being withheld which will not be necessary as offset against determined overpayments. Where no overpayment is established, no further surveillance is warranted.

The intermediary should contact the RO at the end of 6 months regarding the current volume of billings, together with any other problems which may have developed. If no indication of a continuing aberrant pattern has been detected at the end of this period, the special controls may be discontinued.

3472. CASE RECORDS AND CONTROLS

The intermediary's program integrity liaison designee should maintain a listing of all pending and closed fraud or abuse situations. This will facilitate the screening of cases, permit the accumulation of statistical data, and provide for periodic intermediary follow-ups on pending cases.

Preferably, the intermediary will maintain individual records of these situations in addition to its regular organization and beneficiary files. This will allow rapid location of cases and all relevant material for use by the intermediary and for review by the Bureau of Health Insurance. The file should consist of the original referral or complaint, investigative reports, reports of telephone contact, correspondence, and any decisions on final disposition.

When cases are closed by the intermediary because they appear to be the result of a clerical error or misunderstanding, it is still important that a record be maintained in the event that the same problem recurs. Recurrences create a need to reevaluate the possibility of fraud or abuse and to determine the extent of the problem.

3474. INTERMEDIARY COORDINATION WITH PART B CARRIERS

It is essential that the intermediary's program integrity liaison designee have an ongoing dialogue with the appropriate carrier's program integrity liaison designee. The carrier's designee should be promptly notified when a specific problem might encompass both Part A and Part B, e.g., problems with a proprietary physician-owned hospital under Part A which might represent Part B physician billing problems. This will insure that a comprehensive investigation is timely initiated to resolve the situation and will prevent possible duplication of investigative efforts.

3476. CASES INVOLVING POSSIBLE FORGERY OF ENDORSEMENT OF HEALTH INSURANCE CHECKS

A. Initial Intermediary Action.--When a payee of a health insurance check alleges that his endorsement on the check was forged, the intermediary will obtain the following items and send them to the HI regional office:

1. A photocopy of the payee's forgery affidavit or statement regarding the circumstances surrounding the alleged forged endorsement;

2. The check;

3. Four photocopies of the front and back of the check; and

4. Any other pertinent information.

B. Investigation by U.S. Secret Service.--The U.S. Secret Service has investigative jurisdiction of alleged Medicare check forgeries since the checks represent Federal funds paid from either the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Fund. Therefore, the BHI regional office will refer cases to the U.S. Secret Service for investigation. The regional office will notify the intermediary of the results of the Secret Service investigation.

C. Final Intermediary Action.--

1. If the Check was Forged.--If the report furnished is that the endorsement was forged, the intermediary will issue a new check to the payee with an explanation stating that the U.S. Secret Service has assumed jurisdiction over the forgery. Reclamation proceedings should also be started to have the intermediary's bank credit the amount of the check to the health insurance account.

If restitution is made during the investigation or as a result of prosecution, the intermediary and its bank will be notified. Likewise, the intermediary should notify the BHI regional office if it should happen to receive restitution after the case is submitted.

2. If the Check was Not Forged.--If the report furnished by the U.S. Secret Service is that the endorsement was not forged, the intermediary will notify the payee of this fact.

If the information furnished raises any unresolved question, return the case to the HI regional office.

3478. THEFT OF MEDICARE CHECKS FROM AN INTERMEDIARY'S OFFICE

If the intermediary discovers that blank checks, unissued checks, or checks which were issued but returned uncashed have been taken from its office, the HI regional office should be notified at once. The regional office will insure that further investigative efforts are coordinated with Federal, State or local authorities. The intermediary should not release or issue a statement to the press about the theft without first consulting the HI regional office.

3479. HANDLING NEGOTIABLE INSTRUMENTS

Should the intermediary inadvertently receive a remittance with an agent/agency of the United States as payee (such as a civil fraud settlement check), the instrument should be forwarded along with any pertinent correspondence to the RO for appropriate disposition.

3480. REFERRAL OF CASES INVOLVING POSSIBLE UNETHICAL OR UNPROFESSIONAL CONDUCT BY A PRACTITIONER

A. General.—Regulation No. 1 of the Social Security Administration specifically authorizes carriers and intermediaries to refer cases of apparent unethical practices to medical or other professional societies and State licensing boards.

Information obtained from a beneficiary is only to be disclosed to medical or other professional societies and State licensing boards if he (or his representative) has given his written authorization, unless it would necessitate the revealing of medical information that may be harmful to him or other considerations would make it inappropriate to do so. The intermediary will also obtain the assurance from the professional society or the licensing board that the information will be protected against unwarranted disclosure.

Once a case has been brought to the attention of the intermediary by means of whatever utilization safeguards it may have (e.g., manual and/or computer screening, routine or special surveys, etc.) or by a complaint received, the intermediary should take the necessary steps to assure itself that what is actually involved is more than a mere suspicion of unprofessional conduct or that merely a clerical error is involved. Also, an isolated instance of questionable professional conduct would not ordinarily be referred.

On the other hand, the intermediary need not compile sufficient weight of evidence so that a conclusive determination of misconduct is made prior to the referral; rather, the intermediary is to ascertain the probability of misconduct, but will leave any further investigation, review and disciplinary action to the appropriate professional society or State board.

Referral of apparent unethical practices or of a course of unprofessional conduct by a physician or other practitioner should only be initiated after proper professional advice has been obtained from the intermediary's physician staff members, medical consultants, or other professional advisors.

Referral should be made to either the professional society to which a physician or other practitioner may belong or to the State licensing board, depending on the nature of the case. In the cases referred to a professional society, the society is to determine whether the practitioner acted in an unethical manner and, if so, whether it will initiate disciplinary action on whether the case is to be referred to the State licensing board.

B. Types of Cases to be Referred.--

1. Overutilization.--This usually refers to a pattern of medical care which consists of providing more services than are medically necessary or which is not in accordance with acceptable medical practice, e.g., an inordinate number of office visits over an extended period of time for a chronic type of illness, a conspicuously high number of injections, the ordering of excessive hospitalization, etc.

2. Misutilization.--This involves the rendering of services that are not medically acceptable according to the standards of the community concerned.

3. Overcharging.--This is to be interpreted as the charging of fees by a physician, or other practitioner, that are not commensurate with the services rendered. Also the billing for amounts in addition to the deductible and coinsurance after an assignment has been accepted falls into this category.

4. Violation of Ethics.--These violations involve conduct of a physician or other practitioner which is contrary to the principles of ethics of the professional society to which he may belong or in such a manner as to make his practice a danger to the health and welfare of his patients or to the public.

5. Violation of the State's Professional Practice Statutes.--This involves the committing of acts which, under the applicable State law, would be grounds for suspension or revocation of his license to practice.

These guidelines are not all inclusive so that any activities by a physician, or other practitioner, in his treatment of program beneficiaries which would warrant concern by professional societies or State licensing boards may be brought to their attention.

3482 ADMINISTRATIVE SANCTIONS - GENERAL

The term "sanctions" as used in this section represents the full range of administrative remedies and actions available to deal with questionable, improper, or abusive practices of providers under the Medicare and Medicaid programs. The purpose of these sanctions is twofold. First, they are designed to be remedial by ensuring that questionable, improper, or abusive practices on the part of providers/suppliers are dealt with appropriately. Providers/suppliers are encouraged to correct their behavior and operate in accordance with program policies and procedures. Second, the sanctions are designed to protect the programs by ensuring that improper payments are identified and recovered and that future improper payments are not made.

NOTE: For purposes of §§ 3482 through 3486, "provider" means a hospital, a skilled nursing facility, a hospice, a comprehensive outpatient rehabilitation facility, or a home health agency that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has a similar agreement, but only to furnish outpatient physical therapy or speech pathology services. "Supplier" or "supplier of services" means an individual or entity, other than a provider or practitioner, that furnishes health care services under medicare and is usually reimbursed on a reasonable charge basis.

Each RO has a contact person in the Office of Inspector General, Office of Health Financing Integrity, (OIG, OHFI), who is responsible for coordinating sanction activities. Direct any sanctions questions to the contact person within the appropriate OIG/RO (see § 3486).

Although the primary focus of this section is on the sanctions authorized in § 1862(d) (exclusions), and 1866 (terminations) of the Social Security Act, the other, less severe administrative remedies are also discussed, since consideration of these less severe measures may precede the more punitive sanctions affecting participation in the programs. The less severs measures do not apply in the case of §§ 1862(d) or 1866 where the exclusion/termination of an entity other than an individual is based on a program-related conviction.

3482.1 Role of Intermediaries--Intermediaries are responsible for:

A. contacting the OIG/RO when it is determined that an administrative sanction against an abusive provider/supplier is warranted;

B. providing the OIG/RO with appropriate documentation in proposed administrative sanction cases;

C. furnishing any available information to the OIG/RO with respect to providers/suppliers requesting reinstatement; and,

D. ensuring that no payments are made for services rendered by a provider/supplier following the effective date of suspension/exclusion/termination (see § 3483.7 for exceptions); and

E. reporting all instances where a suspended/excluded/terminated provider/supplier submits claims for which payment may not be made after the effective date of the suspension/exclusion termination (see § 3484).

This includes ensuring that no payments are made to providers for a salaried individuals who is suspended or excluded from the program. OIG, as it becomes aware of such employment situations, will notify providers that reimbursement for services furnished to Medicare patients by the individual will not be reimbursed. A copy of this notice will be sent to the appropriate HCFA RO as well as the appropriate intermediary, and will serve to alert it to make necessary adjustments to the provider's cost report.

3482.2 Administrative Remedies Considered Initially.—

A. Educational Contact and/or Warning--Contact the provider/supplier and inform them of the questionable or improper practices identified. Instruct the provider/supplier regarding the correct procedure to be followed, and that continuation of the questionable or improper practice may result in more severe administrative sanctions. Properly document all contacts and/or warnings with written reports and correspondence. If the questionable or improper practices continue, consult with the OIG/RO contact person regarding sanction action against the provider.

B. Removal or Reduction of Periodic Interim Payment (PIP)-- (NOTE: The following instructions apply to those providers who have not yet been phased in to the Prospective Payment System of reimbursement.)

The periodic interim payment (PIP) method of reimbursement to providers of services provides for interim payments to them at fixed times (normally biweekly) without regard to individual billings. However, providers are required to complete billings in detail as under other methods of reimbursement. The amount paid to the provider must approximate, on the average, the cost of covered inpatient or home health services renered by the provider during the period for which payment is made.

As stated in 42 CFR 405.454 (j) (3), the "intermediary's approval of a provider's request for reimbursement under the PIP method will be conditioned upon the intermediary's best judgement as to whether payment can be made to the provider under the PIP method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, inadequate billing practices, or other circumstances. The intermediary may terminate PIP reimbursement to a provider at any time it determines that . . . the provider's experience under the PIP method shows that proper payment cannot be made under this method." Therefore, if it is determined that a provider is continuing to engage in improper or abusive practices, the right of that provider to receive reimbursement under the PIP method may be revoked, or the amount reimbursed reduced to bring the payment rate in line with actual costs.

C. Withdrawal of Favorable Waiver Presumption--A provider will be held liable for noncovered services if it is determined that it (1) had actual knowledge of the noncoverage of services in a particular case, or (2) could reasonably have been expected to have such knowledge. When a provider has been found to make all reasonable efforts to ensure that its Medicare coverage decisions are correct, and has demonstrated the ability to make accurate Medicare coverage decisions, it may be presumed that the provider did not have knowledge of noncoverage. All of the provider's claims for Part A hospital and SNF services and Part A and B home health agency visits may be processed and payment may be made for services denied because of medical necessity or custodial care under the presumption that it had no knowledge of noncoverage, unless the evidence in a particular case shows that, in fact, it had such knowledge.

If HCFA or the intermediary determines that a provider has submitted an excessive number of claims for a category of noncovered ancillary services or outpatient services, the favorable waiver presumption for the provider for that particular category of service may be withdrawn. A written notice of this withdrawal is sent to the provider by the intermediary. If the favorable waiver presumption is withdrawn, subsequent bills submitted by the provider which are determined to be for noncovered services will not be paid based solely on a presumption that the provider was unaware of the noncoverage.

D. Withholding of Payments/Recovery of Overpayments--Whenever the intermediary determines that an overpayment has occurred, OIG may, in conjunction with HCFA, direct the intermediary to withhold payment to the provider or other supplier of services (42 CFR 405.370). In cases involving abuse, the intermediary shall notify the provider or other supplier of its intention to suspend payment, in whole or in part, and the reasons for making the suspension. The provider or other supplier has 15 days following the date of notification to submit additional evidence, unless an extension is granted (42 CFR 405.371 (a)).

Where the intermediary has reliable evidence to indicate fraud or willful misrepresentation is involved, it may suspend payment prior to notifying the provider or other supplier of the suspension and the reasons for the action (42 CFR 405.371 (b)).

In any cases involving an overpayment where there is a strong likelihood of fraud, do not attempt recovery of the overpayment unless requested to do so, since this may jeopardize the government's entitlement under the False Claims Act.

In these cases, recovery action is normally deferred until the investigation is completed and the Department of Justice determines how the overpayment should be recovered.

If the provider or other supplier continues aberrant billing practices during the period he is being investigated for possible sanction, continue prepayment surveillance and adjust payments accordingly.

E. Referral of Situations to State Licensing Boards or Medical/Professional Societies--When apparent unethical or improper practices or unprofessional conduct are identified, refer them to State Licensing authorities, medical boards, or professional societies for review and possible disciplinary action. Coordinate with the OIG/RO on any referrals. Bring to the attention of the referral entity any activity (overutilization, misutilization, overcharging, etc.) which warrants their involvement. When referring a case to peer review, etc., that meets the criteria described in § 3483.1, notify the OIG/RO.

Additionally, request the peer review body to determine whether or not the items and services being furnished by the subject of the referral are substantially in excess of the needs of the beneficiaries or of a quality which fails to meet professionally reorganized standards of health care, as this is the language used in OIG's sanction authority. The review decision should address the specific problems identified in individual cases, in terms easily understood by the layman, rather than simply issuing a general statement concerning the pattern of practice.

3483 AUTHORITY TO SUSPEND, EXCLUDE, OR TERMINATE PAYMENT TO PRACTITIONERS, PROVIDERS, AND SUPPLIERS OF SERVICES

The Office of Health Care Financing Integrity (OHFI), (OIG) has been delegated the authority, under §1128 (a) of the Social Security Act, to suspend from participation in the title XVIII (Medicare) program, physicians and other individuals who have been convicted of fraudulent activities against the Medicare or Medicaid programs. Suspension from the Medicare program causes an automatic suspension from participation in the title XIX (Medicaid) program. These cases will be handled by the OIG/ROs through central office.

OIG/OHFI has also been delegated the authority provided by §1862 (d) (1) (A), (B) and (C) of the Act to exclude from coverage items and services furnished by practitioners, providers, or other suppliers of health care services who have made false statements in applying for Medicare payment or have engaged in certain forms of program abuse (e.g., unnecessary services, improper billing practices, etc.), and to terminate provider agreements for the same reasons under §1866 (b) (2) (D), (E) and (F). Where Medicare reimbursement is precluded as a result of exclusion/termination, Federal financial participation is not available for title XIX (Medicaid). Submit all §1862 (d) and 1866 sanction cases originating at the intermediary level directly to the OIG/RO.

Further authority under § 1157 of the Social Security Act has been delegated to OIG to exclude items and services furnished by individuals and terminate agreements with providers who have been determined by a PRO to have violated their obligations under § 1156 of the Act. This section also contains the authority to impose a monetary penalty in lieu of exclusion/termination. § 1156 exclusion actions will be submitted by PSROs/PROs to the OIG/RO.

3483.1 Basis for Exclusion Under §1862 or Termination Under § 1866—Exclusions or terminations under §§ 1862 and 1866, respectively, may be effected upon a determination that a provider, has:

A. knowingly and willfully made or caused to be made any false statement or misrepresentation of a material fact in a request for payment under Medicare or for use in determining the right to payment under Medicare;

B. submitted or caused to be submitted, bills or requests for payment containing charges (or costs) that are substantially in excess of its customary charges (or costs) or

C. furnished items or services that are substantially in excess of the beneficiary's needs or of a quality that does not meet professionally recognized standards of health care.

For the purposes of the exclusion /termination procedures, "furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider or other supplier of services. NOTE: A proposal to exclude must be based solely on the provider's title XVIII acts.

3483.2 Identification of Potential Exclusion or Termination Cases

A. Potential Abuse Exclusion or Termination Cases--Cases in the abuse workload should be evaluated to determine if they warrant exclusion or termination action. Examples of abuse cases suitable for exclusion or termination include, but are not limited to:

1. providers who have been the subject of an adverse peer review finding;
2. providers whose bills must be consistently reviewed because of repeated instances of overutilization;
3. providers who furnish items or services that are substantially in excess of the beneficiary's needs or are of a quality that does not meet professionally recognized standards of health care; or
4. providers who are the subject of pre-payment review for an extended period of time (longer than 6 months). Generally, to be considered for exclusion or termination due to abuse, the practices would have to consist of a clear pattern which the provider refuses or fails to remedy in spite of efforts on the part of the RO, contractor, PSRO/PRO or peer review groups. A termination or exclusion recommendation will be implemented only where efforts to get the provider to change the pattern of practice are unsuccessful. The educational or persuasive efforts are not necessary nor desirable when the issues involve life threatening or harmful care or practices.

If a case involves the furnishing of items or services in excess of the needs of the individual or of a quality that does not meet professionally recognized standards of health care, obtain reports documenting the medical determination as appropriate from one or more of the following:

(a) the PSRO/PRO for the area served by the provider;
(b) State of local licensing or certification authorities;
(c) peer review committees;
(d) State or local professional societies;
(e) intermediary medical reviewers; or
(f) other sources deemed appropriate.

B. Cases Where Convictions Have Been Obtained--Any case in which there is a conviction for a program related offense on other than an individual is considered for sanction action. These cases will be handled by OIG/RO and OIG/CO. Convicted institutional providers can be excluded under § 1862 (d) and terminated under § 1866 (see § 3483.1).

3483.3 Development of Potential Exclusion or Termination Cases.—

A. Case considerations—When recommending cases to the OIG/RO for exclusion or termination, consider:

best copy available

1. the nature and seriousness of the acts in question;
2. documentation of corrective actions taken to bring about a willingness to abstain from further questionable acts;
3. the experience gained from monitoring payments to the provider after corrective action was taken;
4. the degree of deterrence which might be brought about by termination or exclusion;
5. the effects of exclusion on the delivery of health care services to the community; and
6. any other factors deemed appropriate.

B. Documentation Needed—In cases being recommended to the OIG/RO for exclusion/termination where there has not been a conviction, a pattern of one of the following must be shown to exist:

1. misrepresentation;
2. excessive charges (costs); or
3. excessive services or services of a quality which fail to meet professionally recognized standards.

In all three instances, the documentation must include the length of time that the problem has existed and the dollars lost by the program as a result. Documentation of excessive services or quality of care issues requires a medical opinion from a qualified physician. All cases involving excessive services or poor quality of care issues must also contain documentation of prior unsuccessful efforts to correct the problem through the use of less serious administrative remedies as described in § 3482.2.

C. Intermediary Notification to a Provider—If a situation is identified as a result of development of potential fraud or abuse which meet one or more of the § 3483.1 criteria, consult the OIG/RO sanctions contact person. With approval, send the provider a written notice containing the following information:

1. identification of the provider;
2. the nature of the problem;
3. the health care services involved;
4. the basis or evidence for the determination that a violation has occured. In cases concerning medical services, the evidence must include reports and opinions from a PSRO/PRO or a peer review committee, or a State/local professional society;
5. the sanction to be recommended;
6. an invitation to discuss the problem with contractor and OIG/RO staff or to submit written information regarding the problem; and
7. that a recommendation for consideration of sanctions will be made to the RO within 30 days if the problems are not satisfactorily resolved.

If the provider/supplier accepts the invitation to discuss the issues, a report of the meeting must be made for the record. This does not have to be a professionally transcribed report.

Copies of the letter to the provider/supplier and his/her response or the summary of the meeting must be in the file.

Refer cases which demonstrate a strong fraud potential to the OIG/RO for investigation.

Refer any case which reaches the level where a provider is notified of a problem in accordance with this section to the OIG/RO even if the provider is convincing in an allegation that there was a legitimate reason for the problem or that the problem has been corrected.

Document and refer cases involving harmful care as rapidly as possible. Handle requests received from the OIG/RO for additional information as a priority item.

D. Additional Information—Additional information which may be of value in supporting a proposal to exclude/terminate includes such factors as: 1) any other related offenses; 2) any adverse impact on beneficiaries; 3) the amount of damages incurred by the programs; and 4) potential program savings.

E. Mitigating Circumstances—Any significant factors which do not support a recommendation for exclusion/termination or which tend to reduce the seriousness of the problem will also be considered. One of the primary factors here is the impact of the sanction action on the availability of health care services in the community. This is important in considering actions against hospitals and nursing homes and must be addressed in the proposal. Bring mitigating circumstances of which you are aware to the attention of the OIG/RO when forwarding your sanction recommendation.

3483.4 Contents of Sanction Recommendation.—The sanction recommendation forwarded to the OIG/RO should contain (to the extent appropriate) the following information:

A. Identification of the Subject—The identification contains the subject's name and address and a brief description of the subject's special field of medicine. If the subject is an institution or corporation, include a brief description of the type of services it provides and the names of officers and directors of the corporation.

B. Origin of the Case—Include a brief description of how the violation was discovered.

C. Nature of the Violation—Include a description of the subject's fraudulent or abusive practices, and the type of health service(s) involved.

D. Statement of Facts—A statement of the facts in chronological order describing each failure to comply with an obligation with specific dates, places, circumstances, and any other relevant information. (NOTE: Do not use patient names; replace with identification codes.)

E. Pertinent documentary evidence available to support the case determination. Include records reviewed, norms, criteria and standards of care, profiles of the provider recommended for sanction, and relevant information provided by other program administrative entities.

F. Copies of written correspondence and written summaries of the meetings held with the provider regarding the violation;

G. Copies of all notices to the party;

H. Other Significant Issues—Include any additional information that may be of value in supporting the proposal to exclude or which would support the action in the event of a hearing before the Office of Hearings and Appeals.

I. Program Earnings—Include data for program monies paid by program (XVIII, XIX, XX) and on assigned/non-assigned basis, for the last 3 years, if available.

3483.5 Notice of Administrative Sanction Action—A determination to suspend, terminate or exclude is made by the Office of Health Financing Integrity (OHFI), Office of Inspector General (OIG). When there is a determination to suspend, exclude or terminate, OIG sends a written notice to the provider at least 15 days prior to the effective date of the action. The notice includes:

A. the basis for the exclusion, termination or suspension;
B. the duration of the sanction and the factors that were considered,
C. the requirements for reinstatement;
D. the appeal rights;
E. the fact that Federal matching funds for title XIX (Medicaid) are curtailed in exclusion or termination cases and that the Medicaid agency is required to stop all payments in suspension cases for the determined period; and
F. the fact that should claims continue to be submitted during the period of sanction for which payment may not be made, the provider/supplier may be subject to a civil monetary penalties action.

3483.6 Notification to Other Agencies.—Concurrent with the mailing of the notice to the provider, OIG sends a copy of the notice with a cover letter (memorandum) which references the entities to be notified to the HCFA Regional Administrator. The HCFA/RO is responsible for notifying intermediaries, Medicaid State agencies, PSROs/PROs and the Railroad Retirement Board of the sanction action. HCFA is also responsible for ensuring that the sanction actions are properly effectuated.

The OIG notifies the appropriate licensing agency, the public, generally through a newspaper notice, and all known employers of the sanctioned provider where Medicare or Medicaid is involved.

3483.7 Effective Date of Suspensions/Exclusions/Terminations.--

A. Exclusion and Suspensions.--The effective date of an exclusion under section 1862(d) or suspension under section 1128(a) is 15 days from the date of the notice to the provider. Section 1160 exclusion actions are effective 30 days from the date of the notice to the provider. Section 1156 exclusions will be effective 15 days from the date the provider receives the notice of exclusion.

Payment is not made to a provider for items and services furnished on or after the effective date of exclusion/suspension specified above, except in the following cases:

1. in the case of inpatient hospital services or post-hospital skilled nursing facility care furnished to a beneficiary who was admitted to a hospital or skilled nursing facility before the effective date of the exclusion/suspension, payment for services furnished is available for up to 30 days after that date; and

2. in the case of home health services furnished under a plan established before the effective date of exclusion/suspension, payment is available for 30 days after the date on the notice.

B. Terminations.--To give the provider and the public sufficient advance notice of the termination of a facility's agreement, the effective date of the termination is determined in the following manner:

1. Two or three days are allowed for delivery of the notice to the institution, depending on its location;

2. To this is added the time needed for actual publication of the public notice in the local newspaper (which, in turn, depends on the newspaper deadline); and

3. The date of termination is the sum of the above two factors, plus 15 days. Thus the facility will receive notice sometime before the publishing of the public notice and the public will receive 15 days notice before the effective date of termination. For example, if a notice is released October 1, and 3 days are allowed for mailing, and 5 days are needed by the local newspaper for publishing the notice, termination of the agreement would be effective on October 23. However, to allow for any unexpected delays in mailing or publication, up to 30 days from the date of the notice to the effective date of the termination may be allowed.

Payments may be made after the effective termination date for:

a. inpatient hospital services, and post-hospital extended care services furnished to any eligible individual who was admitted to the institution prior to the effective date of such termination for up to 30 additional days; or

b. home health services furnished to an individual under a plan established before such effective date, if the services are furnished within 30 days of the date of the notice.

3483.8 Denial of Payment to Beneficiaries—

A. Suspensions.—If a benficiary submits claims for items or services furnished by a suspended party or by a supplier which is wholly owned by a suspended party, on or after the effective date of the suspension:

1. HCFA pays the first claim submitted by the beneficiary and immediately gives the beneficiary notice of the suspension.
2. HCFA does not pay the beneficiary for items or services furnished more than 15 days after the date on the notice to the beneficiary.

B. Exclusions.—If a beneficiary submits claims for items or services furnished by an excluded practitioner, provider, or other supplier of services after the effective date of the exclusion:

1. HCFA pays the first claim submitted by the beneficiary and immediately gives notice of the exclusion.

2. HCFA does not pay the beneficiary for items or services furnished more than 15 days after the date on the notice to the beneficiary or after the effective date of the exclusion, whichever is later.

C. Terminations.—The denial of payment to beneficiaries as described in B. above also apply to those claims submitted by beneficiaries for items and services furnished by a provider whose agreement has been terminated under § 1866(b) (2) (D), (E), or (F).

3483.9 Appeals Process.—An excluded provider may try to have the suspension, exclusion or termination decision reversed or modified, through the appeals process. The OIG is responsible for processing hearing requests from sanctioned providers.

3483.10 Reinstatements.—A suspended, excluded, or terminated party may apply for reinstatement at the expiration of the suspension, exclusion or termination period or any time thereafter. Reinstatements are not granted automatically. All requests for reinstatement are referred to the OIG/RO. The OIG then initiates an inquiry designed to determine whether the cause(s) of the sanction has been eliminated and is not likely to recur. The intermediary will be is asked to furnish information regarding the subject requesting reinstatement.

3483.11 Monthly Notification of Sanction Actions.—A listing containing suspension, exclusion, termination, and reinstatement/withdrawal actions taken by the Office of Inspectior General is distributed to the intermediary on a monthly basis.

Use the information contained in this listing to:

1. determine whether a physician/practitioner, provider or other health care supplier who seeks certification as a provider of services in the Medicare/Medicaid programs is eligible to receive reimbursement; and

2. insure that physicians/practitioners, providers or other health care suppliers currently sanctioned are not being inappropriately reimbursed.

The dates reflected on the listing are the dates the notices were released to the sanctioned party. Section 1128(a) suspension actions and §1862(d) exclusion actions are effective 15 days from the date of the notice. Section 1160 exclusion actions and § 1866 termination actions are effective 30 days from the date of the notice. Section 1156 exclusion actions will be effective 15 days from the date the provider receives the notice of exclusion. Reinstatements/withdrawals are effective as of the date indicated.

Upon receipt of this listing, check your systems to determine whether any physician/practitioner, provider or other health care supplier is being reimbursed for items or services provided subsequent to the date they were suspended, excluded or terminated from participation in the Medicare program. In the event a situation is identified where inappropriate payment is being made, notify the Regional Office of Health Financing Integrity, Office of Inspector General, and take appropriate action to correct the situation. Also consider the instructions contained in § 3484 with respect to civil monetary penalties.

3484. CIVIL MONETARY PENALTIES LAW

Intermediaries are notified on a case by case basis when practitioners, providers or other health care suppliers are suspended, excluded or terminated from the Medicare program. In addition each intermediary receives a monthly report of sanctioned individuals or entities.

Intermediaries are responsible for ensuring that no payments are made after the effective date of a sanction except as provided for in regulations at 42 CFR 420.126, 420.155, and 489.55.

Under the Omnibus Budget Reconciliation Act of 1981, Congress enacted a Civil Monetary Penalties Law, § 1128(A) of the Social Security Act (the Act) (42 USC 1320a-7a).

This statute gives the Secretary the authority to impose a monetary penalty upon any person who presents or causes to be presented a claim that the Secretary determines...

(1) is for a medical or other item for service...

(A) that the person knows or has reason to know was not provided as claimed, or

(B) for payment which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under § 1128, 1160(b), 1862(d) or 1866(b)(2) . . .

Check payment systems periodically to determine whether any provider, practitioner, or other health care supplier, who has been suspended, excluded or terminated since January 1982, is submitting claims for which payment is prohibited. If any such claims are submitted by practitioners, providers or other health care suppliers who have been sanctioned under § 1128(a)(1), 1862(d)(1), 1160(b) or 1866(b)(2) forward them to the Office of Health Financing Integrity (OHFI), Office of the Inspector General, at the regional office that services the intermediary.

3486. OFFICE OF INSPECTOR GENERAL REGIONAL OFFICE CONTACTS

REGION	STATES
Region I - Boston Office of Health Financing Integrity Room 1305 - JFK Building Government Center Boston, Massachusetts 02203 (617) 223-6881 (FTS) 223-6881	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
Region II - New York Office of Health Financing Integrity Room 38-100 Federal Office Building 26 Federal Plaza New York, New York 10278 (212) 264-5295 (FTS) 264-5295	New Jersey New York Puerto Rico Virgin Islands
Region III - Philadelphia Office of Health Financing Integrity Room 10460 (P.O. Box 13618) 3535 Market Street Philadelphia, Pennsylvania 19101 (215) 596-0607 (FTS) 596-0607	Delaware District of Columbia Maryland Pennsylvania Virginia West Virginia
Region IV - Atlanta Office of Health Financing Integrity Suite 1403 101 Marietta Tower Atlanta, Georgia 30323 (404) 221-4108 (FTS) 242-4108	Alabama Florida Georgia Kentucky Mississippi North Caolina South Carolina Tennessee
Region V - Chicago Office of Health Financing Integrity Suite A-935 175 W. Jackson Boulevard Chicago, Illinois 60604 (312) 353-9867 (FTS) 353-9867	Illinois Indiana Michigan Minnesota Ohio Wisconsin

REGION	STATES
Region VI - Dallas Office of Health Financing Integrity Room 4 E 6 1100 Commerce Street Dallas, Texas 75242 (214) 767-6371 (FTS) 729-6371	Arkansas Louisiana New Mexico Oklahoma Texas
Region VII - Kansas City Office of Health Financing Integrity P.O. Box 26248 1100 Main Street Kansas City, Missouri 64196 (816) 374-3697 (FTS) 758-3697	Iowa Kansas Missouri Nebraska
Region VIII - Denver Office of Health Financing Integrity Room 1185, 13th Floor Federal Office Building 1961 Stout Street Denver, Colorado 80294 (303) 844-2491 (FTS) 564-2491	Colorado Montana North Dakot South Dakot Wyoming Utah
Region IX - San Francisco Office of Health Financing Integrity 50 United Nations Plaza Room 365 San Francisco, California 94102 (415) 556-3132 (FTS) 556-3132	Arizona California Guam Hawaii Nevada Samoa
Region X - Seattle Office of Health Financing Integrity Mail Stop 408 2901 Third Avenue Seattle, Washington 98121 (206) 442-0577 (FTS) 399-0577	Alaska Idaho Oregon Washington

Limitation on Assignment of Claims

3488 ASSIGNMENT OF A PROVIDER'S RIGHT TO PAYMENT

A. Basic Prohibition.--Except as provided in B. below, the intermediary may pay benefits due a provider only to the provider and may not pay the provider's benefits to any other person or organization under an assignment or reassignment or power of attorney or under any other arrangement where the other person or organization receives the payment directly. A "power of attorney" means any written authorization by a principal to an agent:

1. To receive in the agent's own name amounts due the principal;

2. To negotiate checks payable to the principal;

3. To receive in any other manner direct payment of amounts due the principal.

This prohibition against assignment of a provider's benefits applies not only to payments due the provider in its own right but also to payment of benefits due a provider as a reassignee of the physician under §3604.1ff.

Payment is considered to be made directly to an ineligible person or organization if that person or organization can convert the payment to its own use and control without the payment first passing through the control of the provider or other party eligible to receive the payment under the exceptions in subsection B. below. (For payment to a bank, see §3488.2.)

The forwarding of amounts due a provider to the location of its home office under the procedures described in §3703.1 is not affected by the prohibition described in this section. Payment under those procedures is considered payment to the provider.

B. Exceptions

1. Payment to a Governmental Agency.--The law does not preclude the Medicare program from paying benefits due a provider to a governmental agency or entity under an assignment by the provider. We are making no administrative provision currently, however, for such payment. (This has no bearing, of course, on the situation where the provider is owned by the governmental agency or entity; in that case payment to the agency or entity is considered payment to the provider.)

2. Payment Pursuant to a Court Order.--The Medicare program may make payment in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions set forth in Part A Intermediary Manual Part II, §2755.

3. Payment to an Agent.--The Medicare program may make payment, in the name of the provider, to an agent who furnishes billing or collection services. The payment arrangement must satisfy the conditions set forth in §3488.1.

C. Background and Purpose.--In 1972, the Congress acted to stop a practice under which some physicians and other suppliers providing services covered under Medicare and Medicaid reassigned their Medicare and Medicaid receivables to other organizations and groups, which then claimed and received payment. Often the organizations purchased the claims at a percentage of face value. By 1972, it had become apparent that such reassignments were a source of incorrect, inflated, and even fraudulent Medicare and Medicaid claims. The Social Security Amendments of 1972, Public Law 92-603, therefore, included a prohibition against payment on a charge basis for covered services to anyone other than the patient, his physician or other person who provided the service, with limited exceptions.

Despite these efforts to stop the factoring of Medicare and Medicaid receivables, some physicians and other suppliers circumvented the intent of the law by granting a power of attorney. This allowed the factoring company or other person to receive the Medicare or Medicaid payments in the name of the physician or other supplier, thus permitting continuation of program abuses that were shown to be associated with payment to such persons in the past.

Section 2(a) of Public Law 95-142, effective with respect to care and services furnished on or after October 25, 1977, modified existing law to preclude the use of power of attorney as a device for reassignment of benefits under Medicare subject to limited exceptions. It also provided for a similar prohibition with respect to payment for care furnished by providers of services.

While those provisions are primarily designed to preclude providers from selling their Medicare claims to factors, they also preclude providers from pledging their claims to lenders and include restrictions precluding payment to many other persons.

D. Effect of Payment to an Ineligible Recipient.--An otherwise correct Medicare payment made to an ineligible recipient under an assignment or other authorization by the provider does not constitute a program overpayment. Sanctions may be invoked against a provider under §3488.4 to prevent it from executing or continuing in effect such an authorization in the future but neither the provider nor the ineligible recipient will be required to repay the Medicare payment.

3488.1 Payment to an Agent

A. Conditions.--The intermediary may make payment in the name of the provider to an agent who furnishes billing or collection services if:

1. The agent receives the payment under an agency agreement with the provider;

2. The agent's compensation is not related in any way to the dollar amount billed or collected;

3. The agent's compensation is not dependent on the actual collection of payment;

4. The agent acts under payment disposition instructions which the provider may modify or revoke at any time, and

5. In receiving the payment, the agent acts only on behalf of the provider.

B. Background.--The primary purpose of the exceptions to the prohibition in §3488A is to permit computer and other billing services to claim and receive Medicare payment on behalf of and in the name of the provider. The conditions for payment are designed to insure that the billing agent has no financial interest in how much is billed or collected and is not acting on behalf of someone who has such an interest, other than the provider itself.

The conditions specified in subsection A do not apply if the agent merely prepares bills for the provider and will not receive and negotiate the checks payable to the provider.

C. Documentation.--If payment is being made or is requested to be made in the name of a provider to an agent, the intermediary may assume that the conditions for such payment are met in the absence of evidence to the contrary. If there is evidence to the contrary, the agent must document the agency agreement by submitting to the intermediary a copy of the written agreement between it and the provider, if such a written agreement exists. The written agreement may be a formal legal document or merely an exchange of correspondence between the parties. If there is no written agreement of either a formal or informal nature or all the required conditions for payment are not clear in the agreement, the intermediary shall obtain a statement from the agent describing the pertinent terms of the agreement or of those specified provisions which need to be clarified. The intermediary shall then verify the agent's allegations by obtaining statements from one or more providers that have agreements with the agent. See §3488.3E. for reviewing endorsements on benefit checks.

3488.2 Payment to a Bank.--If payment due a provider is being sent or is requested to be sent to a bank (or other financial institution), the intermediary may assume that this procedure is consistent with the requirements of §3488 in the absence of evidence to the contrary. If there is evidence to the contrary, the intermediary should develop the circumstances.

There are a number of reasons why a provider may want the intermediary to send its Medicare check to a bank: (1) to make payments of interest and principal on a loan from the bank, (2) for deposit in the provider's business account, or (3) because the bank is the provider's billing and collection agent. Where the bank deposits the provider's check in an account from which the provider is free to withdraw any deposited funds, the intermediary, in sending the provider's check to the bank, is considered to be making payment to the provider. This is true even though the bank also has the right to remove funds from that account to satisfy the provider's obligation to the bank for payment of interest and principal under a loan agreement or for agents' fees under an agency agreement.

On the other hand, the intermediary is considered to be making direct payment to the bank contrary to the prohibition in §3888A if it mails the provider's check to the bank and the bank deposits the check in a special account (e.g., a loan or agency account) from which the bank may deduct interest and loan repayments or agent's fees as they become due but from which the provider may not freely withdraw funds. This is true whether the special account is established in the name of the provider or otherwise. The intermediary may not honor such a payment arrangement in connection with a loan agreement and may honor such an arrangement in connection with an agency agreement only if the requirements in §3488.1A are met.

It is common practice for a bank to receive direct payment as described in the preceding paragraph where the provider has pledged its Medicare and other receivables as security on a loan. The Medicare law does not, however, preclude the provider from giving the bank a security interest in its Medicare payments as long as that interest is nonpossessory; i.e., is merely an enforceable right to the providers' Medicare payments once they have reached the hands of the provider and does not call for the Medicare program to pay the lender directly.

If the intermediary finds that the provider has two accounts in a bank--one which qualifies to receive his Medicare checks under the above guidelines and the other which does not--any Medicare check sent to the bank on behalf of the provider must include in the designation of the payee on the check, the identification number of the qualified account.

Section 3488.3 Correcting Unacceptable Payment Arrangements

A. Disseminating Information.--Soon after the effective date of these instructions (August 1980), and from time to time thereafter, the intermediary shall disseminate through professional relations media information regarding the prohibition in §3488. The following language may be used or adapted for this purpose:

> "The Medicare law prohibits us from paying benefits, due a provider of services, to another person or organization under an assignment, power of attorney or any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:
>
> (1) We may pay a provider's benefits (in the provider's name) to a billing or collection agent, if
>
> (a) The agent receives the payment under an agency agreement with the provider;
>
> (b) The agent's compensation is not related in any way to the dollar amounts billed or collected; and
>
> (c) The agent's compensation is not dependent upon the actual collection of payment; and

(d) The agent acts under instructions which the provider may modify or revoke at any time, and

(e) The agent, in receiving the payment, acts only on the provider's behalf.

(2) We may pay the provider's benefits (in the provider's name) to a bank or other financial institution for deposit in an account from which the provider may freely withdraw any deposited funds

(3) We may pay the provider's benefits in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction.

"A provider should notify us immediately if:

(1) We have been mailing its benefits to the address of another person or organization; and

(2) The provider has given that other person or organization power of attorney or other advance authority to negotiate its benefit checks; and

(3) None of the above exceptions which would permit payment to another person or organization apply in the provider's case.

"A provider which hereafter enters into or continues such a prohibited payment arrangement may have its participation in the program terminated and its right to receive assigned payment for physician services revoked."

B. When to Develop Questionable Payment Arrangements.--The intermediary may assume that an arrangement in which Medicare payment is being sent or is to be sent to an address other than the physical location of the provider is consistent with the requirements of §3488 in the absence of evidence to the contrary. The intermediary shall develop the facts of any case in which:

1. It becomes aware that it is mailing or is being asked to mail the provider's payments to the address of another person or organization; and

2. It is likely the other person or organization is not qualified to receive the payments under one of the exceptions in §3488B or is a financial institution receiving the funds for deposit in an account from which the provider may not freely withdraw deposited funds. (See §3488.2.)

The intermediary shall develop the facts of the case, for example, where it appears that it is mailing the provider's payments to the address of a known factor.

C. How to Develop Questionable Payment Arrangements.--The exact procedure to follow in developing questionable payment arrangements is subject to intermediary discretion. The first step is usually to ascertain the reason for the special address. Once the intermediary has determined that payments due the provider are being made to another party (although in the name of the provider), it will be necessary to ascertain whether any of the exceptions in §3488B that could permit payment apply. After initial contact with the provider, the intermediary may find the other party to be the best source of information about the arrangement. The intermediary shall establish the crucial elements of the arrangement by obtaining a copy of the formal agreement, if any, between the parties, copies of pertinent correspondence, or signed statements of the parties. As indicated in §3488.4B and C, the failure of the provider to cooperate in furnishing the necessary information (or in giving any necessary authorization for others to furnish information) is grounds for terminating the provider's participation in the program and revoking its right to receive assigned payment.

D. Change of Address.--If the intermediary determines that a person or organization is ineligible under §3488-3488.2 to receive payments due a provider, it shall not ordinarily mail the provider's payments to that person or organization's address. However, such a mailing address is acceptable if:

1. The parties to the arrangement have given written assurances that the person or organization to whose address the check is mailed will not convert the check to its own use and control; and

2. The purpose of the arrangement makes those assurances credible.

An acceptable mailing arrangement could exist, for example, where the provider wants its checks mailed for bookkeeping purposes to a business agent who is ineligible to receive the payment, and both the agent and the provider state in writing that the agent will forward the checks to the provider's bank for deposit in a business account from which it is free to withdraw any deposited funds.

E. Reviewing Endorsements on Checks.--In any case where the intermediary, after developing the facts, continues to mail the provider's payments to an address which may be that of another person, but still has a doubt that the arrangement is inconsistent with these instructions, it shall after a reasonable interval review endorsements on the returned checks for indications that the checks are being negotiated under a power of attorney. Where someone negotiates a provider's checks under a power of attorney, he typically prints the provider's name on the back of the checks and enters his signature below, followed by "p.p." "p.p.a." (for per procuration or per power of attorney).

3488.4 Sanctions for Prohibited Payment Arrangement.--

A. Advice to a Provider.--If the intermediary finds that a provider has entered into or is considering entering into a payment arrangement prohibited by section 3488, the intermediary will advise that provider in writing that the arrangement violates the Medicare law and regulations and subjects the provider to the penalties described in B and C below. Where the improper payment arrangement is already in effect, the intermediary will normally require a change in the address to which the provider's checks are to be sent. For an exception see §3488.3D.

B. Bases for Termination of a Provider's Medicare Participation Agreement.--HCFA may terminate a provider's Medicare participation agreement if the provider:

1. Executes or continues an assignment or a power of attorney, or enters into or continues any other arrangement, that authorizes or permits Medicare cost-basis payments to be made contrary to §3488 (contrary to 42 CFR 405.1668 and section 1815(c) of the Social Security Act) after having been advised under A above; or

2. Fails to furnish upon request by HCFA or the intermediary such information as HCFA or the intermediary finds necessary to establish compliance with the requirements of this section.

The provider has the usual appeal rights applicable to agreement termination determinations.

C. Bases for Revocation of Assignment Privilege.--HCFA may revoke the right of a provider to receive assigned payment for physician services if the provider:

1. Executes or continues a reassignment or power of attorney, or enters into or continues any other arrangement, that authorizes or permits Medicare charge basis payments to be made contrary to §3488 (contrary to 42 CFR 405.1680 and §1842(b)(5) of the Social Security Act), after HCFA, or after the carrier or intermediary (whichever has jurisdiction of the claims), gives the provider advice about such violation;

2. Fails to furnish upon request by HCFA, or by the carrier or intermediary (whichever has jurisdiction of the claims), evidence needed to establish compliance with the requirements of §3488 (42 CFR 405.1680 and section 1842(b)(5) of the Social Security Act);

3. Violates the terms of assigned payment; e.g., by collecting or attempting to collect more than the reasonable charge, after HCFA, or after the carrier or intermediary (whichever has jurisdiction of the claim), gives the provider advice about such violations; or

4. Fails to desist from collection efforts already begun, or to refund monies incorrectly collected, in violation of the terms of assigned payment, after HCFA, or after the carrier or intermediary (whichever has jurisdiction of the claim), gives the provider instructions to cease to take such action.

A special appeals procedure is provided within HCFA when action is taken to revoke a provider's right to accept assignment.

The fact that a provider's right to accept assignment is revoked does not preclude it from billing the beneficiary for the services or changing its arrangement with the physician to permit him to bill for his own services, either on an assigned or unassigned basis. By the same token, a provider is not ordinarily precluded from accepting assignment from a beneficiary for the services of a physician whose assignment privilege has been revoked if he has entered or enters into an agreement with the provider giving it the right to bill for his services. There is, however, an exception to this rule: The revocation of a physician's assignment privilege automatically revokes the assignment privilege of any corporation, partnership, or other entity in which he directly or indirectly has or obtains all or all but a nominal part of the financial interest. Such entity may not accept assignment for the services of the physician or anyone else. What is a nominal interest depends on the circumstances. The carrier may assume that an interest by other persons totalling at least 5 percent of the financial interest of the entity is more than nominal. The term "indirect interest" refers to the situation where the entity billing for the physician's services is owned by another entity in which the physician has most of the financial interest.

D. Action By the Intermediary When It Finds Violations.--When the intermediary finds that the provider has, after warning to the contrary, entered into or continued a prohibited payment arrangement, failed to cooperate in furnishing the information necessary to resolve the issue, violated its assignment agreement or failed to correct a violation of its assignment agreement, it shall forward a copy of the file to the program integrity staff in the regional office. The RO will consider whether further development of the facts or admonition of the provider will be useful before taking steps to terminate its participation agreement and/or to revoke its right to accept assignment.

In imposing the administrative sanction of revocation of the assignment privilege the RO will notify the provider of the proposed revocation of its right to receive assigned benefits and give it 15 days in which to submit a statement, including any pertinent evidence, explaining why its right to payment should not be revoked. After the statement has been submitted or the 15-day period has expired without the filing of the statement, the RO will determine whether to revoke the provider's right to receive assigned payment. If its determination is to revoke, the RO will notify the carrier and intermediary to suspend payment on all assigned claims submitted by the provider and received after the effective date of the revocation and will notify the provider of the revocation and of its right to request a hearing on the revocation within 60 days. (The RO may extend the period for requesting a hearing.)

If the provider requests a formal hearing (to be conducted by a member of the Hearings Staff of the Office of Eligibility Policy, Bureau of Program Policy, HCFA) and the hearing officer reverses the revocation determination, the RO will instruct the carrier and the intermediary to pay the provider's assigned claims (the physician component). If the hearing officer upholds the revocation determination or if no request for a hearing is filed during the period allowed for this, the RO will instruct the carrier and the intermediary to make any assigned payments otherwise due the provider to the beneficiary who received the services, or another person or agency authorized under the law and regulations to receive the payments (e.g., the beneficiary's legal guardian or representative payee or, if he is deceased, the person who paid the bill). The revocation will remain in effect until the RO finds that the reason for the revocation has been removed and that there is reasonable assurance that it will not recur. The RO decision to continue the revocation in effect is not appealable.

The law provides that any person who accepts assignment of benefits under Medicare and who "knowingly, willfully, and repeatedly" violates the assignment agreement shall be guilty of a misdemeanor and subject to a fine of not more than $2000 or imprisonment of not more than 6 months or both. The RO may invoke the administrative sanction in appropriate cases to deny payment while criminal prosecution is being considered or in process, or, as an alternative, when prosecution is inappropriate or not feasible. Since this sanction may in some cases interfere with effective prosecution, imposition of the sanction is discretionary rather than mandatory.

3488.5 Prohibition of Assignments by Beneficiaries.-

A. Basic Prohibition.—Except as provided in B below, an intermediary may pay only the beneficiary (or his legal representative or representative payee) benefits payable directly to the beneficiary (e.g., payment for certain services furnished by nonparticipating hospitals, indemnification under waiver of liability, and direct refunds by the intermediary of provider overcollections from the beneficiary of deductible and coinsurance amounts). (This prohibition does not, of course, apply to payment under an assignment of benefits by the beneficiary to the physician or other supplier who furnished the services or to his qualified reassignee, e.g., a hospital.)

B. Exceptions.—

1. Payment to a Government Agency.—The law does not preclude the Medicare program from paying the benefits due a beneficiary to a governmental agency or entity. In practice, no administrative provision has been made for such payment by an intermediary.

2. Payment Pursuant to Court Order.—The Medicare program may make payment of amounts due a beneficiary, in accordance with an assignment established by, or pursuant to the order of, a court of competent jurisdiction. The assignment must satisfy the conditions set forth in §2755 of the Intermediary Manual, Part 2.

Automobile Medical and No Fault Insurance

3489. SERVICES REIMBURSABLE UNDER AUTOMOBILE MEDICAL OR NO FAULT INSURANCE

3489.1 General.—Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services, under automobile medical or no fault insurance (including a self-insured plan). Medicare is secondary to automobile medical or no fault insurance even if State law or a private contract of insurance stipulates that Medicare is primary. If Medicare payments have been made but should not have been because they are excluded under this provision, or if the payments were made on a conditional basis in accordance with §3489.4E and F, they are subject to recovery.

If services are covered under automobile medical or no fault insurance, the automobile insurer must be billed first. If the automobile insurer does not pay all of the charges, a claim for secondary Medicare benefits can be submitted in accordance with S3489.4D3 to supplement the amount paid by the automobile insurer. Medicare can pay for services related to an automobile accident, if benefits are not currently available under the individual's automobile medical or no fault insurance coverage because that insurance has paid maximum benefits for the accident on items or services not covered by Medicare or on nonmedical items such as lost wages. Efforts to ascertain coverage under automobile medical or no fault insurance are subject to the tolerance in S3489.4B.

The question to be asked in each case involving automobile related medical expenses is whether automobile medical or no fault benefits can be paid for these particular services. If so, the automobile insurance is primary. If not, Medicare may be primary. Primary Medicare benefits cannot be paid merely because the beneficiary wants to save his/her automobile insurance benefits to pay for future services. Since automobile insurance benefits would be currently available in that situation, they must be used before Medicare can be billed.

In accordance with a "grace period" granted in the regulations, make no attempt to recover Medicare payments if an automobile insurance payment was received by the beneficiary before June 6, 1983. The "grace period" does not apply to insurance payments to providers of services. However, no effort will be made to recover if the provider turned the insurance payment over to the beneficiary before that date.

If there is an indication that the individual has filed, or intends to file, a liability claim against a party that allegedly caused an injury, follow instructions in SS3419ff.

A. Effective Dates.—The general rule is that these provisions are effective with respect to services related to injuries which occurred on or after December 5, 1980. If benefits might be payable under automobile medical or no fault insurance but, for whatever reason, such benefits have not been paid, the provisions are effective with respect to services furnished on or after June 6, 1983.

Thus, for example, where an automobile insurer refuses to pay primary benefits for services furnished before June 6, 1983, because a State law or private contract of insurance stipulated that Medicare is primary, Medicare primary benefits may be paid. In the case of services furnished on or after June 6, 1983, Medicare pays only secondary benefits notwithstanding such a provision in the State law or private contract.

The specific application of the general rule follows:

1. Automobile Payment Made

   a. Deny Medicare payment; or

   b. Recover Medicare payment, but not if the beneficiary received the automobile payment before June 6, 1983.

2. Automobile Payment Not Made — Automobile Medical or No Fault Insurance Coverage Exists

a. Make Medicare primary payment for services furnished before June 6, 1983.

b. Deny or recover Medicare primary payment for services furnished on or after June 6, 1983. (Conditional primary Medicare payments permissible if automobile insurer contests liability.)

B. Effect on Deductibles and Utilization.—Expenses for services for which Medicare payment may not be made because payment has been made or can reasonably be expected to be made under automobile medical or no fault insurance are not counted toward Part A or Part B deductible amounts or against the number of inpatient care days available to the beneficiary. For instance, if an individual is hospitalized twice in the same benefit period and the first hospitalization is paid in full under automobile insurance, the inpatient hospital deductible would apply to the second hospitalization and the first hospitalization would not affect the beneficiary's utilization.

3489.2 Definitions.—

A. Automobile.—Any self-propelled land vehicle of a type that must be registered and licensed in the State where it is owned.

B. Automobile Medical or No Fault Insurance.—Insurance coverage (including a self-insured plan) that pays for all or part of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile, regardless of who may have been responsible for causing the accident. (This insurance is sometimes called "personal injury protection," "medical payments coverage" or "medical expense coverage.")

C. Liability Insurance.—Insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. This exclusion does not apply where the homeowner receives payment under his or her own homeowners insurance policy since such a payment does not constitute a liability insurance payment.

D. Self-Insured Plan.—A plan under which an entity (or an individual) is authorized by State law to carry its own risk instead of insuring itself with a carrier.

E. Uninsured Motorist Insurance.—Liability insurance under which the policyholder's insurer will pay for damages caused by a motorist who has no automobile liability insurance or who carries less than the amount of insurance required by law or is underinsured.

3489.3 Provider Actions.—

A. Information Obtained from Patient or Representative At Time of Admission or Start of Care.—Medicare providers are instructed to ask Medicare patients, or the patient's representative, at the time of admission or start of care, if the services are for the treatment of an injury or illness which resulted from an automobile or other accident or for which he or she holds another party responsible. For automobile accidents, the provider obtains the name, address and policy number of any automobile medical, no fault or liability insurance company which may be responsible for payment of medical expenses that resulted from the accident.

B. Provider Billing Where Services Are Related to an Automobile Accident.—

1. If a provider learns that an automobile medical or no fault insurance company may pay for otherwise covered services, the provider is instructed to bill the automobile insurance company as primary insurer. It may bill Medicare for secondary benefits per §3489.4D3 if the automobile insurer does not pay in full for the services. If the insurer pays for all Medicare covered services, the provider is instructed to submit a no payment bill.

2. If the services are related to an automobile accident and an automobile insurer has been billed but does not make payment because, for example, the individual's automobile coverage expired, or the automobile medical or no fault claim is contested by the insurer, or for any other reason there will be substantial delay in resolving the claim, the provider is instructed to bill Medicare and to annotate the bill in accordance with §3680K. If the provider later receives payment from the automobile medical or no fault insurer, the provider is instructed to refund the Medicare payment by submitting an adjustment bill.

3. If the individual files a claim against a third party for injuries suffered in an automobile accident, the provider may bill Medicare for otherwise covered expenses to the extent that payment has not or cannot be made by an automobile or no fault insurer or has not been made by a liability insurer. For example, an individual incurs $20,000 in medical expenses due to an automobile accident. The individual receives $5,000 in no fault insurance benefits and also has a liability claim pending against the driver of the other car. Medicare will not pay benefits for the $5,000 in expenses paid for by the no fault insurer but will pay benefits based on the additional $15,000 in expenses, subject to recovery when the liability claim is paid.

C. Provider Receives Request From Insurance Company or Attorney.—The provider is instructed to notify you promptly if it receives from an attorney or insurance company a request for a copy of a medical record or a request for a bill concerning a Medicare patient. You are to be given a copy of the request or, if it is unavailable, full details of the request including the name and Medicare number of the patient, name and address of the insurance company and/or attorney, and date(s) of services for which Medicare has been billed or will be billed.

D. Provider Receives Duplicate Payments.—The provider will refund the Medicare payment by submitting an adjustment bill, if it receives duplicate payments from an automobile insurer and from Medicare, regardless of which payment it received first and even if it refunded the insurance payment to the beneficiary or the insurer. See §3489.4C2.

3489.4 Processing of Claims Indicating Possibility of Payments Under Automobile Medical or No Fault Insurance.—

A. Identification of Claims.--Use the guides listed below to identify claims for otherwise covered services in which there is a possibility that payment has been, or can be, made by automobile medical or no fault insurance.

1. You receive information from a provider (see §3489.3), a beneficiary, your own operations (e.g., medical or utilization review) or those of your non-Medicare counterpart, another Medicare carrier or intermediary or any other source, indicating Medicare has been billed for services when there is a possibility of payment by an automobile insurer.

2. On Form HCFA-1450, another insurer is shown on line A of item 57. On other billing forms a primary insurer is identified in the "Remarks" portion of the bill.

3. On a HCFA-1450, occurrence code 01 or 02 is shown in items 28-32. On other billing forms the annotation "automobile accident" is shown in "Remarks."

4. The billing form shows as complementary insurer an insurance organization that does not issue health insurance.

5. You (or the RO) are asked to endorse a check from an automobile insurer payable to Medicare and the beneficiary. Return the check to the insurance carrier and request the insurer to reimburse Medicare the amount of benefits paid to the full extent of the third party's payment for medical expenses. (Follow the recovery instructions in paragraph B2 below.) As necessary, follow up with the beneficiary and/or attorney to ascertain if the beneficiary receives payment from the insurer.

6. You receive or are informed of a request from an insurance company or from an attorney for copies of bills or medical records (see §3489.3C).

7. There is indication that the beneficiary previously received benefits under automobile insurance or that a claim for such benefits is pending; e.g., a "Y" trailer containing code "C" or "D" on the query reply. (See §3512.8 and §3535.1.) There is no need to investigate this lead, however, if your records show that automobile medical or no fault insurance benefits for the same injury or illness have been exhausted. (Automobile medical or no fault insurance policies generally pay benefits up to specific dollar limits as long as the individual requires medical care for the covered injury or illness.)

8. The claim reflects one of the diagnosis/trauma codes shown below. The following list consists of selected ICD-9-CM codes which should be used to identify claims which may involve coverage under automobile medical or no fault insurance. Whenever one of these codes appears on a claim, process the claim as detailed in paragraph B, below. (You may add to this list any ICD-CM codes which experience indicates are good leads. Based on contractor input, HCFA may later modify this list to reflect actual experience.)

CODE ICD-9-CM	DIAGNOSIS
800.0 - 800.99	Fracture of vault of skull
801.0 - 801.99	Fracture of base of skull
802.0 - 802.99	Fracture of face bone
803.0 - 803.99	Other and unqualified skull fractures
804.0 - 804.99	Multiple fractures involving skull or face with other bones
805.0 - 805.98	Fracture of vertebral column without mention of spinal cord injury
806.0 - 806.99	Fracture of vertebral column with spinal cord injury
807.0 - 807.69	Fractures of rib(s), sternum, larynx, and trachea
810.0 - 810.13	Fracture of clavicle
811.0 - 811.19	Fracture of scapula
828.0 - 828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum
839.0 - 839.3, 839.7 - 839.9	Other multiple and ill-defined dislocations
847.0	Sprains and strains of the neck (whiplash)
850.0 - 850.9	Concussion
851.0 - 851.99	Cerebral laceration and contusion
852.0 - 852.59	Subarachnoid, subdural, and extradural hemorrhage, following injury
853.0 - 853.19	Other and unspecified intracranial hemorrhage following injury

CODE ICD-9-CM	DIAGNOSIS
854.0 - 854.19	Intracranial injury of other and unspecified nature
860.0 - 860.5	Traumatic pneumothorax and hemothorax
861.0 - 861.32	Injury to heart and lung
862.8	Injury to multiple and unspecified intrathoracic organs, without mention to open wound into cavity (crushed chest)
863.0 - 863.99	Injury to gastrointestinal tract
864.0 - 864.19	Injury to liver
865.0 - 865.19	Injury to spleen
866.0 - 866.13	Injury to kidney
867.0 - 867.9	Injury to pelvic organs
868.0 - 868.19	Injury to other intra-abdominal organs
869.0 - 869.1	Internal injury to unspecified or ill-defined organs
887.0 - 887.7	Traumatic amputation of arm and hand
896.0 - 896.3	Traumatic amputation of foot
897.0 - 897.7	Traumatic amputation of leg(s)
900.0 - 900.9	Injury to blood vessels of head and neck
925	Crushing injury of face, scalp, and neck
926.8	Crushing injury of trunk (multiple sites)
929.0 - 929.99	Crushing injury of multiple and unspecified sites
958.4	Traumatic shock
958.5	Traumatic anuria
996.0 - 996.5	Complications peculiar to certain specified procedures

B. Action if There Is Possibility of Payments Under Automobile Medical or No Fault Insurance.--

1. Medicare Benefits Have Not Been Paid.--If Medicare is being billed as primary payer but there is an indication of possible coverage under automobile medical or no fault insurance, ask the provider to explain why the claim was filed with Medicare rather than an automobile insurer. Unless the provider submits a satisfactory explanation, preferably a copy of the auto insurer's notice, that full or partial payment under an automobile insurance policy cannot be made (for example, auto insurance deductible applies--see §3489.5) or a decision on the automobile claim will be substantially delayed (see paragraph E below), return the claim for primary Medicare benefits and tell the provider to bill the automobile insurer as primary payer, since Medicare is primary payer for automobile injuries only if payment cannot be made under automobile medical or no fault insurance. You need not develop claims in which the amount payable by Medicare is less than a designated amount. You may set your development tolerance at any dollar level you deem cost effective, but no higher than $200. The development tolerance applies to development efforts only and does not supersede the overpayment recovery tolerance in §3709.2 if you have enough evidence to determine that an overpayment exists.

2. Medicare Benefits Already Paid.--If a Medicare claim for charges totalling $200 or more has been paid and there is indication of coverage under automobile medical or no fault insurance, develop with the beneficiary and/or his attorney to determine whether payment has been made by an automobile insurer or whether an automobile insurance claim has been or can be filed. Use the Form HCFA-L365, Report to Medicare of Automobile or Liability Insurance Coverage (see §3419.10, Exhibit 1), for this development. Enter necessary identifying information before sending the form. Also, ask for the claim number which the insurance company has assigned to the claim. The tolerance provision in paragraph 1 also applies where Medicare has already paid.

If the beneficiary or attorney does not respond within 30 days, follow up by telephone or letter. If you are unable to obtain the required information from the beneficiary or attorney by letter or by phone, and you determine that further contacts would be unproductive, attempt to recover from the beneficiary in accordance with §§3707ff.

If a beneficiary states that an automobile accident was the fault of an uninsured motorist, find out if the beneficiary has uninsured motorist coverage on his own policy. This is a type of liability insurance, so follow §3419.5 if a liability claim has been or may be filed. If it appears that payment may be made under both automobile medical or no fault insurance and under liability insurance, follow the instructions in §3489.6.

If the development indicates that the services are covered by automobile medical or no fault insurance, ask the insurer to pay you an amount equal to Medicare's payments (up to the policy limits). If the insurer refuses to reimburse you even though its contract covers the services, inform the insurer (1) that it is obligated to do so under the Medicare law and (2) that Medicare has the right to recover the benefits it paid from any insurer responsible for paying benefits for the injury. (Section 1862(b) of the law, as amended by Section 2344 of the Deficit Reduction Act of 1984 (Pub. L. 98-369) gives the Government, through filing a court action, if necessary, the right to recover conditional Medicare payments from private insurers that are primary insurers for Medicare beneficiaries.) If the insurer still refuses to reimburse Medicare, refer the case to the RO.

3. Recovery When a State Medicaid Agency Has Also Requested a Refund from the EGHP.--Situations may arise in which both Medicare and another insurer or a State Medicaid agency have conditionally or erroneously paid for services and the amount payable by an automobile medical or no fault insurer is insufficient to reimburse both programs. Under the law, Medicare has the right to recover its benefits from an automobile medical or no fault insurer before any other entity, including a State Medicaid agency. Also Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by an automobile medical or no fault insurer.

The superiority of Medicare's recovery right over those of other entities including Medicaid derives from the Medicare statute, which states that where Medicare is secondary to another insurer (1) HCFA may recover Medicare benefits from the responsible insurer, (2) HCFA is subrogated to the right of the Medicare beneficiary and the right of any other entity to payment by the responsible insurer, and (3) HCFA may recover its payments from any entity that has been paid by the responsible insurer.

Medicare's right to recover its benefits from an automobile medical or no fault insurer or from a beneficiary that has been paid by an automobile medical or no fault insurer is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort, and therefore doesn't pay its benefits until after Medicare has paid. Medicare's priority right of recovery from insurance plans that are primary to Medicare, does not violate the concept of Medicaid's being payer of last resort. Under §1862(b)(1) of the Social Security Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by a third party that is primary to Medicare. Where the third party pays right away, Medicare makes no payment to the extent of the third party payment. Delay of the third party payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, if the third party pays less than the charges, Medicare may be responsible to pay secondary benefits. And if the third party pays the charges, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid would have the effect of creating a Medicare payment where none is authorized under the law or improperly increasing the amount of any Medicare secondary payment.

Moreover, the right of Medicaid agencies to recover their benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. Since the beneficiary can assign to the State a right no higher than his own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is higher than that assigned to the State.

Thus, where both Medicare and Medicaid are seeking reimbursement from an insurer, inform the insurer that it must first reimburse Medicare before it can pay any other entity, including a State Medicaid agency. Also, where a beneficiary, provider or supplier receives payment from an insurer, inform the beneficiary, provider or supplier that it is obligated to refund the Medicare payment up to the full amount of the insurer's payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary, provider or supplier have the right to reimburse Medicaid or any other entity.

If a State Medicaid agency is reimbursed from an insurer's payment before Medicare, ask the State agency to reimburse Medicare up to the full amount the agency received. Explain the legal basis for Medicare's right to recover. If the State refuses to reimburse Medicare in full, refer the case to the HCFA RO. The RO's recovery actions may include offset of Medicare's claim against any Federal Financial Participation funds otherwise due the State. Explain to the insurer that in future cases involving claims by Medicare and Medicaid, Medicare must be reimbursed first.

4. Coordination with Other Intermediaries or Carriers.—Coordinate your determination regarding insurance coverage and/or your recovery efforts with other contractors. If you have information that other contractors may have received claims for expenses related to the same injury, notify them of any development or recovery action you undertake regarding Medicare claims for that injury. See §3419.9.

C. Action if Payment Has Been Made Under Automobile Medical or No Fault Insurance.—

1. General.--If you are aware at the time you are processing a Medicare claim that payment has been made either to the provider or to the beneficiary under automobile medical or no fault insurance, deny the claim unless secondary Medicare payments can be made under D3 below. If you learn, after you have paid Medicare benefits, that payment has also been made by an automobile insurer, the excess Medicare benefits determined in accordance with paragraph (2) below are subject to recovery in accordance with §§3708ff. Section 3708.2 indicates when a provider is liable for refunding the primary Medicare payments. The beneficiary is liable in all other situations.

2. Amount of Medicare Benefits to be Refunded Where Payment Has Been Made by Automobile Medical or No Fault Insurance.—

(a) Other Insurer Paid Provider.—Upon receipt of information that an automobile insurer paid a provider for services previously paid for by Medicare, determine the amount of Medicare secondary benefits payable on the claim, if any, and recoup from the provider any portion of the amount Medicare paid in excess of the amount of Medicare secondary benefits payable, subject to the overpayment recovery tolerance specified in §3709.2. In any case where no Medicare secondary benefits are payable, the amount to be recovered will be the Medicare payment.

(b) Other Insurer Paid Beneficiary.—If an automobile medical or no fault insurance payment is made to the beneficiary, recover the amount of primary benefits you paid in excess of any secondary Medicare benefits payable. (Regulations do not permit reducing that amount to allow for the beneficiary's costs in procuring automobile medical or no fault benefits. If the beneficiary claims such procurement costs combined with procurement costs to obtain liability insurance payments, request a breakdown of the costs between the two.)

D. Automobile Medical or No Fault Insurance Does Not Pay in Full.—

1. Insurance Pays Service Benefits.—If the amount of payment for particular services under automobile medical or no fault insurance is less than the provider's charges but is deemed payment in full under State law, Medicare benefits are not payable. The insurance payment constitutes a service benefit; i.e., the payment constitutes full discharge of the patient's liability to the provider.

2. Other Situations.--In other cases, automobile medical or no fault insurance may not pay the provider's charges because the beneficiary's total medical expenses exceed the dollar limit of the coverage, or because of some other coverage limit, deductible or coinsurance applicable to all policyholders. (See §3489.5.)

A provider of services or any other facility may not charge a beneficiary or any other party for Medicare covered services, if the provider or facility has been paid by an automobile insurer an amount that equals or exceeds the gross amount payable by Medicare, as defined in subparagraph 3 below. This prohibition is based on the terms of providers' Medicare participation agreements, under which a provider may bill a Medicare beneficiary only for deductible and coinsurance amounts and for noncovered services. (See §§3005, 3005.1 and 3313.)

If you have reason to question the correctness of the amount shown on the Medicare claim as having been paid by automobile insurance, confirm the amount with the insurer or beneficiary. A copy of an automobile insurer's explanation of benefits is the best evidence of what payments have been made. If the beneficiary does not submit this or other satisfactory evidence, contact the insurer by phone to find out what payments have been made.

3. Secondary Medicare Payments.--If an automobile insurer pays for Medicare covered services an amount which is less than the provider's charges and the gross amount payable by Medicare (without considering the effect of the Medicare deductible or coinsurance or the payment by the automobile insurer), and the provider is not obligated to accept the insurance payment as payment in full, Medicare secondary payments can be made. In general, the Medicare secondary payment will be the gross amount payable by Medicare minus the amount paid by the automobile insurer for Medicare covered services, minus any applicable deductible or coinsurance amount.

The gross amount payable by Medicare is (1) the current Medicare interim reimbursement amount (as defined in §3683) for providers reimbursed on a reasonable cost basis; or (2) the Medicare payment rate (which consists of the total prospective payment amount for the discharge and interim payments for those items that will be reimbursed retroactively and is determined without regard to deductible and coinsurance), for hospitals reimbursed on a prospective payment basis.

For detailed billing and reimbursement instructions, and the utilization to be charged to the beneficiary refer to §3680C (for providers on cost reimbursement) and to §3685 (for hospitals on prospective payment).

E. Contested and Delayed Automobile Medical or No Fault Claims.--If an individual submits conclusive documentary evidence (e.g., a denial notice) establishing that a claim has been contested by an automobile medical or no fault insurer, or if for any other reason there will be substantial delay (i.e., 60 days or more) in resolving the claim, Medicare payments may be made on condition that the beneficiary will reimburse the program to the extent that payment is subsequently made by the automobile medical or no fault insurer. When making such payments, notify the beneficiary and the insurer of the requirement for repayment. (However, your failure to do so will not relieve them of the obligation to refund the payments.) Ask the insurer to notify you when it is prepared to pay the claim, so that direct refund can be arranged, in accordance with §3489.4B2.

Flag all cases for possible follow-up action to recover the conditional payments.

Refusal by an individual to file a claim with an automobile medical or no fault insurer or to cooperate with a provider in filing such a claim is not a basis for making a conditional Medicare payment.

F. Automobile Insurer Denies that It Is Primary Payer.--Denial by an insurer on the ground that Medicare is primary payer may be a forerunner of similar action on multiple claims. Try to correct the problem by contacting the insurer and explaining that under Federal law automobile insurance is primary payer and Medicare is secondary regardless of the provisions of the automobile insurance policy or the provisions of the State insurance law. If that does not help, refer the case to the RO for contact with the insurer or to consider legal action.

3489.5 Automobile Medical or No Fault Insurance Does Not Pay All Charges Because of Deductible or Coinsurance Provision in Policy.-- In a number of States automobile insurers may reduce automobile medical or no fault insurance benefits by deductible or coinsurance amounts. If such contract provisions apply to all policyholders, Medicare pays benefits with respect to otherwise Medicare-covered expenses that are not reimbursable under such an automobile insurance contract. The usual Medicare deductibles and coinsurance are applied in calculating the Medicare secondary payment. Therefore, if an automobile medical or no fault insurer has been billed and has made no payment or only a partial payment (e.g., the automobile insurance deductible has been bridged) because of a deductible or coinsurance, the provider may bill Medicare and should complete the billing form in accordance with §3680.

Example 1: Beneficiary receives outpatient hospital services covered by no fault automobile insurance. Total charges are $200. The automobile insurer is billed but makes no payment because of $1000 deductible in policy. Hospital bills Medicare for $200 in accordance with §3680K.

Example 2: Beneficiary's hospitalization is covered by no fault automobile insurance, which allows hospital's full charges but reduces payment by $800 remaining unmet in $1000 deductible provision in policy. Hospital requests payment from Medicare for $800 in accordance with §3680C.

Example 3: Beneficiary's hospitalization paid for by no fault automobile insurance except for $1000 deductible, for which hospital requests payment from Medicare in accordance with §3680C. Beneficiary also receives home health services which are covered by automobile insurance, but insurance payments are reduced by $200 because of coinsurance provision in policy. Home health agency requests payment from Medicare for $200 in accordance with §3680J.

3489.6 Services Covered Under Automobile Medical or No Fault Insurance and Liability Claim Also Filed.--If injuries are covered under automobile medical or no fault insurance, and the individual also files a claim against a third party for injuries suffered in the same accident, a claims determination must first be made by the automobile medical or no fault insurer before a claim for Medicare benefits can be paid. Medicare payment may be made to the extent that payment is not made under the automobile medical or no fault insurance, subject to recovery under the procedures described in §3419.8, if the individual later receives payment from a liability insurer.

3489.7 Allocation of Recovered Medicare Payments.--If the amount recovered is less than the amount claimed, apply the refund so that available Part A benefits are restored, in the following order: inpatient hospital days first, SNF days second, and other Part A benefits third. Likewise, if you have paid for both Part A and Part B services, apply the refund first to Part A expenses in the same order.

3489.8 Claimant's Right to Take Legal Action Against an Automobile Medicare or No Fault Insurer.--The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to take legal action against, and to collect double damages from, an automobile medical or no fault insurer that fails to pay primary benefits for services covered by the automobile medical or no fault insurer where required to do so under §1862(b) of the Act.

3490 LIMITATION ON PAYMENT FOR SERVICES TO INDIVIDUALS ENTITLED TO BENEFITS SOLELY ON THE BASIS OF END STAGE RENAL DISEASE WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

3490.1 General.--Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP) in the case of individuals entitled to benefits solely on the basis of end stage renal disease (ESRD) (see §3001.3), during a period of up to 12 months, which is defined in §§3490.5 and 3490.6. Medicare is secondary during this period even though the employer policy or plan contains a provision stating that its benefits are secondary to Medicare's, or otherwise excludes or limits its payments to Medicare beneficiaries.

Under this provision, providers and facilities must bill the EGHP first for services rendered on or after January 21, 1988. Pay secondary benefits in accordance with §3490.8 if:

o the plan payment is less than the provider's charges for Medicare covered services,

o the plan payment is less than the gross amount payable by Medicare, and

o the provider does not accept, and is not obligated to accept, the EGHP payment as payment in full.

This provision applies to all Medicare covered items and services furnished to beneficiaries who are in a 12-month period, including services for non-ESRD treatment and services required by kidney donors in cases of transplantation. (See §3178.5.) Consider the possible application of this limitation when processing claims for items or services furnished to ESRD beneficiaries who are in their first year of entitlement.

In these instructions, the term provider includes dialysis facilities and other facilities which provide Medicare covered services.

In the case of services rendered before January 21, 1988, providers have the option of billing either Medicare or the EGHP first. If you receive a claim for primary benefits for services rendered before January 21, 1988, pay conditional primary benefits. After you have paid the claim, determine whether Medicare is secondary payer for the particular services in accordance with the instructions in §3490.4A and if so, take recovery action in accordance with §3490.4G.

NOTE: These instructions do not apply to beneficiaries entitled to Medicare because of age 65 or disability.

3490.2 Definitions.--

A. Employer--The term "employer" means, not only individuals and organizations engaged in a trade or business, but organizations exempt from income tax, such as religious, charitable, and educational institutions as well as the governments of the United States, the States, Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands and the District of Columbia, including their agencies, instrumentalities and political subdivisions. For purposes of the ESRD secondary payer provision the term "employer" is defined without regard to the number of employees.

B. Employer Group Health Plan or Employer Plan (EGHP)—These terms mean any health plan that is of, or contributed to by, an employer; and that provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, and/or their families. It includes the Federal Employees Health Benefits program but not the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). "Employee pay all" plans, i.e., group health plans under the auspices of an employer which do not receive any contributions from the employer, also meet the definition of EGHP.

Assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the current or former employment of the beneficiary or of a member of the beneficiary's family meets this definition.

C. Secondary— The term "secondary," when used with respect to Medicare payment, means that Medicare is the residual payer to all employer group health plans under which the Medicare beneficiary is covered and will not pay for any expenses that are reimbursable by any such plan or plans. Consider the workers' compensation exclusion (§3407) and no fault and liability insurance provisions (§3419 and §3489) in determining the extent of Medicare's liability as a residual payer since in some cases there may be a primary insurer in addition to the EGHP. (See §3490.4H.)

D. Coordination Period—The term "coordination period" means a period of up to 12 months determined in accordance with §§3490.5 and 3490.6 during which Medicare benefits are secondary to benefits payable under employer group health plans.

3490.3 Retroactive Implementation.—If cases come to your attention in which you paid primary benefits for services rendered during a coordination period and EGHP benefits may be payable, e.g., the provider indicated there is EGHP coverage or did not indicate EGHP status, notify the provider or facility to take the following actions on each claim:

o to ascertain whether there is EGHP coverage (if the provider has not indicated on the bill that it exists) and if so, the name and address of the EGHP, if that information is not annotated on the claim,

o to check its records and ascertain whether Medicare paid primary benefits for other services rendered during a coordination period in which there was EGHP coverage,

o to notify you of the results of its development efforts.

Inform the provider that the requested information is necessary for Medicare to determine its proper payment. Follow up after a reasonable period on any of these claims on which you receive no response from the provider. If the provider does not furnish the requested information, recover the entire conditional primary payment from the provider.

Also notify the provider that if the EGHP pays or has paid the provider for all or part of the services, to submit a corrected bill and to refund any excess Medicare benefits paid to it.

3490.4 Processing Claims.--

A. Provider Bills Medicare for Primary Benefits.--Where the provider has indicated Medicare as the primary payer in accordance with §3681A, assume in the absence of evidence to the contrary, that it has correctly determined that there is no primary EGHP coverage and process the claim in the usual manner. Primary Medicare benefits may be paid only if the services were not rendered during a coordination period, or if the EGHP denies a claim because the beneficiary is not entitled to any benefits under the plan, or benefits under the plan are exhausted for the particular services, or the services are not covered by the EGHP, and the beneficiary is not appealing the EGHP denial. But primary Medicare benefits may not be paid if you have reason to believe that the EGHP covers the services. (See subsection F.) If you pay primary Medicare benefits and later learn that the beneficiary is appealing the EGHP denial, treat the payment as a conditional primary payment and take action in accordance with subsection E.

If you believe that an EGHP may be primary payer, e.g., based on information in your records, an outside source or a "Y" trailer containing code "B" or "C" on the query reply, return the bill or contact the provider with the information you have and ask the provider to ascertain whether primary EGHP benefits are payable, and if so, to bill the employer plan for primary benefits. Also instruct the provider that if an EGHP has denied its claim for primary benefits, the provider must annotate item 94 "Remarks" of the Medicare claim form with the reason for the denial of EGHP primary benefits and enter occurrence code 24 and date of denial in items 29 - 32. No attachment is needed. Annotate your records with the reason for the denial of EGHP primary benefits to avoid needless recoupment efforts under paragraph G.

An employer plan's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on you. Continue to evaluate claims under existing guidelines to assure that the services are in fact covered by the program regardless of EGHP involvement.

Refer to subsections E and F if the claim is for conditional primary Medicare benefits. When processing the first claim in which an EGHP is primary payer, consider the possibility of prior Medicare primary payments. See §3490.3 for retroactive implementation.

B. Medicare Claim is for Secondary Benefits.--Where an EGHP has paid primary benefits, and Medicare is being billed for secondary benefits, calculate the amount of secondary benefits payable in accordance with §3490.8.

If an EGHP payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare (as defined in §3490.8A) in the absence of EGHP payment, and the provider does not accept and is not obligated to accept the plan's payment as payment in full, determine the amount of secondary Medicare benefits due in accordance with §3490.8 and reimburse the provider that amount. In this situation and where the employer plan paid an amount which equals or exceeds the amount that Medicare would have paid in the absence of EGHP payment, follow the bill review instructions in §3681 for processing claims from providers on cost reimbursement, and §3685 for providers on prospective payment.

C. Intermediary File On Cases in Which Medicare May Be Secondary.--Based on the information that you obtain from providers and renal dialysis facilities in accordance with §3490.15A, from other intermediaries and carriers, or from your own development, maintain a file containing information concerning ESRD beneficiaries on whose behalf claims have been filed. Include the first and last months of the 12-month period, whether the individual is covered by an EGHP during that period, and, if so, the name and address of the plan. If this information is not available , request the provider to obtain it.

D. EGHP Claims That Its Benefits Are Secondary to Medicare's.--If a provider bills an EGHP and the plan refuses to pay primary benefits to the provider because it claims that its benefits are secondary to Medicare's, do not pay conditional benefits. Refer the case to the RO in accordance with paragraph G6. If you have already paid conditional benefits in such a case, seek recovery in accordance with paragraph G.

E. Conditional Primary Medicare Benefits.--Conditional primary Medicare benefits may be paid if (1) the beneficiary has appealed or is protesting the EGHP denial of the claim for any reason other than that the EGHP offers only secondary coverage of services covered by Medicare, or (2) the EGHP denied the claim because the time limit for filing the claim with the EGHP has expired (whether appealed or not). Before making a conditional primary payment in cases involving appealed or protested claims, notify the EGHP and the beneficiary that the payment is being made on condition that both the insurer and the beneficiary are responsible for reimbursing the program up to the amount it has paid, if the EGHP subsequently approves the claim. Also notify the EGHP that if it pays the beneficiary, it is still liable to reimburse Medicare for the amount of the conditional benefits (up to the EGHP primary payment). (However, your failure to so notify the parties does not relieve them of the obligation to refund the payment.) Follow up periodically with the insurer to determine the outcome of the disputed claim. If the EGHP allows the claim, recover the Medicare payment directly from the EGHP. (See subsection G.) Where an EGHP has denied payment because its claim filing deadline has expired, promptly notify the EGHP that it must reimburse Medicare the amount of conditional benefits Medicare paid. Follow the recovery instructions in subsection G.

F. When Primary Benefits and Conditional Primary Medicare Benefits Are Not Payable.--Neither primary benefits nor conditional primary Medicare payments may be made where an EGHP denies payment for particular services on the grounds they are not covered by the plan, and you have reason to believe the plan does cover the services. Also do not pay conditional benefits if a plan offers only secondary coverage of services covered by Medicare. Conditional primary benefits may not be paid in this situation even if the EGHP has only collected premiums for secondary rather than primary coverage. Where an EGHP has denied the claim because the plan provides only secondary coverage, deny the claim for Medicare primary benefits. Contact the EGHP to explain that:

o it is obligated to pay primary benefits under §1862(b)(2) of the Social Security Act,

o Medicare payment cannot be made for services that are covered by the plan until the plan has paid primary benefits in accordance with its policy, and

- o if the employer plan primary payment does not pay the full charge, then a claim for secondary benefits can be submitted to Medicare.

Send a denial letter to the beneficiary including similar information and a statement that the beneficiary may not be charged more than the deductible and coinsurance amounts and charges for noncovered services. (Services that are or could have been paid for by the EGHP are not considered "noncovered.") Also, include an appeals paragraph in the letter to the beneficiary. Advise the beneficiary to consult his employer and the State Insurance Commissioner or other official having jurisdiction if necessary. Also advise him of the private right of legal action to collect double damages. (See §3490.19.) See subsection G6 for further action to take after you have denied the claim and notified the EGHP of its obligation to pay primary benefits. Also, notify the provider of your actions.

G. Recovery of Conditional Primary Benefits.--

1. General.--If, after you have paid primary benefits in a particular case which exceed the overpayment recovery tolerance in §3709.2, you receive information indicating that an EGHP is primary payer, recover the overpayment. The Medicare overpayment is the difference between the conditional primary payment and the amount Medicare should have paid as secondary payer. Recover from the EGHP or from the provider. When recovering from an EGHP, the amount requested may be more than the overpayment amount. (See paragraph 2.) If you believe that an EGHP, which has refunded benefits to you or to a provider, has paid less than the amount required under its contract, attempt to resolve the question with the EGHP, provider, and beneficiary. If unsuccessful, refer the case to the RO.

2. Recovery from the EGHP.--Request the EGHP to refund, within 90 days, the gross amount payable by Medicare as defined in §3490.8 or the amount the plan pays as primary payer, whichever is less. If the EGHP informs you that it has already made payment for the items and services, e.g., it has paid secondary benefits to the provider or beneficiary, request the EGHP to refund the gross amount payable by Medicare or the plan's primary payment amount less any amount the EGHP has already paid for the items and services. Include in the recovery letter to the EGHP a full explanation of the reasons you believe the EGHP is primary payer, a copy of the Medicare claim and/or the beneficiary's name, his Medicare claim number, his EGHP identification number, the provider or facility's name, services rendered and charges, and the dates services were rendered. Also, request the EGHP to include a copy of the plan's EOB along with its refund.

When requesting an EGHP to refund a payment, inform the EGHP that any deductible and coinsurance amounts that had been subtracted from the Medicare payment to the provider or facility will be sent to the provider or facility with instructions to refund them to the beneficiary if the beneficiary has paid them.

When you receive an EGHP refund, send the provider or facility any deductible and coinsurance, and retain the remainder of the EGHP payment up to the amount you paid. When refunding deductible and coinsurance amounts to a provider, instruct the provider or facility to either credit amounts paid toward the deductible and coinsurance to the beneficiary's account, or to refund such amounts to the beneficiary if the beneficiary has already paid them. Send a copy of the letter sent to the provider or facility to the beneficiary. If the EGHP voluntarily reimburses Medicare an amount in excess of the gross amount payable by Medicare, return the excess. Advise the EGHP to send the excess payment to the provider with an appropriate explanation or directly to the Medicare beneficiary depending upon the terms of the EGHP contract. The provider or you prepare an adjustment bill showing the revised Medicare liability and utilization.

In summary, when you receive an EGHP refund,

- o set aside any deductible and coinsurance,
- o calculate and recover the Medicare overpayment,
- o return the excess to the EGHP.

EXAMPLE: A beneficiary was hospitalized for 8 days in 1987. The covered charges were $4,000. The gross amount payable by Medicare was $3,600. A primary Medicare payment of $3,080 ($3,600 - $520 deductible) was made to the provider. Subsequently, an EGHP reimbursed you $4,000 for the Medicare covered services. The entire Medicare payment of $3,080 is recovered because the EGHP payment of $4,000 exceeded the gross amount payable by Medicare of $3,600. Therefore no secondary Medicare benefits are payable.

Set aside the $520 deductible from the EGHP payment, and deduct the Medicare overpayment of $3,080 to determine the "excess" EGHP refund: $4,000 - $520 = $3,480 - $3,080 = $400.

Send $520 of the EGHP payment to the provider with instructions to refund the $520 to the beneficiary if the beneficiary has already paid the hospital that amount. Return the $400 "excess" to the EGHP.

If you are also the responsible EGHP, a transfer of funds is the most convenient method of recovery. Return the deductible and coinsurance to the provider, recover the Medicare overpayment and distribute any "excess" to the provider or the beneficiary in accordance with your EGHP guidelines.

If an EGHP sends you a refund on its own initiative, allocate the payment in accord with the above rules. (Refund any "excess" to the EGHP. Do not return the full payment to the EGHP with instructions for it to pay the provider rather than make payment directly to you.)

If an EGHP has not responded to your request for repayment within 90 days, refer the case to the RO. If progress is being made toward recovery but full recovery has not been made within 90 days, continue to work with the EGHP to recover the Medicare payments. When progress is not deemed reasonable, refer the case to the RO.

If an EGHP which is primary to Medicare refuses to reimburse you for conditional primary benefits, it must submit an EOB or letter explaining its reason. If the explanation is that plan benefits are not payable to any party because, for example, the services are not covered under any circumstances, or benefits are exhausted, or the beneficiary is not entitled to benefits, accept the explanation in the absence of evidence to the contrary. If some other reason is given, such as: the plan has not received a claim from the beneficiary, its claim filing deadline has expired, the insurance policy does not provide for payments to third parties, the plan maintains it is secondary payer for individuals who are in a 12-month period as defined in §3490.5 (see subparagraph D), or if the plan does not respond, follow-up by informing the plan that it is obligated to refund such payments to you under the Medicare statute.

Section 1862(b)(2)(B) of the statute, as amended by §2344(b) of the Deficit Reduction Act of 1984 (Pub. L. 98-369), gives the Government the right to recover conditional Medicare payments from private insurers that are the primary insurers for Medicare beneficiaries. Therefore, such insurers must reimburse Medicare where it paid conditional primary benefits. Also, advise the plan and the beneficiary of the private right of legal action to collect double damages. (See §3490.19.) If the plan still refuses to reimburse Medicare or does not respond to your requests, refer the case to the RO. Also if you believe that, under the EGHP's contract, it should have paid more than it did, contact the plan and explain that under the statute it must make full payment in accordance with its contract. If the plan still refuses to cooperate, refer the case to the RO if the amount in question exceeds the recovery tolerance in §3709.2. The regional office will determine the need for further action.

General guidelines for recouping Medicare payments from other carriers are in §3711.1.

If the EGHP refuses to refund a payment to you because it has made payment to the provider, facility or to the beneficiary, obtain a copy of the EOB from the EGHP or the party that received the EGHP payment. Request the party that received the EGHP payment to refund the excess Medicare payment. The excess Medicare payment is the difference between the Medicare conditional primary payment and the amount Medicare is obligated to pay as secondary payer.

3. Recovery from the Provider.—If duplicate payment was made to the provider, i.e., the provider received both primary EGHP payments and primary Medicare benefits, recover from the provider the excess Medicare payment, subject to the overpayment recovery tolerance in §3709.2. If Medicare paid the provider and the EGHP paid the beneficiary, the beneficiary is liable. (See §3708.3A.)

If an EGHP payment has been made to a provider, the provider or you should prepare an adjustment bill showing the revised Medicare liability and utilization. When the provider receives an EGHP payment equal to or greater than the Medicare deductible and coinsurance amounts, instruct the provider to either credit the beneficiary's account for unpaid Medicare deductible and coinsurance amounts or to refund these amounts to the party that paid them. The provider may retain any excess EGHP payment over the gross amount payable by Medicare. (See §3490.9.)

4. Recovery from the Beneficiary.—If Medicare paid the provider and the EGHP paid the beneficiary, recoup from the beneficiary subject to the tolerance in §3709.2, that portion of the Medicare payment that exceeds Medicare's obligation as secondary payer, or an amount up to the provider's customary charges, whichever is less. (See §§3711.4A3 and B2.) Obtain a copy of the plan's EOB from either the beneficiary or the EGHP in order to determine the excess Medicare payment amount.

5. Recovery When a State Medicaid Agency Has Also Requested a Refund from the EGHP.—Medicare and a State Medicaid agency may conditionally or erroneously pay for services, and the amount payable by an EGHP is insufficient to reimburse both programs. Under the law, Medicare has the right to recover its benefits from an EGHP before any other entity, including a State Medicaid agency. Also Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by an EGHP.

The superiority of Medicare's recovery right over other entities, including Medicaid, derives from the Medicare statute, which states that where Medicare is secondary to another insurer

o HCFA may recover Medicare benefits from the responsible insurer,

o HCFA is subrogated to the right of the Medicare beneficiary and the right of any other entity to payment by the responsible insurer, and

o HCFA may recover its payments from any entity that has been paid by the responsible insurer.

Medicare's right to recover its benefits from an EGHP or from a beneficiary that has been paid by an EGHP is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort, and therefore doesn't pay its benefits until after Medicare has paid. Medicare's priority right of recovery from insurance plans that are primary to Medicare, does not violate the concept of Medicaid's being payer of last resort. Under §1862(b)(2) of the Social Security Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can be expected to be made by an EGHP which is primary to Medicare as promptly as would otherwise be the case if payment were made by Medicare. Where the EGHP pays right away, Medicare makes no payment to the extent of the EGHP payment. Delay of the EGHP payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, if the EGHP pays less than the charges, Medicare may be responsible to pay secondary benefits. And if the third party pays the charges, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid would have the effect of creating a Medicare payment where none is authorized under the law or improperly increasing the amount of any Medicare secondary payment.

Moreover, the right of Medicaid agencies to recover benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. Since the beneficiary can assign to the State a right no higher than his own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is higher than that assigned to the State.

Thus, where both Medicare and Medicaid are seeking reimbursement from the EGHP, inform the EGHP that it must reimburse Medicare before it can pay any other entity, including a State Medicaid agency. Also, where a beneficiary, provider or supplier receives payment from an EGHP, inform the beneficiary, provider or supplier that it is obligated to refund the Medicare payment up to the full amount of the EGHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary, provider or supplier have the right to reimburse Medicaid or any other entity.

If a State Medicaid agency is reimbursed from an EGHP payment before Medicare, ask the State agency to reimburse Medicare up to the full amount the agency received. State the legal basis for Medicare's right to recover. If the State refuses to reimburse you in full, refer the case to the HCFA RO. The RO's recovery actions may include offset of Medicare's claim against any Federal Financial Participation funds otherwise due the State. Tell the EGHP that in future cases involving claims by Medicare and Medicaid, it must reimburse Medicare first.

6. Referral of Cases to Regional Office.--Refer to the RO all cases where recovery is not made. Also, refer all cases where an EGHP claims that it is secondary to Medicare (irrespective of whether or not any Medicare benefits were paid). When referring a case subsequent to the first case involving a particular EGHP, advise the RO of the total number of cases which have been referred to them involving this EGHP, and the total dollar amount of Medicare overpayments. Whenever you paid primary benefits that should have been paid by an EGHP and the EGHP refuses to reimburse you, refer the case to the RO. The RO will notify the State Insurance Commissioner, or other official having jurisdiction over the EGHP, that evidence suggests that the EGHP has violated Federal law and will request that the EGHP's actions be investigated, and that it be ordered to comply with Federal law and to make appropriate refund to Medicare. The RO also advises the Insurance Commissioner, or other responsible official, that the Medicare beneficiary is placed at risk by the EGHP's actions and that Medicare will not make future primary payments for items and services covered by the EGHP for this individual. Further, the official should be advised of Medicare's right to recover from any parties to whom it has made improper payments. The RO will also consider possible legal action against the EGHP or employer.

H. Multiple Insurers.--There may be instances where Medicare is secondary payer to more than one primary insurer, e.g., an individual covered under his own EGHP as well as under the EGHP of his spouse or under automobile insurance. In such cases, the other primary payers will customarily coordinate benefits. If a portion of the Medicare gross amount payable remains unpaid after the other insurers have paid primary payments, pay appropriate secondary benefits.

3490.5 Determining the 12-Month Period During Which Medicare May Be Secondary Payer.--Medicare is secondary payer to EGHPs for items and services furnished during a period of up to 12 consecutive months which begins with the earlier of:

- the month in which a regular course of renal dialysis is initiated, or
- in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

NOTE: In the extremely rare case of an untimely application by an individual who receives a transplant, the 12-month period could begin with the first month in which the individual would have been entitled to Medicare benefits if a timely application had been filed. (See §3001.3A for the earliest possible month of entitlement in transplant cases.) It is not necessary to consider this possibility absent a specific indication, e.g., information in file that the transplant occurred before the first actual month of entitlement. If further development is required contact the SSO.

When the 12-month period begins before the month the individual becomes entitled to Medicare, Medicare pays secondary benefits for the portion of the period during which the individual is entitled to Medicare benefits. The latter is the coordination period (see §3490.2D). Since Medicare entitlement usually begins with the third month after the month in which the individual starts a regular course of dialysis, Medicare is usually the secondary payer for the first 9 months of an individual's entitlement. However, for individuals who undertake a course in self-dialysis training or who receive a kidney transplant during the 3-month waiting period, Medicare may be the secondary payer for up to the first 12 months of the individual's entitlement.

The following examples illustrate how to determine the number of months in which Medicare pays secondary benefits for various situations in which benefits are payable by an employer group health plan:

(1) Individual became entitled to Medicare after a waiting period

(i) Janice started a regular course of dialysis in October 1981. The 12-month period begins in October 1981 (the month in which Janice started a regular course of dialysis) and the waiting period consists of October, November and December 1981. Medicare is secondary payor from January through September 1982.

(ii) Peter started a regular course of dialysis in January 1982 and was hospitalized and received a kidney transplant in March 1982. The 12-month period begins with January 1982. The kidney transplant cuts short the dialysis waiting period so that Peter becomes entitled in March 1982. Medicare is secondary payor from March through December 1982.

(2) Individual became entitled to Medicare without a waiting period.--In October 1982 John began a regular course of dialysis. In December 1982 John began a course of self-dialysis training. Since the self-dialysis training course was initiated during the first 3 months of dialysis, he is exempt from the waiting period and becomes entitled as of October 1982, the first month of dialysis. In this situation the first month of entitlement coincides with the beginning of the 12-month period. Thus, the coordination period extends from October 1982 through September 1983. Medicare is secondary payor during this period.

3490.6 Effect of the Changed Basis for Medicare Entitlement.--If the basis for an individual's entitlement to Medicare changes from ESRD to age 65 or disability, the coordination period terminates with the month before the month in which the change is effective. See §3687 for intermediary development when the basis for entitlement changes from ESRD to ESRD and disability (S3 trailer code).

3490.7 Subsequent Periods of ESRD Entitlement.--If an individual has more than one period of entitlement based solely on ESRD, a coordination period will be determined for each period of entitlement in accordance with §§3490.5 and 3490.6.

3490.8 Amount of Secondary Medicare Payments Where Employer Group Health Plan Pays In Part for Items and Services

A. General.--If an EGHP payment for Medicare covered services is less than a provider's charges for those services and less than the gross amount payable by Medicare (as defined below), and the provider does not accept and is not obligated to accept the payment as payment in full, Medicare secondary payment can be made. The Medicare secondary payment will be the lower of:

- the gross amount payable by Medicare minus the amount paid by the EGHP for Medicare covered services, or

- the gross amount payable by Medicare minus any applicable deductible or coinsurance amount.

The gross amount payable by Medicare is:

o the current Medicare interim reimbursement amount (as defined in §3683) for providers reimbursed on a reasonable cost basis;

o the Medicare payment rate (as defined in §3685) for providers reimbursed on a prospective payment basis;

o the composite rate for maintenance dialysis services;

o the reasonable charge for separately billable items furnished by independent renal dialysis facilities (see §3644.1).

The gross amount payable by Medicare includes applicable Medicare deductible and coinsurance amounts. If a provider furnishes services that are reimbursable under more than one payment method (e.g., composite rate for dialysis treatments and reasonable cost for separately billable items associated with dialysis) the gross amount payable by Medicare is the combined amount of Medicare reimbursement for the services (without regard to the effect of the Medicare deductible or coinsurance or the payment by the EGHP).

For detailed billing and reimbursement instructions, refer to §3681 (for reasonable cost reimbursement) and to §3685 (for prospective payment).

B. Special Rules for Dialysis Equipment for Which Medicare Paid the Full Reasonable Cost.—Where a provider or renal dialysis facility is paid its full reasonable costs for the purchase of dialysis equipment pursuant to an agreement with HCFA (see 42 C.F.R. 405.690) the provider or facility should be instructed to bill the employer plan based on the usual rates in the area for the same or similar equipment. Any amounts received from the employer plan should be refunded to the intermediary or used to adjust future payment as the intermediary determines to be appropriate. There is no secondary Medicare payment in this situation because Medicare has already paid the provider or facility 100 percent of its reasonable costs for the equipment. (The 100 percent reimbursement option for dialysis equipment is discontinued effective August 1, 1983. However, any equipment already purchased under a full reasonable cost reimbursement agreement will be handled under the pertinent regulations and terms of the agreement.)

3490.9 Employer Group Health Plan Pays in Full.—If an employer plan payment for Medicare covered services equals or exceeds the provider's charges for those services or the gross amount payable by Medicare (as defined in §3490.8A), or if the provider accepts or is obligated to accept the plan payment as payment in full, no Medicare payment is due. Any excess of the employer plan payment over the gross amount payable by Medicare will not be subtracted from the provider's Medicare reimbursement. The provider will submit a no payment bill in accordance with §3681 or §3685 as appropriate.

3490.12 Effect of Secondary Payments on Part A Utilization.--Where no Medicare secondary benefit is payable, no utilization is charged the beneficiary. Where a Medicare secondary payment is made, the beneficiary will be charged with utilization in accordance with §3681C3 for providers reimbursed on a reasonable cost basis or §3685A3 for providers reimbursed on a prospective payment basis. These procedures also are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

3490.13 Effect of EGHP Payments On Deductible and Coinsurance.--EGHP payments are credited to the Part A and Part B deductible amounts. Thus, expenses that would be credited to a beneficiary's Part A or Part B cash or blood deductibles if Medicare were primary payer, are credited to the deductibles even if the expenses are reimbursed by an EGHP. This is true even if the EGHP paid the entire bill and there is no Medicare benefit payable. Also, EGHP payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, EGHP payments are credited to deductibles before being used to satisfy the coinsurance. (See §3681.)

3490.14 Limitation on Right of Provider or Facility to Charge a Beneficiary.--A provider of services, renal dialysis facility or other facility that receives direct payment from the Medicare program may not charge a beneficary or any other party, other than an insurer that is primary under §1862(b) of the Act, for Medicare covered services, if it has been or could be paid by an EGHP at least an amount equal to any applicable deductible or coinsurance amount. This limitation applies to situations where an insurer is primary under §1862(b) but offers only secondary benefits.

EXAMPLE: A Medicare beneficiary with EGHP coverage was a hospital inpatient for 20 days in 1987. The hospital's charges for Medicare covered services were $5,000. The inpatient deductible had not been met. The gross amount payable by Medicare for the stay in the absence of EGHP coverage is $4,000. The employer plan paid $4,500, $520 of which was credited to the inpatient deductible. Medicare will make no payment, since the plan's payment was greater than the gross amount payable by Medicare of $4,000. No part of the $500 difference between the hospital's charges and the employer plan's payment can be billed to the beneficiary since the beneficiary's obligation, the deductible, was met by the employer plan's payment. The provider files a no-payment bill reflecting a fully satisfied deductible.

3490.15 Responsiblity of Providers of Services and Renal Dialysis Facilities

A. Identification of Cases in which Medicare may be Secondary to EGHPs .--Providers of services investigate cases in which information available to them (e.g., the beneficiary's Medicare card) indicates that the beneficiary is entitled to Medicare based on ESRD for 1 year or less at the time the services were rendered to ascertain whether the services were rendered during the 12-month period described in §§3490.5 and 3490.6. Providers determine whether the services were rendered in the 12-month period by checking their own records; e.g., information contained on Form HCFA-2728 or, if the potential Medicare payment is $50 or more, with other providers or facilities, or the beneficiary's physician, if necessary, to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant). If the individual is in the 12-month period, the provider asks the beneficiary if he/she is insured under any health insurance plan which provides coverage through the employer or through a union. If the response is yes, the provider asks for the name and address of the plan and the beneficiary's identification number.

If the information obtained does not indicate EGHP coverage, the provider annotates the bill to that effect (e.g., EGHP coverage lapsed, benefits exhausted). If the information indicates that EGHP coverage exists, the provider obtains the information indicated above from the beneficiary or the beneficiary's representative.

B. Action by Provider Where Medicare May be Secondary to EGHP.--

(1) Submittal of Bill for Primary Benefits to EGHP . If Providers determine, based on their development, conducted in accordance with subparagraph A , that Medicare may be secondary to an EGHP, they must bill the employer plan for primary benefits. When a provider bills an EGHP as primary payer, the bill to the employer plan should itemize the services rendered even though they are services for which Medicare reimburses on a composite rate basis.

(2) Submittal of Bill to Medicare After EGHP Has Processed Claim.--After an EGHP has processed a claim for primary benefits, the provider submits a bill for secondary payment or a no payment bill as appropriate, in accordance with §3681 for providers reimbursed on a reasonable cost basis, or §3685 for providers reimbursed on a prospective payment basis. If an EGHP denies a claim for primary benefits, the provider submits a bill for conditional primary benefits with an explanation of any reason given by the plan for its denial, in accordance with §3681A.

3490.17 Action by Intermediary When EGHP Erroneously Pays Primary Benefits.—Cases may come to your attention where an EGHP has inappropriately paid primary benefits. In such cases, instruct the provider to bill Medicare as primary payer and to refund to the EGHP the amount it paid, except for an amount equivalent to the Medicare deductible and coinsurance amounts, and charges for noncovered services.

3490.18 Referral to RO of Cases Involving Discrimination Against ESRD Patients.—

A. Health Benefits Discrimination.—Section 162(i)(1) of the Internal Revenue Code stipulates that expenses incurred by an employer for contributions to an EGHP are not allowed as a tax deduction if the plan differentiates in the benefits it provides between individuals having ESRD and other individuals covered by the plan.

Refer any cases of potential discrimination by employers which come to your attention to the RO, which decides whether the case warrants referral to the IRS. The decision as to whether a plan differentiates between individuals having ESRD and other individuals covered under the plan and as to any action to be taken is made by the IRS.

The following are examples of potential health benefits discrimination cases:

o the plan does not cover routine maintenance dialysis services or kidney transplants;

o the plan excludes benefits, makes itself secondary to government benefits, or charges a higher premium for individuals with ESRD;

o the plan imposes limitations on benefits for persons with ESRD which are not applicable to others , e.g., a higher deductible or coinsurance, a longer waiting period or a lower annual or lifetime benefit limit.

B. Job Discrimination.--HCFA is responsible for investigating complaints of potential job discrimination against ESRD beneficiaries which may occur as a result of the law making Medicare secondary payer to employer group health plans. HCFA must report its findings to Congress periodically.

If you become aware of any employer or plan which in any way denies employment, or conditions or restricts employment or promotional opportunities, because a job applicant or employee or a dependent of a job applicant or employee has ESRD, refer the case to the regional office. The RO will investigate the complaint and send a report of the facts to HCFA's Central Office.

3490.19 Claimant's Right to Take Legal Action Against an EGHP.--The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right to take legal action against, and to collect double damages from, an EGHP that fails to pay primary benefits for services covered by the EGHP where required to do so under §1862(b) of the Act.

3490.20 Medical Services Furnished to ESRD Beneficiaries by Source Outside EGHP Prepaid Health Plan.--

A. Services By Outside Sources Not Covered.--If an ESRD beneficiary is in a 12-month period as defined in §3490.5 and is enrolled in an employer sponsored prepaid health plan (e.g., Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP)), Medicare does not pay for services obtained from a source outside the prepaid employer health plan if:

- The same type of services could have been obtained as covered services through the prepaid employer health plan, or
- The particular services can be paid for by the plan (e.g., emergency or urgently needed services).

Medicare benefits are precluded under these circumstances even if the individual receives services outside of the prepaid health plan's service area, e.g., while the individual is away from home.

At the time of admission, providers are to ask beneficiaries that are enrolled in EGHPs whether the plan is a prepaid health plan. If the individual is enrolled in such a plan, Medicare is not billed. (However, a no-payment bill is required per §§3624 and 3679B.) Any request for payment is made to the EGHP.

NOTE: This restriction only affects Medicare beneficiaries enrolled in employer sponsored prepaid health plans which either do not have a Medicare contract or have a Medicare cost contract. Beneficiaries in HMO/CMPs that have Medicare risk contracts are not affected because beneficiaries enrolled in a risk-basis HMO/CMP are locked into the plan in all instances except for emergency or urgently needed services.

B. Exception.--If a beneficiary obtains services from a source outside the prepaid employer health plan, and has not yet been notified in writing of this special rule, Medicare pays for the services, provided the plan will not pay for the services for legitimate reasons. In general, it is assumed that written notification has not been given in the absence of evidence to the contrary, e.g., where the remarks portion of the MSP Regional Data Exchange System indicates that the beneficiary has been notified. (See subsection C.) Where payment is made for services from a source outside the prepaid health plan, the Medicare Benefits Notice (HCFA-1533), or the EOMB, where applicable, states the following:

"Our records show that you are a member of an employer sponsored prepaid health plan. Since Medicare is secondary payer for you, services from sources outside your health plan are not covered. However, since you were not previously notified of this, we will pay this time. In the future, payment will not be made for nonplan services which could have been obtained from or through the prepaid health plan."

C. Notice to Beneficiary.--Any bills received for Medicare payment from, or on behalf of a beneficiary enrolled in an EGHP Prepaid Health Plan who has previously been notified in writing, are denied and the Medicare Benefit Notice or the EOMB includes the following:

"Our records show that you are a member of an employer sponsored prepaid health plan. Since Medicare is secondary payer for you, services from sources outside your health plan that could have been obtained from or through the prepaid health plan are not covered. Our records show that you were previously informed of this rule. Therefore, payment cannot be made for the nonplan services you received."

D. Update MSP Regional Data Exchange System.--When you have identified a beneficiary under subsection A and, either you have notified him in writing that Medicare does not pay for services obtained outside of the plan or you have information that he was previously notified of this, update the MSP Regional Data Exchange System. (See §3696.) This is accomplished by entering the following information in remarks line 1: "MSP-Code 13, ESRD beneficiary belongs to prepaid EGHP. Notified that Medicare will not pay."

Limitation on Payment for Services to Employed Aged Beneficiaries and Spouses

3491. LIMITATIONS ON PAYMENT FOR SERVICES TO THE EMPLOYED AGED AND THE AGED SPOUSES OF EMPLOYEES WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

3491.1 General.--Medicare benefits are secondary to benefits payable under employer group health plans (EGHPs) for employed individuals age 65 or over and the spouses age 65 or over of employed individuals of any age. Section 3491.3 further defines individuals subject to this limitation on payment.

If primary Medicare benefits have been paid for services furnished on or after January 1, 1983 to an individual who meets the criteria in §3491.3, recover the excess Medicare payment in accordance with §3491.15. Billing instructions are in §3682 for providers reimbursed on a cost reimbursement basis and §3685 for hospitals reimbursed on a prospective payment basis.

In general, providers are instructed that, where an individual meets the criteria in §3491.3, they should bill the EGHP first and, if (1) the plan payment is less than the provider's charges for Medicare covered services, (2) the plan payment is less than the gross amount payable by Medicare, and (3) the provider does not accept and is not obligated to accept the EGHP payment as payment in full, Medicare secondary benefits may be payable in accordance with §3491.13.

The Age Discrimination in Employment Act (ADEA) which is administered by the Equal Employment Opportunity Commission requires employers (as defined below) to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare. This equal benefit rule applies to coverage offered to full-time and part-time employees. From January 1, 1985 through April 30, 1986, employers were required to furnish such coverage to their age 65 - 69 employees and to the age 65 - 69 spouses of employees of any age through age 69. From January 1, 1983 through December 31, 1984 employers were required to offer primary EGHP coverage to their employees age 65 - 69 and to the spouses age 65 - 69 of such employees.

Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as the primary coverage. When Medicare is primary payer, employers cannot offer such employees or their spouses secondary coverage of items and services covered by Medicare. The requirements for employer compliance with the Medicare secondary payer provisions may differ in some respects from the requirements for compliance with the ADEA. Thus, for example, the ADEA law applies only to employees while the Medicare provision applies also to self-employed individuals. (See §3491.2B.)

Where an EGHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid as prescribed in §3491.13, to supplement the amount paid by the EGHP for Medicare covered services. If an EGHP denies payment for particular services because they are not covered by the plan, primary Medicare benefits may be paid for them if covered by Medicare.

An EGHP's decision to pay or deny a claim because it determines that the services are or are not medically necessary is not binding on the Medicare intermediary. Medicare will continue to evaluate claims under existing guidelines derived from the law and regulations to assure that services are in fact covered by the program regardless of employer plan involvement.

3491.2 Definitions--

A. Employer.--The term "employer" as used in these instructions means not only individuals and organizations engaged in a trade or business, but also includes organizations exempt from income tax, such as religious, charitable, and educational institutions. Included are the governments of the United States, the States, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, Puerto Rico and the District of Columbia.

Only employers with 20 or more employees are required to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. This requirement is met if an employer has 20 or more full-time and/or part time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Self-employed individuals who participate in an employer plan are not counted as employees for purposes of determining if the 20 or more employees requirement is met. Where an employer does not have 20 or more employees in the preceding year, he is required to offer his employees and spouses age 65 or over, primary coverage beginning with the point in time at which the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees drops below 20 after the employer has met the requirement.

The "20 or more employees" requirement must be met at the time the individual receives the services for which Medicare benefits are claimed. If at that time, the employer has met the "20 or more employees" requirement in the current year or in the preceding calendar year, the EGHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the employer plan.

Employers are not required to provide any coverage to self-employed individuals. However, any coverage provided to self-employed persons age 65 or older and age 65 or older spouses of self-employed persons of any age by an employer of 20 or more employees must be the same as coverage provided to younger self-employed persons, that is, coverage primary to Medicare. The employer must also provide primary coverage to older self-employed individuals even if there are no younger self-employed individuals enrolled in the plan.

Assume for purposes of developing claims and the requirement that EGHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. An employer allegation that the 20-employee requirement is not met or a multiemployer plan's statement identifying specific members as employees of employers of fewer than 20 employees, can be accepted as a basis for making Medicare primary payer. Refer questionable cases to the RO.

B. Employed Individual.--

1. General.--The term "employed individual" as used in these instructions refers not only to employees but also self-employed persons such as directors of corporations, and owners of businesses. If a self-employed individual enrolls in an EGHP which meets the definition in subsection C, the employer plan may be primary for that individual and the individual's spouse. The term "employed individual" also includes members of the clergy and members of religious orders who are reimbursed for their services by a church, religious order, or other employing entity.

2. Members of the Clergy and Religious Orders.--The following guidelines apply in determining the employment or retirement status of members of the clergy and members of religious orders, where an EGHP alleges that such an individual is retired.

(a) A member of the clergy or a member of a religious order who has not taken a vow of poverty is

o considered employed if he or she is receiving from a church, religious order or other employing entity cash remuneration for services rendered whether or not the individual's earnings are exempt from social security coverage, and

o considered retired if the church, religious order or other employing entity states that the individual is retired and that he or she receives only retirement pay from the entity rather than remuneration for services rendered.

(b) A member of a religious order who has taken a vow of poverty is considered retired if the order submits a written statement that

o an election of coverage under §3121(r) of the Internal Revenue Code of 1954 is in effect for the order of the subdivision to which the member belongs, i.e., the order has agreed to waive its exemption from payment of Federal Insurance Contributions Act (FICA) taxes on behalf of members of the order, and

o the individual has retired including the date of retirement; and

o it has or will report the retirement on its tax return. (The noncash compensation of members of religious orders who have taken a vow of poverty is "deemed earnings" for social security and tax purposes depending on the level of services they render. Religious orders are required to report retirement of members on their tax returns.)

3. Individuals Age 65 and Older Who Receive Disability Payments.--A person who is age 65 or older and is receiving disability payments from an employer is considered employed if such payments are subject to taxes under FICA. Employer disability payments are subject to FICA tax for the first 6 months of disability after the last calendar month in which the employee worked for that employer.

EXAMPLE: Adam Green stopped working because of disability in December 1985 at age 66. His employer began paying him disability payments as of January 1986. Since sick pay is taxed under FICA for 6 months after the last month in which the employee worked, Medicare is the secondary payer through June 1986. Beginning with July 1986, Medicare becomes the primary payer as the sick payments are no longer considered wages under FICA.

4. Insurance Agents.--The following guidelines apply in determining the status of insurance agents. (See subsection D to determine when an insurance company's plan meets the definition of an EGHP.)

o A self-employed insurance agent is considered employed if he actually conducts business on behalf of the company. The fact that a self-employed insurance agent is authorized to represent the company; e.g., to write policies on behalf of the company, does not itself confer the status of "employed individual.

NOTE: An insurance company that offers EGHP coverage to any self-employed insurance agent who writes policies on behalf on the company, must offer the same coverage under the same circumstances to older and younger agents. For example, a company that provides EGHP coverage for younger insurance agents who sell at least $10,000 of insurance during a calendar year is required to furnish the same coverage under the same conditions to agents age 65 and over, including "retirees" who sell at least $10,000 of insurance during the same time period.

o Since a full-time life insurance agent is considered an employee for social security purposes, such an individual is also considered an employee for purposes of the working aged provision. (See subsection D for the effect of this rule in determining whether a plan is an EGHP.)

5. Senior Federal Judges.--Senior Federal judges are retired judges of the U.S. court system and the Tax Court. They may continue to adjudicate cases, but they are entitled to full salary as a retirement benefit whether or not they perform judicial services for the Government. By law, the "remuneration" they receive as senior judges is not considered wages for social security retirement test purposes. Since they are considered retired for social security purposes, they are also considered retired for purposes of the working aged provision.

6. Volunteers.--Volunteers are not considered employed unless they perform services or are available to perform services for an employer and receive remuneration for their services. For example, for purposes of §1862(b) VISTA volunteers are considered employed by the Federal Government since they receive remuneration.

7. Directors of Corporations.--Directors of corporations, i.e., persons serving on a Board of Directors of a corporation, who are not officers of the corporation, are self-employed. (Officers of a corporation are employees.) Directors who receive no remuneration for serving on the Board ("unpaid directors") are not considered employed.

However, remuneration may consist of "deferred compensation;" i.e., amounts earned but not payable until some future date, usually when the individual reaches age 70 and is no longer subject to the social security retirement test. A director receiving deferred compensation is an employed individual.

C. Plan.--The term "plan" means any arrangement by an employer or by more than one employer, or by an employee organization to provide health benefits or medical care to employees. An arrangement by more than one employer is considered to be a single plan if the arrangement provides for common administration of the health benefits, for example, by the employers directly, or by a benefit administrator, or by a multiemployer trust, or by an insuring organization under a contract or contracts which stipulate that the organizations provide all employees enrolled in the plan the same benefits or the same benefit options.

D. Employer Group Health Plan or Employer Plan (EGHP).--These terms mean any health plan that is of, or contributed to by, an employer of 20 or more employees and which provides medical care, directly or through other methods such as insurance or reimbursement to current or former employees, or to current or former employees and their families. This includes a multiemployer group health plan that has at least one employer with 20 or more employees. These plans may identify members who are employees of employers with fewer than 20 employees. Such members and their spouses are considered not to meet the conditions in §3491.3. Similarly, if an employer of fewer than 20 employees enrolls in the EGHP that is offered to employees, that employer is not considered to meet the conditions in §3491.3.

A plan that does not have any employees as enrollees, e.g., a plan for self-employed persons only, does not meet the definition of EGHP and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than full-time life insurance agents, the plan would not be considered an EGHP. But if the plan includes full-time life insurance agents or other employees or former employees, it would be considered an EGHP. (Subsection B.4 states that full-time life insurance agents are considered employees.)

The Federal Employees Health Benefits program meets the definition of an EGHP. Employee-pay-all plans, i.e., group health plans which are under the auspices of an employer and which do not receive any contribution from the employer, also meet the definition of EGHP. Coverage by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is secondary to Medicare, since it is not considered to meet the definition of an EGHP.

Assume in the absence of evidence to the contrary, that any health plan (including a union plan) in which a beneficiary is enrolled because of the beneficiary's or the beneficiary's spouse's employment meets this definition.

NOTE: Medicare is secondary to EGHP coverage only if the EGHP coverage is by reason of the employed person's current employment. Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. (See §3336.4.)

E. Secondary.-The term "secondary", when used with respect to Medicare payment, means that Medicare is the residual payer to all EGHPs under which the Medicare beneficiary is covered by reason of current employment and will not pay for any expenses that are reimbursable by any such plan or plans. Consider the workers' compensation and automobile and liability insurance exclusions (§§3407-3416, 3419, and 3489) in appropriate cases in determining the extent of Medicare's liability.

(Also refer to §3491.7C regarding claims in which there is an EGHP and another primary and/or secondary payer involved, e.g., an EGHP, an automobile insurer and a retirement plan.)

F. Age 65 through 69.--Means a period beginning with the first day of the month in which an individual attains age 65 and ending with:

- For services furnished on or after July 18, 1984, the last day of the month before the month the individual attains age 70.
- For services furnished before July 18, 1984, the last day of the month in which the individual attains age 70.

An individual attains a particular age on the day preceding his or her birthday.

G. Spouse.--Means any individual who has spousal coverage under the employer plan.

3491.3 Individuals Subject to Limitation on Payment.--

A. General.--Medicare is secondary payer for Part A and Part B benefits under this provision for an individual who:

1. Is age 65 or over for services on or after May 1, 1986; is age 65 through 69 for services before May 1, 1986, and

2. Is entitled to Part A (hospital insurance) of Medicare on the basis of the individual's own social security or railroad retirement earnings record, or Federal quarters of coverage, or the earnings record or the Federal quarters of coverage of another person, and

3. Is either

   - Employed and covered by reason of that employment by an EGHP; or
   - The spouse of an employed person, covered by an EGHP by reason of that person's employment, and the employed person is:

- Any age - for services on or after May 1, 1986; or

- Any age through 69 - for services on or after January 1, 1985, through April 30, 1986, or

- Age 65 through 69 - for services on or after January 1, 1983, through December 31, 1984.

B. Re-employed Retirees and Annuitants.--If a retiree or annuitant returns to work even for temporary periods, the employer is required to provide the same coverage under the same conditions that he furnishes to other employees (i.e., non-retirees). Medicare is secondary payer to the EGHP that the employer provides to the re-employed retiree even if the premiums for coverage in the plan are paid from a retirement pension or fund. Medicare is also secondary payer for self-employed individuals such as consultants who are former employees if the employer provides coverage for other such individuals.

3491.4 Individuals Not Subject to the Limitation on Payment.--This Medicare secondary provision does not apply to:

o Individuals entitled, or who could upon application become entitled, to Medicare under the ESRD provisions, i.e., individuals who meet the requirements for ESRD entitlement even though their current Medicare entitlement may be on the basis of age 65.

o Individuals who are enrolled in Part B only.

o Individuals enrolled in Part A on the basis of a monthly premium.

o Anyone who is under age 65. (Effective for items and services rendered on or after January 1, 1987 through December 31, 1991, §9319 of OBRA provides that Medicare is secondary to large group health plans that cover at least one employer of 100 or more employees for certain disabled individuals under age 65.

o With respect to services rendered before May 1, 1986, anyone who is over age 69 and age 65-69 spouses of employees over age 69.

o Individuals covered by a health plan other than an EGHP as defined above, e.g., one that is purchased by the individual privately, and not as a member of a group.

o Employees of employers of fewer than 20 employees.

o Members of multiemployer plans whom the plan identified as employees of employers with fewer than 20 employees.

o Retired beneficiaries (other than spouses of employed individuals) who are covered by EGHPs as a result of past employment and who do not have EGHP coverage as the result of current employment.

3491.5 Identification of Cases by Providers of Services.—To obtain the information needed to ascertain whether to bill an EGHP as primary payer, providers ask Medicare Part A beneficiaries age 65 or over (other than beneficiaries with ESRD) admitted for inpatient care or receiving outpatient care, or their representatives, selected questions. These include the age of the beneficiary, the employment status of the beneficiary and the spouse, whether the beneficiary is covered under an EGHP because of the beneficiary's or the spouses's current employment, the patient's identification number and the name and address of the EGHP.

3491.6 Identification of Cases and Action Where There Is Indication of Possible EGHP Coverage.—Consider the possible application of this limitation on benefits when processing claims for items or services furnished to beneficiaries who meet the criteria in §3491.3. Develop with the provider and the beneficiary to determine if primary benefits may be paid by another insurer. See §3686 for development of claims where there may be other payer involvement.

When processing a claim for secondary benefits for services furnished an individual who meets the criteria in §3491.3, search your records for any claims on which you paid primary benefits for services provided within the time limit stipulated in the following sentence, and which have not been annotated in accordance with §3491.11 to indicate a valid prior EGHP denial which would apply to subsequent claims.

In each instance, you must search your records for all claims for services provided within the current and preceeding 27 months. If you believe it would be cost-effective in a particular situation, you may search your records for a longer prior period (not to extend prior to January 1, 1983). There may be instances when beneficiaries who meet §3491.3 are identified through special projects in connection with which you will be directed to search your records for a prior period exceeding 27 months.

Where such a prior claim(s) is identified, contact the provider to ascertain from its records whether there is any indication that there is EGHP coverage, e.g., a statement that the individual was employed, and if so, instruct the provider to bill the EGHP identified in the current or prior claim for the prior stay (unless the information available to you on the prior claim clearly shows why the employer plan should not be billed as primary). The provider submits an adjustment bill when the EGHP payment is received. Follow the instructions in §3491.15 on any claim on which you paid primary benefits and the available information indicates that an EGHP may pay primary benefits if billed. See §3899.9 for criteria which must be met in order to count any amounts from such claims as Medicare secondary payer savings on the Form HCFA-1653.

3491.7 Action by Providers Where Medicare Is Secondary to EGHP.—

A. General.—Providers seek reimbursement from the EGHP before billing Medicare when there is indication that an EGHP is primary payer, i.e., where the services were rendered to an individual who meets the criteria in §3491.3, and there is no evidence that the definitions in §3491.2 are not met. Bill the EGHP as primary payer even where there may be EGHP coverage for only part of the stay (e.g., split stays where the beneficiary terminates employment during the stay and EGHP coverage terminated concurrently).

B. Submittal of Bill to Medicare after Employer Plan Has Made Payment.--If an EGHP pays primary benefits to a provider, secondary Medicare benefits may be payable in accordance with §3491.13 to supplement the amount paid by the EGHP. If the EGHP primary payment for a particular stay or particular services is less than the provider's charges for Medicare covered services, and is less than the gross amount payable by Medicare (as defined in §3491.13) and the provider does not accept and is not obligated to accept the EGHP payment as payment in full, the provider submits a bill for secondary benefits in accordance with §3682 or §3685 as appropriate. If the EGHP payment equals or exceeds the gross amount payable by Medicare (as defined in §3491.13), or equals or exceeds the provider's charges for Medicare covered services or the provider accepts or is obligated to accept the EGHP payment as payment in full, it will submit a no payment bill in accordance with §3682 or §3685 as appropriate. Any excess of the EGHP payment over the gross amount payable by Medicare is not subtracted from the provider's Medicare reimbursement at final cost settlement. If the EGHP denies a provider's claim for primary benefits, the provider submits a claim for primary Medicare benefits or conditional primary benefits as provided for in §3491.11.

C. Multiple Insurers.--There may be instances where Medicare is secondary payer to more than one primary insurer, e.g., an individual who meets the criteria in §3491.3 is also covered under his own EGHP, and under the EGHP of an employed spouse who meets the criteria in §3491.3 or under automobile insurance. In such cases, the other primary payers will customarily coordinate benefits. If a portion of the charges remains unpaid after the other insurers have paid primary payments, a secondary Medicare payment may be made.

Coordination of benefits arrangements between private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to certain EGHPs for individuals and spouses age 65 or over. Therefore, where the individual has EGHP coverage based on current employment in addition to EGHP coverage as a retiree, Medicare is secondary to the EGHP coverage based on current employment and primary to the EGHP coverage based on retirement regardless of the coordination of benefits arrangements between the plans.

Where a plan's payment would normally be secondary to Medicare, but under coordination of benefit provisions, the payment is primary to a primary payer under §1862(b), the combined payment of both plans constitutes the primary payment to which Medicare is secondary.

EXAMPLE: John Jones, age 67, is a Medicare beneficiary with coverage under Part A and Part B. He retired from the Acme Tool Company in 1986 and received retirement health insurance coverage which is secondary to Medicare. His wife Mary, age 62, has been employed continuously with the local police department since 1960 and since that time has received coverage for herself and her husband under the department's EGHP. The priority of payment for John's medical expenses is as follows:

1) The employed spouse's EGHP is primary payer.
2) Medicare is secondary payer.
3) The retirement plan is either tertiary payer or the retirement plan may choose to coordinate benefits with the employed spouse's EGHP so that the combined benefit of the two plans is primary to Medicare.

3491.8 Limitation on Right of Provider or Facility to Charge a Beneficiary.--A participating provider of services or any other facility that receives direct payment from the Medicare program may not charge a beneficiary or any other party other than an insurer which is primary under §1862(b) of the Act for Medicare covered services if the provider or facility has been paid or could have been paid by an EGHP an amount which equals or exceeds any applicable deductible or coinsurance amount. This applies to situations where an insurer is made primary under §1862(b) but offers only secondary benefits.

EXAMPLE: A Medicare beneficiary who had EGHP coverage was hospitalized for 20 days in 1987. The hospital's charges for covered services were $5000. The inpatient deductible had not been met. The gross amount payable by Medicare (as defined in §3419.13) would have been $4000 for the stay if there had been no EGHP coverage. The EGHP paid $4500 (of which $520 was credited to the Medicare deductible). Medicare will make no payment, since the plan's payment was greater than Medicare's gross amount payable of $4000 would have been. No part of the $500 difference between the hospital's charges and the EGHP's payment can be billed to the beneficiary since the beneficiary's obligation, the deductible, was met by the EGHP payment. The provider files a no-payment bill reflecting the $520 credited to the deductible.

3491.9 Effect of EGHP Payments on Deductible and Coinsurance.--Expenses that serve to meet the beneficiary's Part A or Part B cash and blood deductibles, if Medicare were primary payer, are credited to those deductibles even if the expenses are reimbursed by an EGHP. This is true even if the EGHP paid the entire bill and there is no Medicare benefit payable. Also, EGHP payments to a provider are applied to satisfy a beneficiary's obligation to pay a Part A or Part B coinsurance amount. However, EGHP payments are credited to deductibles before being used to satisfy the coinsurance.

3491.11 Employer Plan Denies Claim for Primary Benefits.--

A. Primary Medicare Benefits.--Primary Medicare benefits may be paid if an EGHP denies a claim for primary benefits because the employer does not employ 20 or more employees; or the beneficiary is not entitled to benefits under the plan; or benefits under the EGHP are exhausted for the services involved; or the services are not covered by the EGHP, and the beneficiary is not appealing the EGHP denial. (But primary Medicare benefits may not be paid if you believe that the EGHP covers the particular services. See subsection C.) If you pay primary Medicare benefits and later learn that the beneficiary is appealing the EGHP denial, treat the payment as a conditional primary payment and take action in accordance with subsection B.

B. Conditional Primary Medicare Benefits.--Conditional primary Medicare benefits may be paid if (1) the beneficiary has appealed or is protesting the EGHP denial of the claim for any reason other than that the EGHP offers only secondary coverage of services covered by Medicare, or (2) the EGHP denied the claim because the time limit for filing the claim with the EGHP has expired (whether appealed or not). Before making a conditional primary payment in cases involving appealed or protested claims, notify the EGHP and the beneficiary that the payment is being made on condition that both the insurer and the beneficiary are responsible for reimbursing the program up to the amount it has paid, if the EGHP subsequently approves the claim. Also notify the EGHP that if it pays the beneficiary, it is still liable to reimburse Medicare for the amount of the conditional benefits (up to the EGHP primary payment). (However, your failure to so notify the parties does not relieve them of the obligation to refund the payment.) Follow-up periodically with the insurer to determine the outcome of the disputed claim.

Where an EGHP has denied payment because its claim filing deadline has expired, promptly notify the EGHP that it must reimburse Medicare the amount of conditional benefits Medicare paid. Follow the recovery instructions in §3491.15.

C. When Primary Benefits and Conditional Primary Medicare Benefits Not Payable.--Neither primary benefits nor conditional primary Medicare payments may be made where an EGHP denies payment for particular services on the grounds they are not covered by the plan, and you have reason to believe the plan does cover the services. Also do not pay conditional benefits if a plan offers only secondary coverage of services covered by Medicare, and the EGHP does not allege that the employer has fewer than 20 employees. Conditional primary benefits may not be paid in this situation even if the EGHP has only collected premiums for secondary rather than primary coverage. Where an EGHP has denied the claim because the plan provides only secondary coverage, deny the claim for Medicare primary benefits unless the EGHP alleges that the employer has fewer than 20 employees. Contact the EGHP to explain that:

o it is obligated to pay primary benefits under §1862(b)(3) of the Social Security Act,

o Medicare payment cannot be made for services that are covered by the plan until the plan has paid primary benefits in accordance with its policy, and

o if the employer plan primary payment does not pay the full charge, then a claim for secondary benefits can be submitted to Medicare.

Send a denial letter to the beneficiary including similar information and a statement that the beneficiary may not be charged more than the deductible and coinsurance amounts and charges for noncovered services. (Services that are or could have been paid for by the EGHP are not considered "noncovered.") Also, include an appeals paragraph in the letter to the beneficiary. Advise the beneficiary to consult his employer and the State Insurance Commissioner or other official having jurisdiction if necessary. Also advise him of the private right of legal action to collect double damages. (See §3491.18.) See §3491.12 for further action to take after you have denied the claim and notified the EGHP of its obligation to pay primary benefits. Also, notify the provider of your actions.

D. Annotation of Claims Denied by EGHP's.--Whenever an EGHP denies a claim for primary benefits, the provider should annotate in item 94 "Remarks" of Medicare claim with the reason for the denial of EGHP primary benefits and enter occurrence code 24 and date of denial in items 29 - 32. No attachment is needed to the Medicare claim. The annotation is needed to avoid needless recoupment efforts under §3491.15.

3491.12 Referral of Cases to Regional Office.--Refer all cases where recovery is not made to the RO. When referring a case subsequent to the first case involving a particular EGHP, advise the RO of the total number of cases which have been referred to them involving this EGHP, and the total dollar amount of Medicare overpayments involved. Whenever you paid primary benefits that should have been paid by an EGHP and the EGHP refuses to reimburse you, or it comes to your attention that a beneficiary (who meets the criteria in 3491.3) is covered on a secondary basis by an EGHP for Medicare covered services (see §3491.1), refer the case to the RO. Include all of the documentation of the recovery attempt specified in § 3491.15 F.

The RO notifies the State Insurance Commissioner, or other official having jurisdiction over the EGHP, that evidence suggests that the EGHP has violated Federal law and requests that the EGHP's actions be investigated, and that it be ordered to comply with Federal law and to make appropriate refund to Medicare. The RO also advises the Insurance Commissioner, or other responsible official, that the Medicare beneficiary is placed at risk by the EGHP's actions and that Medicare will not make future primary payments for items and services covered by the EGHP for this individual.

Further, advise officials contacted of Medicare's rights to recover from any parties to whom it has made improper payments. The RO also considers possible legal action against the EGHP or employer and/or referral of the case to the Equal Employment Opportunity Commission.

3491.13 Amount of Secondary Medicare Payments Where EGHP Pays in Part for Items and Services.--If an EGHP payment for Medicare covered services is less than the provider's charges for those services and less than the gross amount payable by Medicare (as defined below), and the provider does not accept and is not obligated to accept the payment as payment in full, Medicare secondary payment can be made. The Medicare secondary payment is the lower of:

- The gross amount payable by Medicare minus the amount paid by the EGHP for Medicare covered services; or

- The gross amount payable by Medicare minus any applicable deductible or coinsurance amount.

NOTE: The gross amount payable by Medicare is (1) the current Medicare interim reimbursement amount (as defined in §3683) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible or coinsurance or the payment by the EGHP, or (2) the Medicare payment rate (as defined in §3685) for hospitals reimbursed on a prospective payment basis without considering the effect of the Medicare deductible or coinsurance or the payment by the EGHP.

Detailed reimbursement and billing instructions are in §3682C, F, H and J for providers reimbursed on a cost reimbursement basis and §3685 for hospitals reimbursed on a prospective payment basis.

3491.14 Effect of Secondary Payments on Part A Utilization.--Where the conditions in §3491.13 are met and a Medicare secondary benefit is payable, utilization is charged the beneficiary. The beneficiary will be charged with utilization as specified in §3682C3 for providers reimbursed on a cost reimbursement basis and §3685A3 for hospitals reimbursed on a prospective payment basis. These procedures are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

3491.15 Recovery of Incorrect Primary Medicare Payments.--

A. General.--If, after you have paid primary benefits in a particular case which exceed the overpayment recovery tolerance in §3709.2, and you receive information indicating that an EGHP is primary payer, recover the Medicare overpayment. (See the next to last paragraph in §3491.6 for the applicable recovery periods.) The Medicare overpayment is the difference between the Medicare conditional primary payment and the amount Medicare should have paid as secondary payer. Recover directly from the EGHP or from the provider. If the provider is unable to recover, you may need to attempt to recover directly. Request the name and address of the EGHP and the beneficiary's EGHP identification number from the beneficiary if you do not have this information. If the beneficiary does not cooperate, take steps to recover the Medicare payment from the beneficiary. (When the beneficiary fails to cooperate, the beneficiary is liable.) (See subsection C.) Note that when recovering from an EGHP, the amount requested may be more than the overpayment amount. (See subsection B.) If you have reason to believe that an EGHP, which has refunded benefits to you or to a provider, has paid less than the amount required under its contract, attempt to resolve the question with the EGHP, provider, and beneficiary. If unsuccessful, refer the case to the RO.

B. Recovery from the EGHP.--Request the EGHP (insurer, third party administrator, or the employer if the plan is self-insured and self-administered) to refund within 90 days the gross amount payable by Medicare as defined in §3491.13. Include a full explanation of the reasons you feel the EGHP is primary payer and request a copy of the plan's EOB. When you receive an EGHP refund, allocate the amount refunded as follows: first send any deductible or coinsurance amounts to the provider; second, recover the Medicare overpayment. Instruct the provider to credit insurance amounts paid toward the deductible and coinsurance to the beneficiary's account, or to refund such amounts to the beneficiary, if the beneficiary has paid them. The provider or the intermediary must prepare an adjustment bill showing the revised Medicare liability and utilization.

If the EGHP informs you that it has already made primary payment, request the EGHP to send you an explanation of the benefits paid. Recover any duplicate payment from the provider.

If the EGHP informs you that it made a secondary payment to the physician, supplier, or the beneficiary, this will not reduce the amount you recover from the EGHP. Recover the entire amount of the incorrect Medicare payment from the EGHP. It is the EGHP's responsibility to recover any overpayment it made.

Whenever requesting the EGHP to make a refund to you, inform the EGHP that any deductible and coinsurance amounts that had been subtracted from the Medicare payment to the provider will be sent to the provider by the intermediary with instructions to refund such amounts to the beneficiary if the beneficiary has already paid them. If an EGHP sends a refund to you in response to your request or if an EGHP sends you a refund at its own initiative, and the amount refunded is more than the gross amount payable by Medicare, return the "excess" EGHP payment to the EGHP. Advise the EGHP that it should send the excess payment directly to the provider with an appropriate explanation or directly to the Medicare beneficiary depending on the terms of the EGHP contract.

In summary, when you receive an EGHP refund, whether as a result of your request or at the EGHP's initiative, (1) set aside any deductible and coinsurance, and (2) calculate and recover the Medicare overpayment. The remainder is the "excess" EGHP refund and is to be returned to the EGHP.

EXAMPLE: A beneficiary was hospitalized for 8 days. The covered charges were $4,000. The gross amount payable by Medicare was $3,600. A primary Medicare payment of $3,080 ($3,600 - $520 deductible) was made to the provider. Subsequently, an EGHP reimbursed the Medicare intermediary $4,000 for the Medicare covered services. The entire Medicare payment of $3,080 is considered an overpayment because the EGHP payment of $4,000 exceeded the gross amount payable by Medicare of $3,600. Therefore no secondary Medicare benefits are payable.

Set aside the $520 deductible from the EGHP payment, then deduct the Medicare overpayment of $3,080 to determine the "excess" EGHP refund: $4,000 - $520 = $3,480 - $3,080 = $400.

Inform the EGHP that $520 of the EGHP refund will be sent to the provider with instructions to refund the $520 to the beneficiary if the beneficiary has paid the hospital that amount. Return the $400 to the EGHP. Advise the EGHP to send the excess payment directly to the provider with an appropriate explanation or directly to the Medicare beneficiary depending on the terms of the EGHP contract.

If an EGHP sends you a refund of a Medicare overpayment at its own initiative, allocate the payment in accord with the rules discussed above. (Refund any "excess" to the EGHP. Do not return the full payment to the EGHP with instructions that the EGHP should pay the provider rather than make payment directly to you.)

If an EGHP has not responded to your request for repayment within 90 days, send a formal demand letter to the plan administrator or general counsel. If you do not receive an acceptable response to the formal letter in 60 days, refer the case to the RO. If progress is being made toward recovery but full recovery has not been made within 90 days, continue to work with the EGHP to recover the Medicare payments. When progress is not deemed reasonable, refer the case to the RO.

If an EGHP which is primary to Medicare refuses to reimburse you for primary conditional benefits, it must submit an Explanation of Benefits (EOB) or letter explaining its reason. If the explanation is that benefits are not payable to any party under the plan because, e.g., the services are not covered under the plan under any circumstances, or plan benefits are exhausted, the explanation can be accepted in the absence of evidence to the contrary. If some other reason is given, such as the plan has not received a claim from the beneficiary, the plan provides benefits secondary to Medicare regardless of the employment status of individual or the individual's spouse, the claim for benefits was not filed in a timely manner as required by the plan, or the insurance policy does not provide for payments to third parties, inform the plan that it is obligated to refund such payments to you under the Medicare law. Section 1862(b) of the law, as amended by §2344 of the Deficit Reduction Act of 1984 (Pub. L. 98-369) gives the Government the right to recover conditional Medicare payments from private insurers which are the primary insurers for Medicare beneficiaries. If the plan still refuses to reimburse Medicare, refer the case to the RO.

General guidelines for recouping Medicare payments from other carriers may be found in §3711.1.

C. Recovery from the Provider.--When recovering from a provider, furnish the provider with the name and address of the EGHP which you believe should have been the primary payer and instruct the provider to file a claim with the EGHP for primary benefits and, upon receipt of the EGHP payment, to refund to Medicare, the amount Medicare paid less the amount received from the EGHP. After you instruct a provider to file a claim for primary benefits with an EGHP, follow up in 45 days with the provider to ascertain whether a claim has been filed and whether payment has been made by the EGHP. If the provider had not filed a claim for primary benefits within 30 days after you have instructed it to do so, recover the Medicare primary payment from the provider, except where the reason the provider does not file a claim with the employer plan is because the beneficiary declines to sign the claims forms and such a signature is required by the EGHP. In that case, recover the overpayment directly from the EGHP. (See §3491.15B.)

Upon receipt of the EGHP payment, the provider submits an adjustment bill showing the revised Medicare liability and utilization. When the provider receives an EGHP refund, instruct it to return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. The provider may retain any excess EGHP payment over the gross amount payable by Medicare. (See §3491.7B.)

If duplicate payment was or will be made to the provider, i.e., the provider received or expects to receive both primary EGHP payments and primary Medicare benefits, recover from the provider, the Medicare overpayment (as defined in subsection A) subject to the overpayment recovery tolerance in §3709.2. If Medicare paid the provider and the EGHP paid the beneficiary, the beneficiary is liable. (See §3708.3A.)

If you have not received an adjustment bill from the provider within 120 days of notifying the provider to file a claim with the EGHP, follow up with the provider to determine the status of the claim with the EGHP. If the EGHP has denied the claim for a reason you would find acceptable if you requested payment from the EGHP directly, the recovery action may be cancelled. If the EGHP has denied the claim for any other reason, or has not responded to the provider's claim, advise the provider that you will attempt to recover from the EGHP. Advise the provider to notify you immediately if it receives payment from the EGHP.

Seek to recover the Medicare overpayment directly from the EGHP in accordance with procedures discussed in this section. (See §3491.15A and §3491.15B.)

D. Recovery from the Beneficiary.--If Medicare paid the provider and the EGHP paid the beneficiary, recoup from the beneficiary subject to the tolerance in §3709.2, that portion of the Medicare payment that exceeds Medicare's obligation as secondary payer, or an amount up to the provider's customary charges, whichever is less. (See §§3711.4A3 and B2.) It is necessary to obtain a copy of the plan's EOB from either the beneficiary or the EGHP to determine the excess Medicare payment amount.

E. Recovery When a State Medicaid Agency Has Also Requested a Refund From the EGHP.--Situations may arise in which both Medicare and another insurer or a State Medicaid agency have conditionally or erroneously paid for services and the amount payable by an EGHP is insufficient to reimburse both programs. Under the law, Medicare has the right to recover its benefits from an EGHP before any other entity, including a State Medicaid agency. Also Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by an EGHP.

The superiority of Medicare's recovery right over those of other entities including Medicaid derives from the Medicare statute, which states that where Medicare is secondary to another insurer (1) HCFA may recover Medicare benefits from the responsible insurer, (2) HCFA is subrogated to the right of the Medicare beneficiary and the right of any other entity to payment by the responsible insurer, and (3) HCFA may recover its payments from any entity that has been paid by the responsible insurer.

Medicare's right to recover its benefits from an EGHP or from a beneficiary that has been paid by an EGHP is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort, and therefore doesn't pay its benefits until after Medicare has paid. Medicare's priority right of recovery from insurance plans that are primary to Medicare, does not violate the concept of Medicaid's being payer of last resort. Under §1862(b)(3) of the Social Security Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by an EGHP which is primary to Medicare. Where the EGHP pays right away, Medicare makes no payment to the extent of the EGHP payment. Delay of EGHP payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, if the EGHP pays less than the charges, Medicare may be responsible to pay secondary benefits. And if the third party pays the charges, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid would have the effect of creating a Medicare payment where none is authorized under the law or improperly increasing the amount of any Medicare secondary payment.

Moreover, the right of Medicaid agencies to recover their benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. Since the beneficiary can assign to the State a right no higher than his own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is higher than that assigned to the State.

Thus, where both Medicare and Medicaid are seeking reimbursement from the EGHP, inform the EGHP that it must first reimburse Medicare before it can pay any other entity, including a State Medicaid agency. Also, where a beneficiary, provider or supplier receives payment from an EGHP, inform the beneficiary, provider or supplier that it is obligated to refund the Medicare payment up to the full amount of the EGHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary, provider or supplier have the right to reimburse Medicaid or any other entity.

If a State Medicaid agency is reimbursed from an EGHP payment before Medicare, ask the State agency to reimburse Medicare up to the full amount the agency received. Explain the legal basis for Medicare's right to recover. If the State refuses to reimburse Medicare in full, refer the case to the HCFA RO. The RO's recovery actions may include offset of Medicare's claim against any Federal Financial Participation funds otherwise due the State. Explain to the EGHP that in future cases involving claims by Medicare and Medicaid, Medicare must be reimbursed first.

F. Recovery Attempt Audit Trails.--You must maintain audit trails for all recovery attempts. These audit trails must link the following items: (1) specific services provided on specific dates to Medicare working aged beneficiaries; (2) the amount which Medicare paid for each service; (3) the specific recovery request to each provider, insurer, or third party administrator; (4) the recovery received with explanation of benefits; and (5) analysis of the difference between the Medicare payment and the recovered amount.

3491.16 Advice to Providers, Physicians and Beneficiaries.--In your professional and public relations activities, inform providers, physicians, and beneficiaries that claims should be directed first to the EGHP where there is EGHP coverage for the services involved.

3491.17 Incorrect EGHP Primary Payments.--Cases may come to your attention in which an EGHP has incorrectly paid a provider primary benefits, e.g., primary payments made by the EGHP of an employer of less than 20 employees. In such cases, instruct the provider to bill Medicare as primary payer and to refund to the EGHP any amount it paid in excess of the Medicare deductible and coinsurance amounts and charges for noncovered services, provided the time limits prescribed in §3799 for reopening and revising Medicare claims has not elapsed. If the beneficiary has not already filed an authorization with the provider to file a Medicare claim, the provider may request, but cannot require, the beneficiary to do so.

If no Medicare claim was filed, e.g., because the insurer paid the expense in full and the claims filing time limit has elapsed for the services, consider the date of receipt of the first written inquiry by either the beneficiary or the insurer to the Medicare contractor concerning the improperly paid EGHP claims as a "protective filing date" on the claims for expenses that were not filed previously with Medicare.

3491.18 Claimant's Right to Take Legal Action Against an EGHP.--The Omnibus Budget Reconciliation Act of 1986 provides that any claimant has the right (1) to take legal action against an EGHP that fails to pay primary benefits for services covered by the EGHP and (2) to collect double damages.

3491.19 Special Rules For Services Furnished By Source Outside EGHP Prepaid Health Plan.--

A. Services By Outside Sources Not Covered.--Where Medicare is secondary payer for a person enrolled in an employer sponsored prepaid health plan (e.g., Health Maintenance Organization (HMO)/Competitive Medicare Plan (CMP)), Medicare does not pay for services obtained from a source outside the prepaid employer health plan if:

o The same type of services could have been obtained as covered services through the prepaid employer health plan, or

o The particular services can be paid for by the plan (e.g., emergency or urgently needed services).

Medicare benefits are precluded under these circumstances even if the individual receives services outside of the prepaid health plan's service area, e.g., while the individual is away from home.

At the time of admission, providers ask beneficiaries that are enrolled in EGHPs whether the plan is a prepaid health plan. If the individual is enrolled in such a plan, Medicare is not billed. (However, a no-payment bill is required per §§3624 and 3679B.) Any request for payment is made to the EGHP.

This rule also applies to ESRD beneficiaries during the period of up to 12 months in which Medicare is secondary payer.

NOTE: This restriction only affects Medicare beneficiaries enrolled in employer sponsored prepaid health plans which either do not have a Medicare contract or have a Medicare cost contract. Beneficiaries in HMO/CMPs that have Medicare risk contracts are not affected because beneficiaries enrolled in a risk-basis HMO/CMP are locked into the plan in all instances except for emergency or urgently needed services.

B. Exception.—If a beneficiary obtains services from a source outside the prepaid employer health plan, and has not yet been notified in writing of this special rule, Medicare pays for the services, provided the plan will not pay for the services for legitimate reasons. In general, it is assumed that written notification has not been given in the absence of evidence to the contrary, e.g., where the remarks portion of the MSP Regional Data Exchange System indicates that the beneficiary has been notified. (See subsection D.) Where payment is made for services from a source outside the prepaid health plan, the Medicare Benefits Notice (HCFA-1533), or the EOMB, where applicable, states the following:

"Our records show that you are a member of an employer sponsored prepaid health plan. Since Medicare is secondary payer for you, services from sources outside your health plan are not covered. However, since you were not previously notified of this, we will pay this time. In the future, payment will not be made for nonplan services which could have been obtained from or through the prepaid health plan."

C. Notice to Beneficiary.—Any bills received for Medicare payment from, or on behalf of a beneficiary enrolled in an EGHP Prepaid Health Plan who has previously been notified in writing, are denied and the Medicare Benefit Notice or the EOMB includes the following:

"Our records show that you are a member of an employer sponsored prepaid health plan. Since Medicare is secondary payer for you, services from sources outside your health plan that could have been obtained from or through the prepaid health plan are not covered. Our records show that you were previously informed of this rule. Therefore, payment cannot be made for the nonplan services you received."

D. When you have identified a beneficiary under subsection A and either you have notified him in writing that Medicare does not pay for services obtained outside of the plan or you have information that he was previously notified of this, update the MSP Regional Data Exchange System. (See §3696.) This is accomplished by entering the following information in remarks line 1: "MSP-Code 12, Working Aged beneficiary belongs to prepaid EGHP. Notified that Medicare will not pay."

3492 MEDICARE AS SECONDARY PAYER FOR DISABLED INDIVIDUALS

A. General.—Under §1862(b)(4) of the Social Security Act, Medicare is secondary payer to "large group health plans" for "active individuals" (as defined in subsection C3) under age 65 entitled to Medicare on the basis of disability. Under the law a large group health plan (LGHP) may not "take into account" that an "active individual" is eligible for or receives benefits based on disability. The individual's coverage under the LGHP must be based on the individual's employment or the employment of a family member, as explained in subsection C.3. Apply the instructions in §§3491.7 - 3491.11 and §§3491.13 - 3491.17 in processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to an EGHP of 20 or more employees, substitute the term "large group health plan" as defined in subsection C1, for the purpose of applying them to disabled individuals.

B. Effective Date.—This provision is effective for items and services furnished on or after January 1, 1987 and before January 1, 1992. The effective dates are fixed by law.

C. Definitions.—

1. Large Group Health Plan.—A "large group health plan" means any health plan of, or contributed to by an employer or by an employee organization (including a self-insured plan) that provides health care directly or through other methods such as insurance or reimbursement, to employees or former employees, the employer, others associated, or formerly associated with the employer in a business relationship, or their families. The plan covers employees of at least one employer that normally employed at least 100 full or part-time employees on a typical business day during the previous calendar year. The term employer for purpose of this provision has the same meaning as the term has for purpose of the working aged provision. That definition is in §3491.2A. It includes the Federal government and other governmental entities. The tax penalty for nonconforming LGHPs does not apply to Federal and other governmental entities. (See subsection I.)

A group health plan that covers employees of at least one employer that had 100 or more employees on 50% or more of its business days during the preceeding calendar year is considered to meet the above definition of LGHP. If the plan is a multiemployer plan, such as a union plan, which covers employees of some small employers and also employees of at least one employer that meets the 100 or more employees requirement, Medicare is secondary for all employees enrolled in the plan including those that work for small employers. This differs from the rule for multiemployer plans under the working aged. (See §3491.2C.)

2. Nonconforming Large Group Health Plan.—A "nonconforming large group health plan" means an LGHP that at any time during the calendar year takes into account that an active individual is eligible for or receives benefits based on disability, e.g., an LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with subsection C.3.

NOTE: Although the term "large group health plan" includes a plan for former employees or persons formerly associated with the employer in a business relationship, or their families, these individuals are not included within the definition of "active individual" in subsection 3, i.e., Medicare is not secondary for them. These individuals are included within the definition of LGHP for tax purposes. (See the tax penalty described in subsection I.)

3. Active Individuals Subject to This Limitation on Payment.--An "active individual" is an employee, an employer (e.g., proprietor or partner), an individual associated with the employer in a business relationship (e.g., suppliers and contractors who do business with the employer and their employees) or a member of the family of any of these persons such as the spouse, parent or child of such an individual. Medicare is secondary payer under this provision for active individuals entitled to Medicare based on disability who have coverage under an LGHP.

In some cases, the disabled individual may be the employee, employer, or individual associated with the employer in a business relationship. In other cases, the disabled person may be the "family member" of the employee, employer, or individual associated with the employer in a business relationship. This means that a disabled person who is not an employee as defined in subsection 4, but who is covered under an LGHP of a spouse, parent, or any other family member, is considered to be an "active individual."

4. Employee.--An employee is (1) an individual who is actively working for an employer or (2), since disabled persons are not usually working, a person whose relationship to an employer is indicative of employee status. Whether or not such a person is an employee is established by the unique facts applicable to the person's relationship to the employer. The question to be decided is whether the employer treats a disabled individual who is not working as an employee, in light of commonly accepted indicators of employee status rather than whether the person is categorized in any particular way by the employer. In general, an individual who is not actively working may be considered to have employee status if the relationship is such that:

o The individual is receiving payments from an employer which are subject to taxes under the Federal Insurance Contributions Act (FICA) or would be subject to such taxes except that the employer is one that is not required to pay such taxes under the Internal Revenue Code.

o The individual is termed an employee under State or Federal law or in accordance with a court decision.

o The employer pays the same taxes for the individual as he pays for actively working employees.

o The individual continues to accrue vacation time or receives vacation pay.

- The individual participates in an employer's benefit plan in which only employees may participate.

- The individual has rights to return to duty if his/her condition improves.

- The individual continues to accrue sick leave.

D. Individuals Not Subject to this Limitation on Payment.--Medicare is not secondary for:

- Individuals entitled, or who would upon application be entitled, to Medicare under the ESRD provision, i.e., individuals who have ESRD even though their current Medicare entitlement is on the basis of disability. However, in accordance with §3490, Medicare is secondary payer for persons under age 65 with ESRD during a period of up to 12 months regardless of the number of employees.

You can identify ESRD beneficiaries by the "S" trailer codes when you query inpatient claims (§3512.8) and outpatient claims (§3535.1).

- Individuals who are covered by an EGHP of employer(s) of less than 100 employees, unless the EGHP is a multiemployer plan in which there is at least one employer of 100 or more employees (see subsection C.1.).

- Individuals whose coverage by an LGHP is not based on either employment or a relationship to an employee, employer, or an individual associated with an employer in a business relationship. For example, Medicare is primary for a disabled individual who is covered under an LGHP as a retired former employee (and who does not meet any of the criteria in subsection C.4,) or the spouse of a retired former employee.

E. Action by Providers to Identify Individuals Subject to This Limitation on Payment.--Providers are instructed to identify individuals who meet the conditions in subsection C.3. by asking every Medicare beneficiary under age 65 (1) if the individual is an employee, a self-employed individual, or a member of the family of an employee or self-employed individual and, (2) if so, whether the individual has group health coverage through an employer. If the individual responds affirmatively to both questions, the provider requests the name and address of the employer plan and the individual's identification number and bills the plan for primary benefits, except where the provider has information that clearly shows that the employer plan is not primary payer. If the individual responds that he or she does not meet either (1) or (2) above, or the provider has otherwise determined that the employer plan is not primary payer, the provider bills Medicare for primary benefits and annotates item 57A on Form HCFA-1450, "Medicare."

For audit purposes and to ensure that the provider has developed for other primary payer coverage, the provider retains a record of the development or other information on which it based its determination that Medicare is primary payer. See §3686 for action to take where a claim is received for primary benefits and you have reason to believe that Medicare may be secondary payer.

F. When Medicare Can Pay Secondary Benefits.--If the provider bills the employer plan first, Medicare may pay secondary benefits in accordance with §3491.13, to supplement the employer plan payment, only if all of the following conditions are met:

o the plan payment is less than the provider's charges for Medicare covered services,

o the plan payment is less than the gross amount payable by Medicare (as defined in §3491.13), and

o the provider does not accept and is not obligated to accept the plan's payment as payment in full. Refer to the billing instructions in §3682 (cost reimbursement) and §3685 (PPS reimbursement) as appropriate.

G. Recovery of Primary Medicare Payments.--Under the law, the government may recover incorrect primary Medicare benefits from any LGHP which is primary payer. To recover Medicare payments the government:

o may bring legal action against the LGHP and may collect double damages,

o may take legal action to recover its benefits from any entity that has been paid by the LGHP for items and services furnished an individual who meets the conditions in subsection C.3,

o may join or intervene in any legal action against the LGHP related to the events that gave rise to the need for the items or services, and

o is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from an LGHP.

H. Claimants' Right to Take Legal Action Against Large Group Health Plan.--Any claimant including an individual who received services, and the provider or supplier, has the right to take legal action against an LGHP that fails to pay primary benefits for services covered by both the LGHP and Medicare and to collect double damages.

I. Tax Penalty for Noncompliance.--An excise tax is imposed by §5000 of the Internal Revenue Code (IRC) on any employer or employee organization that contributes to a nonconforming LGHP (see subsection C2 for definition) during a calendar year. The amount of tax is 25 percent of the total amount that the employer or employee organization contributed to LGHPs during that year. This tax penalty does not apply to Federal and other governmental entities.

J. Recovery Notice to Nonconforming Large Group Health Plan.--When recovering incorrect primary payments from a nonconforming LGHP, include in your letter to the plan, a statement that it is obligated to pay primary benefits in this case, in accordance with §1862(b)(4) of the Medicare law, as amended by §9319 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). Explain that State laws and contract provisions are not applicable if they conflict with the Federal requirement even if they were in effect prior to January 1, 1987. Also inform the plan that, under this provision of the law, an LGHP which fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer is subject to legal actions described in subsections G and H , and to the tax penalty described in subsection I.

K. Identification of Cases and Action Where There Is Indication of LGHP Coverage In Prior Claims.--Consider the possible application of this limitation on benefits when processing all claims for items or services furnished on or after January 1, 1987 to beneficiaries for whom Medicare is secondary in accordance with subsection C.3. When processing a claim for secondary benefits for services furnished such an individual, search your records for any prior claims on which you paid primary benefits for services rendered that individual on or after January 1, 1987, and which have not been annotated in accordance with §3491.11 to indicate a valid prior LGHP denial which would apply to subsequent claims. When you identify such claims, notify the provider and request the provider to bill the plan for the prior stays unless its records show clearly that the employer plan should not be billed as primary. The provider submits an adjustment bill when LGHP payment is received. Refer to §3491.15 for further guidance regarding recovery of incorrect Medicare benefits where an employer plan may pay primary benefits if billed.

L. Referral of Cases to Regional Office.--Refer to the RO, any cases of a nonconforming LGHP which come to your attention which either offers secondary coverage for individuals for whom Medicare is secondary under subsection C.3., or which refuses to reimburse you for any primary benefits you have paid to or on behalf of such individuals. Include, in addition to the individual's name and Medicare number, the name and address of the employer and the LGHP, the individual's group health plan identification number, and a full explanation of the reasons for the referral. The RO considers possible legal action to collect double damages from the nonconforming LGHP. The RO also refers such cases to the Internal Revenue Service for imposition of the tax penalty described in subsection I on the contributing employer or employee organization. If the LGHP or employer has agreed to discontinue offering secondary coverage to disabled individuals for whom it is primary payer, or has agreed to reimburse Medicare the amount of incorrect Medicare primary benefits that should have been paid by the plan, the RO includes this information in its referral.

Once the RO refers a nonconforming LGHP to the IRS, the RO does not withdraw the referral solely because the plan has discontinued offering improper secondary coverage or has reimbursed Medicare the amount of incorrect primary benefits Medicare paid.

CHAPTER V

SPECIAL PROVISIONS RELATED TO PAYMENT FOR INTERIM MANUAL INSTRUCTIONS

Section

Government Subrogation Rights in Liability Insuarance Claims.. IM 3419.11

Revised Waiver of Liability Procedures for Providers......... IM 3430

Grace Periods Allowable Under Waiver of Liability............ IM 3441

Determining the Amount of Indemnification.................... IM 3446.6

Conditional Payments for Services to Individuals Entitled to Benefits Solely on the Basis of End Stage Renal Disease and Who are Covered by Employer Group Health Plans (IM 88-2)............... IM 3490

Medicare As Secondary Payer for Disabled Individuals......... IM

Replaced by Rev 137

~~IM3419.11 Government Subrogation Rights in Liability Insurance Claims.—Under §1862(b)(1) of the Social Security Act, all Medicare payments are conditioned on reimbursement to the Medicare program when notice or other information is received that payment with respect to the same items or services has been made, or could be made, under a liability insurance policy or plan (including a self-insured plan). Except where incorporated by reference, these instructions replace existing instructions in §§3419.1 - 3419.9 on Medicare claims involving liability insurance claims.~~

~~The term "liability insurance" means: Insurance (including a self-insured plan) that provides payment based on legal liability for injuries or illness or damages to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners liability insurance, malpractice insurance, product liability insurance, and general casualty insurance.~~

~~Section 2344 of the Deficit Reduction Act of 1984 (Public Law 98-369) amended §1862(b)(1) to make explicit the Federal Government's subrogation rights to recover Medicare benefits where liability insurance benefits are payable. The amendment stipulates that the Government may recover its benefits directly from liability insurance companies and self-insured plans, and from any entity, including the beneficiary, that has been paid by a liability insurer. "Subrogation" literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the Government has the same rights as the beneficiary as a claimant against the responsible party and the liability insurer, but only to the extent that Medicare has made payments to or on behalf of the beneficiary. Under this amendment, the Government can be a party to any claim by a beneficiary or other entity against a liability insurer, can participate in negotiations concerning the total liability insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the liability insurer.~~

IM3419.12 Role of Contractor in Implementing Subrogation Provision.—Under the previous instructions, where Medicare made conditional payments because there was a possibility of payment by a liability insurer, you would recover your payments from the beneficiary after he or she received payment from the liability insurer of the responsible party. Under the law as amended, the Government can be a party to the beneficiary's claim against the liability insurer. When you identify a case in which a liability claim has been or will be filed, ask the liability insurer to refund, at the time of settlement, the amount Medicare has paid in connection with the particular injury (less a proportionate share of the beneficiary's procurement costs). The liability insurer may not be willing to make a full refund because, for example, it contests liability, or the beneficiary may not agree to a settlement which provides full reimbursement to Medicare because the beneficiary feels that this would unduly reduce his or her share of the settlement. If either party suggests that you accept an amount which is less than the full amount claimed, or if you or Medicare is named in any legal proceeding seeking to establish Medicare's right to recovery, refer the case to the HCFA regional office. These contractor responsibilities are explained in §§IM3419.13 through IM3419.23.

You will not participate in negotiations with liability insurers, beneficiaries or other parties regarding the total amount to be recovered from a liability insurer or regarding the amount to be refunded to Medicare, nor will you participate in litigation concerning such matters.

developing Medicare's total claim and in seeking recovery from the liability insurer. If more than one intermediary has paid for expenses related to the injury, the one that has paid the most in benefits should take the lead. If no intermediary paid benefits on the basis of a claim for charges totalling $400 or more (§IM3419.15), but more than one Part B carrier paid benefits, the carrier that paid the most in benefits should take the lead. The lead contractor should review all available information including claims it has received in connection with the accident, contact other contractors that may have paid benefits for that accident and obtain from them information about the payments they made, including dates and place of services, nature of services, and names and addresses of providers and suppliers.

IM3419.17 Notification of Parties.—If development indicates that the beneficiary has filed or intends to file a liability claim, the contractor that is responsible for the development and recovery should notify the beneficiary and the beneficiary's attorney, if there is one, of the total amount Medicare has paid and its right to be reimbursed for the entire amount it has paid for services furnished in connection with the injury or illness, less a proportionate share of the beneficiary's procurement costs determined in accordance with §3419.4G2(b). (This is in addition to any Medicare secondary payer notice included in the notice of utilization issued by HCFA or EOB issued by carriers.) Once you learn that the beneficiary has an attorney, all future contacts should be through the attorney.

Also notify the alleged wrongdoer, and that party's attorney and liability insurer of Medicare's claim. The notice should state (1) the total amount of Medicare's claim; (2) that Medicare has subrogation rights against any party responsible for the particular injury; (3) that Medicare has the right to recover the benefits it paid for that injury from any liability insurer that is responsible for paying benefits for that injury; (4) that the parties may not settle the claim without satisfying Medicare's interests; and (5) that, if the claim is settled without satisfying Medicare's interest, both the liability insurer and the beneficiary will be liable for refunding the amount owed Medicare. If the alleged wrongdoer, or his/her attorney or insurer inquires about the details of Medicare's claim, such as asking for an itemization of the services paid for, refer them to the beneficiary or his/her attorney.

After sending notice to the parties, follow up with the beneficiary or attorney at intervals you deem appropriate to keep abreast of the claim, considering such factors as the amount involved, the status of the claim, and the degree of cooperation shown by the beneficiary and/or his attorney. Once you learn that a settlement is being considered, remind the parties that Medicare's claim must be satisfied.

IM3419.18 Parties Offer to Refund Less Than Medicare's Total Claim.—The liability insurer or beneficiary may not agree to a settlement that provides full reimbursement to Medicare and may, instead, ask that Medicare agree to reduce its claim. If you receive such a request based on the assertion that other third party payers besides Medicare have a claim against any proceeds from the settlement, you should respond that, under the law, Medicare's right to recover its benefits takes precedence over other claimants. Should it appear, however, that the proposed settlement would be jeopardized by Medicare's position or if the other claimant is Medicaid, refer the case to the regional office in accordance with §IM3419.22.

NOTE: Instructions regarding conflicting claims to the settlement by Medicare and Medicaid are under development and will be issued separately.

If you receive a request that Medicare reduce its claim for any reason other than the claim of another payer, request that such a compromise offer be in writing, specify the amount offered, and include the reasons why the parties believe Medicare should be satisfied with less than its total claim. When the offer is received, refer it to the HCFA regional office in accordance with §IM 3419.22.

IM3419.19 Check Made Out To Multiple Payees Received From Liability Insurer.—If you receive from a liability insurer a check intended to repay Medicare benefits paid on the beneficiary's behalf, but made out jointly to you (or Medicare) and to other parties such as the beneficiary or his/her attorney, ask the other payee(s) to endorse the check and return it to you. If you are the contractor with lead responsibility for recovering Medicare benefits paid in connection with the injury and the check is for an amount equal to Medicare's total claim, endorse and deposit the check when it is returned to you. If you are not the lead contractor, refer it to the contractor that has lead responsibility. If you are the lead contractor and the amount is not for the full amount claimed or the other payee(s) refuse to endorse the check and return it to you, refer the check to the regional office in accordance with §IM3419.22.

IM3419.20 Distribution of Recovered Medicare Payments—If the liability insurer or the beneficiary refunds all of the amount Medicare has claimed, the lead contractor should arrange for all contractors to be reimbursed. Since the amount requested is the amount paid less the beneficiary's procurement costs, the amount refunded will not be enough to reimburse all contractors in full. Allocate the money among contractors so that refunds restore available Part A benefits, in the following order: inpatient hospital days first, SNF days second, and other Part A benefits third. Prorate the remainder among carriers according to amount of Part B benefits paid. Likewise an insurer's payment to a contractor that has paid for both Part A and Part B services should be applied first to Part A expenses in the same order.

IM3419.21 Liability Insurer Settles Claim Without Satisfying Medicare's Interests—If a liability insurer settles a liability claim without satisfying Medicare's interests, ask the beneficiary to refund Medicare's payments, less the usual allowance for procurement costs in accordance with the instructions in §§3419ff. If the beneficiary does not refund that amount, refer the case to the regional office in accordance with §IM3419.22 for consideration of negotiations with, or legal action against, the insurer. If it is decided not to act against the insurer, the case will be returned for recovery action against the beneficiary in accordance with §§3700ff.

IM3419.22 Referral of Cases to Regional Office for Possible Government Intervention and/or Legal Action.—If a liability insurer does not refund the full amount of Medicare's claim after receiving a notice sent in accordance with §IM3419.17, the case should be referred to the regional office with (1) full documentation and itemization concerning the amounts paid by all contractors for treatment related to the injury, (2) a report on the status of the liability claim including the names and addresses of the responsible party, the liability insurer and the beneficiary's attorney, and information concerning the liability claim including the amount being claimed, and any limits contained in the insurance coverage and (3) the documentation required in §IM3419.17 or §IM3419.18 concerning any settlement that neglected Medicare's interests or any compromise offer.

Also refer to the regional office (1) any notice from a court that the Government has been made a party to a lawsuit involving a liability claim, or (2) any case involving a lawsuit in which HCFA's claim is at issue. Include pertinent Medicare claims information if not previously forwarded. Do not make referrals simply because a lawsuit has been filed between the beneficiary and the liable third party. However, monitor such lawsuits so that you may make a timely referral if HCFA's claim becomes an issue in the lawsuit.

IM3419.23 Consequences of Acceptance of Check from Liability Insurer.—If you cash a check from a liability insurer, this may commit the Medicare program as a whole to accept that amount as payment in full for payments it has made toward injury-related expenses. Therefore, do not sign such a check unless you are the lead contractor and are certain that you have presented a consolidated Medicare claim based on payments that all Medicare contractors have made for services related to the injury.

If asked to, the lead contractor may also sign a release of further claims for repayment from the proceeds of a particular settlement, since liability settlements generally stipulate that the defendant is not responsible for future medical expenses. If the settlement provides that the proceeds will be paid out over a period of time rather than in a one-time lump sum, Medicare will still be primary payer for medical expenses related to the same injury but incurred after the date of settlement. However, refer to the regional office any offers of payment of the debt to Medicare in installments.

IM 3446.6 Determining the Amount of Indemnification.—Section 4096 of P.L. 100-203 (The Omnibus Budget Reconciliation Act of 1987) revises certain of the limitation of liability requirements for indemnification under §1879(b) of the Act. Under this provision, a beneficiary qualifying for indemnification for denied items and services, furnished on or after January 1, 1988, is no longer responsible for paying deductible and coinsurance charges related to the denied claim. Additionally, where such indemnification is made, the beneficiary's Medicare utilization record is not charged for the denied items and services furnished .

IM3490 Conditional Payments for Services to Individuals Entitled to Benefits Solely on the Basis of End Stage Renal Disease and who are Covered by Employer Group Health Plans

Section 4036(a) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203), enacted December 22, 1987, conforms the rules for making conditional payments under the ESRD Medicare secondary provision with the conditional payment rules for the working aged provision. Previously, in the case of ESRD beneficiaries, HCFA paid conditional primary benefits except when the employer group health plan (EGHP) had already paid or a determination was made that an EGHP would pay as promptly as Medicare. Since there is no practical way for HCFA or the contractors to make uniform determinations as to what constitutes payment as promptly as Medicare, for all practical purposes, HCFA's payment policy was to pay conditional benefits if Medicare was billed first.

Providers no longer have the option to bill Medicare first. Where EGHP coverage exists, they must bill the EGHP for primary benefits during the period of up to 12 months (defined in SS3490.5 and 3490.6) in which Medicare is secondary for ESRD beneficiaries. If the plan payment is less than the charges for Medicare covered services and less than the gross amount payable by Medicare, and the provider does not accept and is not obligated to accept the EGHP payment as payment in full, Medicare may pay secondary benefits in accordance with 3490.8. If Medicare is inappropriately billed first, return the claim and instruct the provider to bill the EGHP for primary benefits.

IM 3491 LIMITATIONS ON PAYMENT FOR SERVICES TO EMPLOYED AGED AND AGED SPOUSES OF EMPLOYEES WHO ARE COVERED BY EMPLOYER GROUP HEALTH PLANS

B. Private Cause of Action.—Effective for items and services rendered on or after January 1, 1987, if an EGHP which is primary payer for an employed beneficiary or spouse age 65 or over described in §3491.3, fails to pay primary benefits or fails to make appropriate reimbursement to Medicare when it has paid for covered services, the beneficiary, the provider, physician, and supplier have a right to take legal action against the EGHP and to collect double damages. This is in accordance with section 1862(b)(5) of the Act as amended by section 9319 of the Omnibus Budget Reconciliation Act of 1986.

THIS PAGE REPLACE BY REV. 1338

IM 3492 MEDICARE AS SECONDARY PAYER FOR DISABLED INDIVIDUALS

A. General.—Section 9319 of the Omnibus Budget Reconciliation Act of 1986 made Medicare secondary payer to "large group health plans" for "active individuals" (as defined in C3 below) under age 65 entitled to Medicare on the basis of disability. Under the law a large group health plan (LGHP) may not "take into account" that an "active individual" is eligible for or receives benefits based on disability. The individual's coverage under the large group health plan (LGHP) must be based on the individual's employment or the employment of a family member, as explained in paragraph C.3. below. The following provides interim instructions dealing with implementation of this provision. In addition, the instructions in §§3491.7 - 3491.11 and §§3491.13 - 3491.17 should be applied in processing claims where Medicare is secondary payer for disabled individuals. Where those sections refer to an EGHP of 20 or more employees, substitute the term "large group health plan" as defined in paragraph C1 below, for the purpose of applying them to disabled individuals.

B. Effective Date.—This provision is effective for items and services furnished on or after January 1, 1987 and before January 1, 1992. The effective dates are fixed by law.

C. Definitions.—

1. Large Group Health Plan.—A "large group health plan" means any health plan of, or contributed to by an employer or by an employee organization (including a self-insured plan) that provides health care directly or through other methods such as insurance or reimbursement, to employees or former employees, the employer, others associated, or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 full or part-time employees on a typical business day during the previous calendar year. The term employer for purpose of this provision has the same meaning as the term has for purpose of the working aged provision. That definition is in §3491.2A. It includes the Federal government and other governmental entities. Note, however, that the tax penalty for nonconforming large group health plans does not apply to Federal and other governmental entities. (See paragraph I below.)

A group health plan that covers employees of at least one employer that had 100 or more employees on 50% or more of its business days during the preceeding calendar year is considered to meet the above definition of LGHP. If the plan is a multiemployer plan, such as a union plan, which covers employees of some small employers and also employees of at least one employer that meets the 100 or more employees requirement, Medicare is secondary for all employees enrolled in the plan including those that work for small employers. Note that this differs from the rule for multiemployer plans under the working aged. (See §3491.4F.)

2. Nonconforming Large Group Health Plan.—A "nonconforming large group health plan" means an LGHP that at any time during the calendar year takes into account that an active individual is eligible for or receives benefits based on disability e.g., an LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with paragraph C.3. below.

NOTE: Although the term "large group health plan" includes a plan for former employees or persons formerly associated with the employer in a business relationship, or their families, these individuals are not included within the definition of "active individual" in 3 below, i.e., Medicare is not secondary for them. These individuals are included within the definition of LGHP for tax purposes (see the tax penalty described in paragraph I below).

3. Active Individuals Subject to This Limitation on Payment.—An "active individual" is an employee, an employer (e.g., proprietor or partner), an individual associated with the employer in a business relationship (e.g., suppliers and contractors who do business with the employer and their employees) or a member of the family of any of these persons such as the spouse, parent or child of such an individual. Medicare is secondary payer under this provision for active individuals entitled to Medicare based on disability who have coverage under an LGHP.

In general, an individual who is receiving any payments from an employer which are subject to taxes under the Federal Insurance Contributions Act (FICA), will be considered an employee. This includes individuals receiving sick pay or disability benefits on which FICA taxes are payable.

In some cases, the disabled individual may be the employee, employer, or individual associated with the employer in a business relationship. This occurs, for example, in cases where the individual's disabling condition continues but the individual is permitted to test his/her ability to work under the "trial work period" provisions of the law, or where the disabled individual returns to work and qualifies for continuation of Medicare coverage for 2 years after disability cash benefit entitlement ends.

Usually, however, the disabled person is the "family member" of the employee, employer, or individual associated with the employer in a business relationship. This means that a disabled person who is not working, but who is covered under an LGHP of a spouse, parent, or any other family member is considered to be an "active individual."

D. Individuals Not Subject to This Limitation on Payment.—Medicare is not secondary for:

1. Individuals entitled, or who would upon application be entitled, to Medicare under the ESRD provision, i.e., individuals who have ESRD even though their current Medicare entitlement is on the basis of disability. However, in accordance with §3490, Medicare is secondary payer for persons under age 65 with ESRD during a period of up to 12 months regardless of the number of employees.

You can identify ESRD beneficiaries by the "S" trailer codes when you query inpatient claims (§3512.8) and outpatient claims (§3535.1).

2. Individuals who are covered by an EGHP of employer(s) of less than 100 employees, unless the EGHP is a multiemployer plan in which there is at least one employer of 100 or more employees (see paragraph C.1. above).

3. Individuals whose coverage by an LGHP is not based on either employment or a relationship to an employee, employer, or an individual associated with an employer in a business relationship. For example, Medicare is primary for a disabled individual who is covered under an LGHP as a retired former employee or the spouse of a retired former employee.

E. Action by Providers to Identify Individuals Subject to This Limitation on Payment.--Providers are instructed to identify individuals who meet the conditions in Paragraph C.3. by asking every Medicare beneficiary under age 65 (1) if the individual is an employee, a self-employed individual, or a member of the family of an employee or self-employed individual and, (2) if so, whether the individual has group health coverage through an employer. If the individual responds affirmatively to both questions, the provider will request the name and address of the employer plan and the individual's identification number and will bill the plan for primary benefits, except where the provider has information that clearly shows that the employer plan is not primary payer. If the individual responds that he or she does not meet either (1) or (2) above, or the provider has otherwise determined that the employer plan is not primary payer, the provider will bill Medicare for primary benefits and annotate item 57A on Form HCFA-1450, "Medicare."

For audit purposes and to ensure that the provider has developed for other primary payer coverage, the provider will retain a record of the development or other information on which it based its determination that Medicare is primary payer. See Section 3686 for action to take where a claim is received for primary benefits and you have reason to believe that Medicare may be secondary payer.

F. When Medicare Can Pay Secondary Benefits.—If the provider bills the employer plan first, Medicare may pay secondary benefits in accordance with §3491.13, to supplement the employer plan payment, only if all of the following conditions are met:

1. the plan payment is less than the provider's charges for Medicare covered services, and

2. the plan payment is less than the gross amount payable by Medicare (as defined in §3491.13), and

3. the provider does not accept and is not obligated to accept the plan's payment as payment in full. Refer to the billing instructions in §3682 (cost reimbursement) and §3685 (PPS reimbursement) as appropriate.

G. Recovery of Primary Medicare Payments.—Under the law, the government may recover incorrect primary Medicare benefits from any LGHP which is primary payer. To recover Medicare payments the government:

1. may bring legal action against the LGHP and may collect double damages.

2. may take legal action to recover its benefits from any entity that has been paid by the LGHP for items and services furnished an individual who meets the conditions in paragraph C.3.

3. may join or intervene in any legal action against the LGHP related to the events that gave rise to the need for the items or services.

4. is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from an LGHP.

H. Claimants' Right to Take Legal Action Against Large Group Health Plan.—Any claimant including an individual who received services, and the provider or supplier, has the right to take legal action against an LGHP that fails to pay primary benefits for services covered by both the LGHP and Medicare and to collect double damages.

I. Tax Penalty for Noncompliance.—An excise tax is imposed by Section 5000 of the Internal Revenue Code (IRC) on any employer or employee organization that contributes to a nonconforming LGHP (see paragraph C2 for definition) during a calendar year. The amount of tax is 25 percent of the total amount that the employer or employee organization contributed to LGHPs during that year. This tax penalty does not apply to Federal and other governmental entities.

J. Recovery Notice to Nonconforming Large Group Health Plan.—When recovering incorrect primary payments from a nonconforming LGHP, include in your letter to the plan, a statement that it is obligated to pay primary benefits in this case, in accordance with Section 1862(b)(4) of the law, as amended by Section 9319 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509). Explain that State laws and contract provisions are not applicable if they conflict with the Federal requirement even if they were in effect prior to January 1, 1987. Also inform the plan that, under this provision of the law, an LGHP which fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer is subject to legal actions described in paragraphs G and H above, and to the tax penalty described in paragraph I above.

K. Identification of Cases and Action Where There is Indication of LGHP Coverage In Prior Claims.—Consider the possible application of this limitation on benefits when processing all claims for items or services furnished on or after January 1, 1987 to beneficiaries for whom Medicare is secondary in accordance with paragraph C.3. When processing a claim for secondary benefits for services furnished such an individual, search your records for any prior claims on which you paid primary benefits for services rendered that individual on or after January 1, 1987, and which have not been annotated in accordance with §3491.11 to indicate a valid prior LGHP denial which would apply to subsequent claims. When you identify such claims, notify the provider and request the provider to bill the plan for the prior stays unless its records show clearly that the employer plan should not be billed as primary. The provider will submit an adjustment bill when LGHP payment is received. Refer to §3491.15 for further guidance regarding recovery of incorrect Medicare benefits where an employer plan may pay primary benefits if billed.

L. Referral of Cases to Regional Office.—Refer to the RO, any cases of a nonconforming LGHP which come to your attention which either offers secondary coverage for individuals for whom Medicare is secondary under paragraph C.3. above, or which refuses to reimburse you for any primary benefits you have paid to or on behalf of such individuals. Include, in addition to the individual's name and Medicare number, the name and address of the employer and the LGHP, the individual's group health plan identification number, and a full explanation of the reasons for the referral. The RO will consider possible legal action to collect double damages from the nonconforming LGHP. The RO will also refer such cases to the Internal Revenue Service for imposition of the tax penalty described in paragraph I on the contributing employer or employee organization. If the LGHP or employer has agreed to discontinue offering secondary coverage to disabled individuals for whom it is primary payer, or has agreed to reimburse Medicare the amount of incorrect Medicare primary benefits that should have been paid by the plan, the RO will include this information in its referral.

Once the RO refers a nonconforming LGHP to the IRS, the RO will not withdraw the referral solely because the plan has discontinued offering improper secondary coverage or has reimbursed Medicare the amount of incorrect primary benefits Medicare paid.

CHAPTER VI

ADMISSION AND QUERY PROCEDURES

	Section	Page
Admission and Start of Care Data	3501	99

Identifying the Patient's Health Insurance Record

	Section	Page
Health Insurance Card	3502	99.2
Temporary Eligibility Notice	3502.1	99.2
Health Insurance Claim Numbers	3503	99.2
Changes in Health Insurance Claim Numbers	3503.1	100
Procedures for Obtaining Missing or Incorrect HI Claim Numbers and Other Data	3504	100
Guidelines for Use of Carrier Alphabetic State List (CAST)--General	3505	100.1
Confidentiality	3505.1	100.2
Receipt and Disposition Procedures	3505.2	100.2
Explanation of CAST Data	3505.3	100.3
Using of CAST	3505.4	100.4
Guidelines for Beneficiary Identification	3505.5	100.5
Tolerances for Use with the Guidelines	3505.6	100.6
Special Conditions in the CAST	3505.7	100.7
Guidelines for Use of the Health Insurance Beneficiary State Tape (BEST) - General	3506	100.8
Confidentiality	3506.1	100.8
Receipt and Disposition Procedures	3506.3	100.10
Description in the BEST	3506.4	101.12
Special Condition in the BEST	3506.5	101.12

Admission Data Transmitted

	Section	Page
Admission Data	3507	101.2
Intermediary Number	3507.1	101.2
Provider Number	3507.2	101.2
Query Code	3507.3	103
Name	3507.4	104
Claim Number	3507.5	104
Date of Admission	3507.6	104
Date of Birth	3507.7	105
HCFA Reply to Admission Query	3510	105
Timeliness of HCFA Reply and Requery Guidelines	3510.1	105
Updating Eligibility Information Furnished in HCFA Reply	3510.2	106
Updating Eligibility When Psychiatric Inpatient Services are Involved	3510.3	106.2

ADMISSION AND QUERY PROCEDURES

	Section	Page
Part A and Part B Automatic Notices from HCFA	3511	106.3
Contents of the HCFA Reply to the Admission Query	3512	106.3
Beneficiary Identification	3512.1	106.4
Date of Admission	3512.2	106.4
Part A Data	3512.3	106.4
Part A Benefits Available	3512.4	106.4
Part A Intermediary Number	3512.5	107
Part B Data	3512.6	107
Disposition Code	3512.7	108
Explanation of Part A Trailer Codes	3512.8	112.3
Explanation of the Health Maintenance Organization (HMO) Identification Code	3512.9	112.2A
HCFA Reply to Hospice Query	3513	112.2h
Types of Replies in Response to Hospice Queries	3513.1	112.2h
Intermediary Action on HCFA Replies	3518	113
Verification of Prior Inpatient Stay	3520	113
Prior-Stay Institution is a Participating Provider	3520.1	113
Prior-Stay Institution is Not a Participating Provider	3520.2	113
Verifying 3-Day Prior Stay and the Transfer Requirement for SNF Admission	3520.3	115
Querying for Part B Services of Providers	3525	116
Part B Deductible Has Been Met	3525.1	117
Deductible Has Not Been Met	3525.2	118
First-In-First-Out	3525.3	118
Expenses for Radiology and Pathology Services	3525.4	118
Querying Expenses for Part B Provider Services	3525.5	118
Reporting Allowable Monthly Charges for Purchases of DME	3525.6	118
Retention of Part B Deductible Data by HCFA	3525.7	118
Part B Query Procedures for the Blood Deductible	3526	119
When to Query	3526.1	119
Data Furnished to HCFA in the Part B Query	3527	119
HCFA Record Maintenance and Replies	3531	123
Interrupted Period of Entitlement Under Part B	3532	123
Part B Automatic Notices From SSA	3533	124
Cross-Referring Health Insurance Claim Numbers	3534	124
Data Furnished in the Part B Reply	3535	124.1
Explanation of Part B Trailer Codes	3535.1	127.5A
Request Guidelines for Part B Queries	3536	128.3A
Requesting Assistance from HCFA in Resolving Problem Areas in the Query/Query Reply Procedures	3537	128.5
HMO Related Master File Corrections	3537.1	128.6

CHAPTER VI

ADMISSION AND QUERY PROCEDURES
Part B Queries and Replies

	Section	Page
Critical Cases		
Critical Case Procedures--Establishing Entitlement Under Part A and Part B	3538	3-128.6
Referral of Critical Cases to the RO	3538.1	3-129
Social Security Office Responsibility	3538.2	3-130
Exhibits	3550	3-131
Admission and Query Procedures for Services to HMO Members	3555	3-153
Inpatient Services to HMO Members	3555.1	3-153
Outpatient and Part B Inpatient Services to HMO Members	3555.2	3-154
Home Health Services to HMO Members	3555.3	3-157
Systems Testing		
Intermediary Systems Testing Project (ISTP)	3560	3-165
Consistency Edit Testing	3561	3-166
Retesting	3563	3-167
Addendum A--Advanced Record System		A-1

3501. ADMISSION AND START OF CARE DATA

When a patient 65 or over, or younger if entitled to Medicare as a disability beneficiary (see §3001.2), or under the provisions for coverage of persons needing kidney transplantations or dialysis (see §3001.3) is admitted as an inpatient to a hospital or SNF, information is obtained to find out if hospital insurance entitlement exists. The provider notifies you of the admission at the time it submits a bill. Send the admission data to HCFA upon receipt of the bill. (Continue to accept the admission notice from a Hospice (election of Hospice benefits)). Do not send home health start of care data to HCFA. If home health entitlement is needed, use a status query.

To expedite your bill processing, use the following guidelines upon receipt of an inpatient hospital or SNF bill to determine entitlement and benefits available:

o Key all billing data (include prior stay dates), perform consistency edits, and place bills that pass your edits on your pending file.

o If the bill fails your consistency edits, develop or reject the bill in accordance with your procedures. When the bill does pass, query the admission date and place the bill on your pending file. Match your query reply to the bill.

o Requery if a reply is not received within 7 days. Upon receipt of the query reply, utilize the data in conjunction with your records.

o In home health billing, status query only if entitlement data is needed.

Apply the inpatient deductible to a hospital bill if:

o Medicare entitlement exists,

o No prior stay is indicated on the billing,

o Your history is at least 60 days, and

o The query reply indicates a new benefit period may be in order (disposition code 01 or 25).

Check that the days used do not exceed available days in the benefit period.

o If Medicare entitlement exists, a prior stay (may be the qualifying stay for a SNF billing) is indicated on the billing, and/or you receive an 02 disposition code (see §3512.7), presume that the prior stay entry is valid and for a covered billing period unless your records indicate otherwise. You may receive an 01 or 25 disposition code if the bill for the prior stay has not been posted. Verify the prior stay entry only if your records indicate that it may be invalid.

Count the days from the prior stay (unless it is a qualifying stay on a SNF billing). Add them to the days shown for the current stay, and compare the result to days shown as available in the query reply and/or your records to determine if days have been overutilized. If days are underutilized and/or the inpatient deductible is present and noncovered days for the current stay do not account for the difference, presume that the prior stay is noncovered. Forward prior stay dates to HCFA via the UNIBILL whether or not the stay is noncovered.

Submit a status query on home health billing only if entitlement data is needed.

The admission data is recorded on HCFA's HI master record and remains as an open admission until closed by:

- o An accepted bill;
- o A delete query; or
- o An RTI VOID bill.

HCFA uses admission data, if queried and still present when a bill is received, to determine to which spell of illness to allocate the billing. (See §3835.) No admission data (open items) trailers are provided when responding to a query.

Providers try to ascertain entitlement from the patient, relatives, their records, etc. If they cannot ascertain entitlement, they may contact you.

Situations which may require your assistance are:

o When the patient dies following admission. It may be necessary to file a claim timely with an estate;

o When the patient is not in a physical or mental condition to discuss his entitlement, and no other person with knowledge of his affairs is available;

o When the provider has reason to believe the beneficiary may need his lifetime reserve days and his signature must be obtained if the available lifetime reserve days are not to be used;

o When the provider suspects that the beneficiary may have exhausted his Medicare benefits and timely confirmation is needed in order to file for possible supplemental benefits; and

o When the patient has had repeated admissions during the same spell of illness and the provider is unable to explain the available benefits to the beneficiary.

Identifying the Patient's Health Insurance Record

3502. HEALTH INSURANCE CARD.

As part of the health insurance electronic data processing, HI cards are prepared and mailed by HCFA (or in some instances by the Railroad Retirement Board where railroad retirement beneficiaries are involved) to individuals who have established entitlement to health insurance. (See § 3550, Exhibit 1A, Health Insurance Cards.) The HI card is used to identify the individual as being entitled and also serves as a readily available source of essential information to facilitate processing of payment under the program. It shows the beneficiary's name and sex, health insurance claim number, and effective date of entitlement to hospital insurance and/or medical insurance.

If you receive an inquiry about replacing a lost or destroyed HI card, inform the inquirer to get in touch with the SSA office nearest his address for assistance.

3502.1 Temporary Eligibility Notice.-- Where there is a need for immediate medical services, the social security office may issue a temporary health insurance eligibility notice. (See § 3550, Exhibit 1B.)

3503. HEALTH INSURANCE CLAIM NUMBERS.

Most HI claim numbers are 9-digit numbers with letter suffixes, e.g., 000-00-0000-A. However, it might also be a 6 or 9-digit number with letter prefixes, e.g., A-000000, A-000-00-0000; or WD-000000, WD-000-00-0000. When the status of a beneficiary changes, it is possible for the prefix/suffix of his claim number to change.

The numeric portion of the health insurance claim number frequently includes a social security number. A description of that number follows:

> The individual social security number always consists of nine digits, all of which are numeric. This 9-digit number is divided into 3 parts and separated by hyphens as follows: 000-00-0000. From left to right, the 3 parts are referred to as the "area," the "group," and the "serial," respectively.
>
> The areas range from 001 through 626 and from 697 through 729. All groups except group 00 are possible. The last 4 digits of the social security number, the serial portion, are a straight numerical series from 0001 through 9999 within each group.

The HI claim number is obtained by the provider from the patient's HI card, temporary eligibility notice, or utilization notice, or by contact with the social security office for assistance. Where the patient cannot furnish a claim number, it may be an indication that he has not filed an application with SSA to establish his entitlement to health insurance benefits, or that SSA action on a pending application has not been completed. In the latter case, there may be a delay in forwarding the admission notice while the provider awaits the SSA determination on the patient's entitlement.

The potentially valid health insurance claim numbers are as follows:

1. HCFA Claim Numbers.--

000-00-0000-	A
000-00-0000-	B, B1, B2, B3, B4, B5, B6, B7, B8, B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ, BR, BT, BW, BY
000-00-0000-	C1, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, etc.
000-00-0000-	D, D1, D2, D3, D4, D5, D6, D7, D8, D9, DA, DC, DD, DG, DH, DJ, DK, DL, DM, DN, DP, DQ, DR, DS, DT, DV, DW, DX, DY, DZ
000-00-0000-	E, E1, E2, E3, E4, E5, E6, E7, E8, E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM
000-00-0000-	F1, F2, F3, F4, F5, F6, F7, F8
000-00-0000-	J1, J2, J3,J4, (See NOTE)
000-00-0000-	K1, K2, K3, K4, K5, K6, K7, K8, K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM (See NOTE)
000-00-0000-	W, W1, W2, W3, W4, W5, W6, W7, W8, W9, WB, WC, WF, WG, WJ, WR, WT

Note: Supplementary medical insurance entitlement may exist for all J and K suffixes. However, for subscripts J3, J4, K3, K4, K7, K8, KB, KC, KF, KG, KL, KM, entitlement to hospital insurance benefits is possible only when the beneficiary is a qualified uninsured individual who secures coverage on a voluntary basis.

2. Health Insurance Claim Numbers Assigned by the Railroad Retirement Board.--
The RRB began using the social security number in their numbering system during 1964. The numbers assigned prior to that time are 6-digit numbers assigned in numerical sequence and have no special characteristics. However, both the 6-digit numbers and the 9-digit social security numbers when used as claim numbers by the RRB always have letter prefixes. (In rare cases, a qualified railroad retirement beneficiary may have a claim number with less than 6-digits; add sufficient zeros between the prefix and other digits to make a 6-digit number, e.g., WD-001234.)

A. Six-Digit Numbers.-- The basic railroad claim numbers assigned to each group of prefixes are shown below. Under the railroad retirement system monthly payment program, it is permissible for two beneficiaries to have identical claim numbers; e.g., when a widower remarries, the second wife is assigned the same claim number that was assigned to the first wife. Under the Medicare program, however, every individual has a distinctive claim number. Therefore, for Medicare purposes, the numbers in the series from 995000 through 999999 are assigned in sequence to railroad retirement beneficiaries who otherwise would have a claim number that has already been assigned to someone else.

Valid RRB claim number prefixes and numbers are:

A, MA, WA, CA, WCA, PA, JA	000001 - 991273	995000 - 999999
WD, WCD, PD	000001 - 415935	995000 - 999999
H, MH, WH, WCH, PH	000001 - 049159	995000 - 999999

B. Valid RRB Health Insurance Claim Numbers.--

A-000000, or
A-000-00-0000

MA-000000, or
MA-000-00-0000

WA-000000, or
WA-000-00-0000

WD-000000, or
WD-000-00-0000

CA-000000, or
CA-000-00-0000

WCA-000000, or
WCA-000-00-0000

WCD-000000, or
WCD-000-00-0000

PA-000000, or
PA-000-00-0000

PD-000000, or
PD-000-00-0000

H-000000

MH-000000

WH-000000

WCH-000000

PH-000000

JA-000000

The highest number assigned is known and is different for each group of prefixes as follows:

Prefixes	Numbers Assigned
A, MA WA, CA, WCA, PA, JA	000001-991273
WD, WCD, PD	000001-415935
H, MH, WH, WCH, PH	000001-049159

best copy available

3. Special Health Insurance Only Claim Numbers.--

000-00-0000- T, TA, TB, TC, TD, TE, TF, TG, TH,
TJ, TK, TL, TM, TN, TP, TQ, TR,
TS, TT, TU, TV, TW, TX, TY, TZ, and
T2, T3, T4, T5, T6, T7, T8, T9

000-00-0000 M
000-00-0000 M1

Suffix letter T indicates the individual is entitled to hospital or hospital and medical insurance and is not entitled to monthly Social Security benefits.

Suffix M indicates that the individual is entitled to supplementary medical insurance benefits. The individual may also be entitled to hospital insurance benefits but only as an uninsured individual who has voluntarily secured coverage under the 1972 amendments.

Suffix M1 indicates the individual is entitled to supplementary medical insurance benefits and has not elected hospital insurance benefits.

3503.1 Changes in Health Insurance Claim Numbers.--Changes in an individual's entitlement to Social Security or railroad retirement benefits may result in an individual being assigned a completely different HI claim number; e.g., an individual not entitled to monthly benefits (000-00-0000T) marries and becomes entitled to wife's benefits on her husband's account (111-11-1111B). If an admission notice or Part B query is submitted under the old number, trailer record code K will be used to notify you of the cross-referred HI claim number. Annotate your record accordingly, and submit all future claims under the cross-referred number.

3504. PROCEDURES FOR OBTAINING MISSING OR INCORRECT HI CLAIM NUMBERS AND OTHER DATA.

Upon receipt of an institutional provider bill (i.e., admission, start of care notice, or an outpatient bill) on which the health insurance claim number or other data is incomplete, inconsistent, missing, or obviously incorrect, no individual control or development is necessary. Return these bills to the provider with some indication of the incomplete, inconsistent, missing or incorrect item(s). This indication need not be elaborate, merely circling the incomplete, inconsistent or incorrect item would meet this requirement. The missing or incorrect data should be identified early in the process, usually in the mailroom, so that the bills can be returned to the provider quickly. Do not count returned bills as receipts.

Apply the following procedures when a query reply disposition code 52 is received or when resolving rejected bills for name and claim number discrepancies.

If the Health Insurance Beneficiary State Tape (BEST) is used, with surname/claim number matching logic routines (see§ 3506), process all bills and claims which contain an HI claim number through the automated claims processing system first. Then, clerically review and develop the pre-query rejects (i.e., partial matches for name and claim number) and post- query rejects (i.e., code 52 replies) as follows:

1. Seek the correct claim number on the Carrier Alphabetic State File (CASF) microfiche (see§ 3505.)

2. Review the source document with the data input to the automated claims processing system for errors.

3. Review the claims history file, if one is maintained and it is readily accessible. NOTE: #1, #2, and #3 may be accomplished in any order.

4. Return the bill or claim to the hospital or provider with some indication of the incorrect or inconsistent data, if the correct data cannot be determined by the preceding three instructions. Do not continue to control the bill or claim, and do not make any further attempts to obtain the correct data.

Following the regional guidelines for methods of requesting the correct name and claim number from claimants on any unassigned claims and to obtain any necessary correction of the beneficiary's health insurance record. Refer any questions to the RO concerning use of the appropriate method.

Apply the procedures in§§ 3502 and 3503 to help reduce the number of claims received with incorrect or missing claim numbers.

The CASF microfiche may be used to resolve address discrepancies resulting in undeliverable EOMB notices (see $ 3728).

3505. GUIDELINES FOR USE OF CARRIER ALPHABETIC STATE FILE (CASF)—GENERAL

The CASF is a microfilm listing of all Medicare beneficiaries residing in a geographic entity (i.e., each State, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and American Samoa). Each State listing is sequenced alphabetically by name and contains basic beneficiary identification data which has been extracted from the HI master file records. The updated CASF is usually distributed in May and November each year. The CASF (and BEST, see§ 3506) data are selected from the same HI master file.

3505.1 Confidentiality.—The CASF is governed by the same confidentiality restrictions as other information obtained in the administration of the program. (See §§ 3760ff.) Under no circumstances should it be used for any purpose other than for title XVIII claims processing. It is not to be reproduced for any purpose. Request additional copies in accordance with § 3505.2C.

Develop controls to ensure that CASF data is used only for program purposes and is not disclosed to an unauthorized party. Such controls should include limiting access to the CASF to those employees applying title XVIII beneficiary identification procedures, and the establishment of strict security procedures to guard against access to the CASF when it is not in use.

The location of the CASF copies must be accounted for at all times.

Section 1106(a) of the Social Security Act imposes criminal penalities for unauthorized disclosure of information.

The HCFA regional office (RO) will periodically review the use and destruction of the CASF.

3505.2 Receipt and Disposition Procedures.—

A. Imperfect or Missing Microfiche.—Upon receipt of new microfiche, check to insure that it is for the correct State, that all portions are printed clearly, and that all alphabetical segments are shown. If a microfiche sheet is missing or a replacement is necessary, send a letter explaining the problem to:

Health Care Financing Administration
Office of Methods and Systems, BPO
G-E-7 Meadows East
6325 Security Boulevard
Baltimore, Maryland 21207

(If a replacement is requested, include the defective microfiche with the letter.)

B. Destruction of Microfiche.—Updated microfiche will be received every 6 months and should be checked as described in A. If no problems are detected with the new microfiche, destroy the outdated CASF by shredding. The outdated CASF must not be given to any third party for use. Part 2, § 2985.3C provides instructions for destroying microfilm, which are also applicable for microfiche.

If segments of the updated microfiche are missing or unreadable, do not destroy any portion of the old microfiche until the replacement segments are received.

C. Requesting Additional Microfiche.—If additional State listings are needed, send a letter to the RO identifying the State, the number of additional listings requested, and a brief explanation justifying their need. The RO will approve or deny the request and notify you of its decision.

3505.3 Explanation of CASF Data.--The heading of each microfiche includes data to identify the contents; e.g., the State, the surname of the first beneficiary listed on the microfiche sheet, date of creation, and microfiche number. The entry for each HI beneficiary is limited to one line of data from left to right in the following order (for an example of the format, see § 3599, Exhibit 3):

A. NAME

Surname (up to 12 characters). Given name (up to 10 characters). Middle initial (1 character).	SMITH, JOHN A

B. SOCIAL SECURITY OR RAILROAD NUMBER

The nine digit Social Security number or the railroad board prefix followed by the six or nine digit number. (The prefix indicates the type of railroad benefits to which the beneficiary is entitled.)	000-00-0000 or WA-000000

C. CURRENT SUBSCRIPT

A one or two position subscript identifying the type of Social Security benefits to which the beneficiary is entitled.	A J1

D. PREVIOUS SUBSCRIPT

A one or two position subscript identifying the type of Social Security or railroad benefits to which the beneficiary was previously entitled.	B J1

E. DATE OF BIRTH

The established six digit date of birth.	12-06-03

F. STATE BUY-IN INDICATOR

If an "S" immediately follows the year of birth, the beneficiary's Part B premium was being paid by a State Medicaid agency at the time the CASF data was selected from the HI Master File.	S

G. SEX CODE

A one character code identifies the beneficiary's sex. The codes are: 1

CODE	SEX
1	Male
2	Female
0	Unknown

H. RAILROAD INDICATOR

If an "R" follows the sex code, the beneficiary was under the Railroad Retirement Board jurisdiction at the time the CASF data was selected. R

I. ZIP CODE AND ADDRESS

The zip code is 5 digits followed by as many as 64 characters of the address.

3505.4 Using the CASF.—Beneficiary data on the CASF reflects the status at the time the data was selected from the HI master file. Treat data that are subject to change (e.g., address, State buy-in indicator, and RRB jurisdiction) as indicators, it may not be current.

The CASF cannot be used to determine eligibility to either Part A or Part B benefits. Use it to obtain or verify missing, incorrect, or incomplete data such as the beneficiary's name, health insurance claim number, or address.

Use these guidelines to determine whether the beneficiary identification data on a document (e.g., HCFA-1453, HCFA-1483, undeliverable EOMB, or correspondence) matches a beneficiary on the CASF. If an item cannot be matched, follow procedures in § 3504.

Take special care when using the microfiche to insure that the correct individual is identified and that data taken from the CASF are transcribed accurately.

3505.5 Guidelines for Beneficiary Identification.—For positive identification of the beneficiary, the source document and the CASF must agree on at least one of the categories in A or B.

A. When looking for an HI claim number because it is missing, incomplete or incorrect, use the claim number on the CASF microfiche if both the source document and the CASF agree on:

1. Surname and address; and

2. (a) Given name or
   (b) First initial and sex

Individuals may be listed twice on the CASF, meeting the above criteria with the same date of birth. It is quite likely that both HI claim numbers were assigned to the beneficiary. One is the active HI claim number, the other is an inactive number which was being cross referred to the active claim number when the CASF data was selected from the HI master file. Use either HI claim number on the admission, bill or claim. If the inactive HI claim number is used, the HI computer system will post the query transaction to the active claim number HI master record and return a cross reference (K) trailer with the query reply. (See § 3512.8 and § 3535.1.)

Status query both HI claim numbers listed on the CASF, to assure that the cross reference action has been completed. If it has not, refer the item to the SSO to avoid Part A overpayments and overapplication of the Part B deductible.

B. When looking for either the given name, the address, or the sex code, and the source document contains the surname and the full HI claim number (see § 3505.3A and B), use the CASF data if both the source document and the CASF agree on the appropriate category:

1. Given Name Missing.—Use the given name on the CASF unless there is an inconsistency in the sex code.

2. Address Missing.—Use the address on the CASF unless there is an inconsistency with the name and sex code information.

3. Sex Code Missing.—Use the sex indicated on the CASF unless there is an inconsistency in the given name information.

Refer any item which cannot be matched using these guidelines, the tolerances in § 3505.6, and the procedures in § 3504, to the SSO.

3505.6 Tolerances for Use With the Guidelines.-- Use the following tolerances to determine whether an item on the source document agrees with an item on the CASF. If these tolerances are met and there is agreement on at least one of the categories listed in § 3505.5, assume that the beneficiary has been positively identified and use the name/HI claim number as it appears on the CASF.

A. Surname.-- Consider the surnames shown on the source document and the CASF to agree if: (Disregard Jr. or Sr.)

1. The spelling is exactly the same; or
2. There is only a one-letter difference in the spelling; or
3. Adjacent letters are transposed; or
4. There is a variation in one vowel or single double consonants; or
5. A "c" is included with an "sh" sound; or
6. The surname is a shortened version (clipped), e.g., Fish and Fisher.

EXAMPLES:

Surname on Source Document	Surname on CASF	Match
FISHER	FISHLER	YES
FISH	FISHER	YES
FISCHER	FISHER	YES
STEIGER	STIEGER	YES
STEINER	STIEGERS	NO

B. Given Name or Initial.-- Consider the given name or initial shown on the source document and the CASF to agree if:

1. They agree exactly; or

2. There is a variation in the spelling or an abbreviation, e.g., Dwayne for Duane, or Wm. for William; or

3. A common byname has been used, e.g., Bill for William, or Betty for Elizabeth; or

4. The initials on one document are consistent with the given name on the other. For example, the initial "J" is consistent with the name John, or any other given name beginning with the letter "J."

C. Social Security or Railroad Number.-- Consider the Social Security numbers shown on the source document and the CASF to be in agreement only if there is an exact match (including subscripts) between the two.

If the beneficiary is entitled on an RRB claim number, there must be exact agreement between the source document and the CASF on the entire claim number (RRB prefix followed by the 6-digit or 9-digit numeric number).

D. Sex.-- The sex shown on the source document and on the CASF must agree.

E. Address.-- Consider the address shown on the source document and on the CASF to be in agreement only if there is a match on house number and street, or RFD number, and zip code. Accept reasonable variations in spelling or in formatting of street or rural route designations.

Part of the address may be omitted as the entry is limited to 64 characters. Use the zip code to determine the proper town or city if it is omitted from the address data.

If the beneficiary omitted his address from the claims form or the correspondence, it may be taken from the CASF.

3505.7 Special Conditions in the CASF.-- In addition to the problems with the quality and readability, there may be other conditions on the microfiche. Some of these problems are listed below. HCFA knows about these conditions and corrective actions are being taken. Therefore, if one of the conditions listed below is shown on the CASF, do not report it to HCFA. However report conditions such as garbled surnames (e.g., O18&AB) to the address shown in § 3505.2A.

A. Names Which Appear to be Out of Sequence.-- A name such as OBRIEN may be shown in the HI computer system as OBRIEN or O BRIEN. A space or blank is a recognizable character for the computer and is treated as preceding the letter "A." Thus, OBRIEN follows OBERON , while O BRIEN might precede OATS on the same file. Names such as McPHERSON as opposed to MACHPHERSON , may also cause some problems as these names would be placed in different segments of the CASF depending upon the spelling used. This spelling is often due to beneficiary preference.

Recognize the names with spelling variations and check the different microfiche segments for them.

B. Out-of-State Railroad Beneficiaries.-- Accretion records to the HI system from the RRB contain a State code which differs from the HCFA State code. Most RRB State codes are converted to the appropriate HCFA State code before the CASF is updated. Those records which have not been converted will be shown in an incorrect State file.

C. Repetition of Names.-- A beneficiary listed twice on the CASF indicates that cross referencing of the two HI master records for the beneficiary was not completed when the microfiche data was selected from the HI master file. Follow the instructions in§ 3505.5A.

D. Missing Zip Codes.-- If the zip code is missing, every attempt will be made to include it on the next update of the CASF. If the zip code is needed, check the National Zip Code Directory.

E. No Address Shown.-- If a temporary HI record is established before receipt of the master accretion record, the address portion of the CASF will show the legend "UNK" followed by the code identifying the source of the temporary record. If the address is needed, request it from the SSO, the hospital, the physician, or supplier.

3506. GUIDELINES FOR USE OF THE HEALTH INSURANCE BENEFICIARY STATE TAPE (BEST)--GENERAL.

The BEST is a magnetic tape file containing records for beneficiaries residing in a geographic entity (i.e., each State, the District of Columbia, Puerto Rico, Guam, Virgin Islands, and American Samoa) when the file is created. The records on each file are sequenced alphabetically by name and contain basic identification data for the beneficiaries. The BEST data is obtained from the same HI master beneficiary file as the Carrier Alphabetic State File (CASF), see§ 3505. Thus, the BEST contains the same data as the corresponding CASF update.

Updates of the BEST files are distributed every 6 months, usually April and October.

3506.1 Confidentiality.-- The BEST is governed by the same confidentiality restrictions as other information obtained in the administration of the program (see§ 3760ff). Since the BEST file contains identification data for HI beneficiaries, under no circumstances should it be used for any purpose other than for title XVIII claims processing. It is not to be reproduced for any purpose, except as specified in§ 3506.5.

Develop controls to ensure that BEST data are used only for program purposes and are not disclosed to an unauthorized party. Such controls should include limiting access to the BEST data to employees for title XVIII claims processing and should establish strict security procedures to guard access to the BEST when it is not in use. Section 1106(a) of the Social Security Act imposes criminal penalties for unauthorized disclosure of information.

The RO will periodically review the use of the BEST.

3506.2 Receipt and Disposition Procedures.-- Upon receipt of a new or updated BEST file, list and review a significant portion of each reel to ensure that it is for the correct State and that all alphabetical segments are included.

If two contractors using the BEST occupy the same premises (e.g., a Blue Cross Plan and a Blue Shield Plan) only one BEST file will be provided.

A. Requesting Initial Tapes.-- To initially receive the BEST, send a letter including the following to the RO:

1. the State tape(s) requested;

2. the specific mailing address to which the file should be forwarded;

3. an explanation of how the BEST will be used; and

4. a brief explanation of how use of the BEST will improve the claims processing operations and not impact unfavorably upon the average cost per claim.

If multiple copies of the CASF microfiche are received for your service area State(s), review their uses and include in the BEST request any reductions in the number of copies required in future CASF distributions.

The RO will approve or deny the request and notify you of its decision.

Do not request the BEST file for a State outside your service area. The claims volume for such a State will usually not justify use of the BEST. Follow the procedures in§ 3504 for resolving name and claim number problems where the beneficiary resides outside your service area.

B. Imperfect (Unreadable) or Incomplete Magnetic Tapes.-- If a volume (reel) or segment of the BEST is missing or cannot be read by the computer, and a replacement is requested, return the file with a brief letter explaining the problem to:

Health Care Financing Administration
Office of Methods and Systems, BPO
G-E-7 Meadows East
6325 Security Boulevard
Baltimore, Maryland 21207

A replacement will be forwarded.

C. Acceptable Magnetic Tapes.-- If the new tapes are complete and readable, establish control of the tape file and use the file for its intended purpose. Decontrol the old tape file and return it to your blank tape stock.

3506.3 Description of BEST.-- The external tape label identifies the file as "HABEST" followed by four alpha/numeric characters.

A. Tape Characteristics.--

1. The tape is 9 track, 6250 BPI density with odd parity.
2. The tape header label is IBM OS Standard.
3. Data records are a fixed length of 125 characters.
4. The blocking factor is 50.
5. A tape mark precedes the trailer label on each reel.
6. The trailer labels are IBM OS Standard.

B. Data Record Description.--

Data Record Position	Data Definition
1 - 12	Surname (up to 12 characters)
13 - 22	First Name (up to 10 characters)
23	Middle Initial (if none, this portion is blank)
*24 - 32	Social Security Number (9 digits)

Data Record Position	Data Definition
*33 - 34	Current Subscript (1 or 2 alpha/numeric characters identifying the type of Social Security benefits to which the beneficiary is entitled).
* - 35	Blank
36 - 37	Previous Subscript (1 or 2 alpha/numeric characters identifying the type of Social Security or railroad benefits to which the beneficiary was entitled. If none, these positions are blank.) If both positions are numeric, ignore them as they are an internal HCFA code.
38 - 43	Date of Birth (the established 6 digit date of birth - MMDDYY).
- 44	State Buy-In Indicator: If an "S" exists in this field, the beneficiary's Part B premium was being paid by a State Medicaid Agency at the time the file was created.
- 45	Sex Code:

Code	Sex
1	Male
2	Female
0	Unknown

- 46	Railroad Indicator. If an "R" exists in this field, the beneficiary was under RRB jurisdiction at the time the file was created.
47 - 51	ZIP Code (5 digits)
52 - 53	Blank
54 - 119	Address (up to 66 characters)
120 - 124	The individual's own Social Security Number in IBM packed decimal format. If it is not available, the field will be zero filled.
- 125	Record Mark (≠)

*For a railroad retirement beneficiary, positions 24 - 35 indicate:

, A Railroad Claim Number. The 1 - 3 character RRB prefix followed by the 6 or 9 digit number. The prefix indicates the type of railroad benefits to which the beneficiary is entitled. The Railroad Number is left justified in all cases, regardless of length.

EXAMPLE: A000000bbbbb or A000000000bb
MA000000bbbb or MA000000000b
WCA000000bbb or WCA000000000

3506.4 Special Conditions in the BEST.—In addition to problems of quality and completeness of the magnetic tape, there may be other conditions to be aware of on the BEST. The contents of both the CASF and the BEST are identical; therefore, the conditions and guidelines in § 3505.7 also apply to the BEST.

3506.5 Using the BEST.—

A. General.—The BEST data reflects the status of master HI records for the beneficiaries at the time the file was created. Treat data that are subject to change (e.g., welfare and railroad indicators, address) as indicators rather than as being current.

NOTE: Current Part A or Part B entitlement cannot be determined, nor should be determined, from the BEST file data.

Use the BEST in the automated claims processing system prior to querying, if its use improves claims processing operations and does not impact unfavorably on the cost per claim. The BEST may be most efficiently used to:

o expand an existing early identification type file with the BEST data to obtain on-line data entry savings of beneficiary names and addresses; and/or

o expand existing early identification or history files (but not both) with the BEST data for matching beneficiary surnames and HICNs on Medicare claims prior to query, using the surname and claim number matching logic routines which HCFA uses to process queries.

Do not use the BEST to update existing records on history or early identification files for names, addresses, etc. This use may actually "downdate" the file(s) since the data is subject to change and may not be current.

It is not recommended that the BEST be used as a screening or early identification type file without using at least one of the HCFA matching logic routines. Seeking an exact match of name, claim number, sex code, address, etc., could cause an increase in the number of prequery partial match exceptions requiring clerical review and development, thereby impacting unfavorably upon claims processing time and cost per claim.

The matching logic routines resolve problems of:

1. surnames - blank spaces, one letter differences, transposition of adjacent letters, extra or missing letters, and Soundex coded equivalent surnames; and

2. claim numbers - one number differences, transposition of adjacent numbers, and where the suffixes are equatable.

The expansion of early identification or history files and the use of the matching logic routines should substantially reduce the pre-query partial match exceptions requiring review and development for the correct names and claim numbers. The number of interim query responses (e.g., code 00) that you receive should be reduced.

Process all claims through the matching logic routines. If the name and claim number pass the routines, query HCFA or pay the claim, depending on the Part B deductible status. Clerically review claims rejected by the routines (see SS 3504 and 3505) and develop for the correct name and claim number prior to query as they will probably result in a query reject and further processing delay. All claims with names and claim numbers not in file (first claim for a newly entitled beneficiary) should not be clerically reviewed and developed before querying HCFA.

The BEST file or data may also be used in intermediary and hospital/provider "on-line" computer networks (e.g., Electronic Media Claims systems) to verify names and HI claim numbers. This use should be cost justified and should not be just a systems "enhancement" or "sophisticated" systems application. The HI card should continue to be the primary source of a beneficiary's name and HI claim number. Obtain the current entitlement status by querying HCFA.

Access to an "on-line" BEST file or data by the hospital/provider, or its billing agent must be through your software program routines. Such access should use the same data as required by the HCFA query/query reply system (i.e., surname, first initial, HI claim number, date of birth/sex code). Establish procedures and criteria, to be approved by the RO, for the hospital/provider to follow in accessing the "on-line" file/data.

Responses to a hospital/provider request for a name or HI claim number verification can be a "yes" or "no", a not-in-file, or to provide the claimant's (patient's) correct name and HI claim number. Do not disclose a list of "possible" names and/or HI claim numbers to any hospital/provider or its billing agent.

Do not disclose beneficiary names and HI claim numbers to a billing agency or company that is not a contractural agent of the hospital or provider of Medicare services.

Other uses of the BEST may be identified or developed. Obtain in writing the RO's approval of such uses, after an evaluation has assured that they are cost effective and will improve the claims processing operations.

B. Documentation of Surname and Claim Number Matching Logic Routines--Copies of flow charts with a narrative of the logic rationale and program line coding (i.e., ANSI-COBOL) for the matching logic routines can be obtained from the RO.

Admission Data Transmitted

3507. ADMISSION DATA.

Upon receipt of an inpatient hospital or SNF bill, make certain all data below is complete and consistent prior to transmitting admission data to HCFA.

3507.1 Intermediary Number.—The number is used in lieu of a name and address and identifies the intermediary processing the claim.

3507.2 Provider Number.--This 6-digit number identifies the provider.

The first 2 digits represent the State or foreign country in which the provider is located. The third, or third and fourth digits indicate the type of institution (e.g., Hospital, SNF, HHA, or Psychiatric Hospital). The remaining digits are assigned sequentially.

Example where the third digit indicates type and the last three digits identify the provider:

21 0 003
State (21) Maryland)
Type (0) (Short stay - general hospital)
Serial (003) (identifies provider)

The following shows the significance of the last 4 numbers:

0001-0899	Short-term (General and Specialty) Hospitals
0900-0999	Multiple Hospital Component in a Medical Complex
1000-1099	Independent Ambulatory Surgical Centers
1100-1199	Hospital-Affiliated Ambulatory Surgical Centers
1200-1299	Alcohol/Drug Hospitals
1300-1499	Physical Therapists in Independent Practice
1500-1799	Hospices
1800-1899	Federally-Funded Comprehensive Health Centers
1900-1989	Reserved for future use
1990-1999	Christian Science Sanatoria (Hospital Services)
2000-2299	Long-Term Hospitals
2300-2499	Chronic Renal Disease Facilities (Hospital Based)
2500-2899	Non-Hospital Renal Disease Treatment Centers
2900-2999	Independent Special Purpose Renal Dialysis Facility
3000-3024	Formerly Tuberculosis Hospitals (Numbers Retired)
3025-3099	Rehabilitation Hospitals (Excluded from PPS)
3100-3299	Reserved for Future Use
3300-3399	Children's Hospitals (Excluded from PPS)
3400-3499	Reserved for Future Use
3500-3699	Renal Disease Treatment Centers (Hospital Satellites)
3700-3799	Hospital Based Special Purpose Renal Dialysis Facility
3800-3974	Rural Health Clinics (Free-Standing)

3975-3999	Rural Health Clinics (Provider Based)
4000-4499	Psychiatric Hospitals
4500-4599	Comprehensive Outpatient Rehabilitation Facilities
4600-4999	Reserved for Future Use
5000-5999	Skilled Nursing Facilities
6000-6499	Reserved for Future Use
6500-6899	Outpatient Physical Therapy Services
6900-6989	Reserved for Future Use
6990-6999	Christian Science Sanatoria (Skilled Nursing Services)
*7000-7299	Home Health Agencies
7300-7399	Subunits of "Nonprofit" and "Proprietary" Home Health Agencies
7400-7799	Continuation of 7000-7299 Series
7800-7999	Subunits of State and Local Governmental Home Health Agencies
8000-8999	Independent Laboratories
9000-9799	Reserved for Future Use
9800-9999-	Portable x-ray suppliers. (For identification only. Portable x-ray suppliers do not submit admission notices.)
S000-S999-	Psychiatric Components
T000-T999-	Rehabilitation Components
U000-U999-	Swing Bed Components
V000-V999-	Alcohol-Drug Units

*In Virginia (State 49) the series 7100-7299 has been reserved for State-wide components of the Virginia Home Health Agencies.

The largest short-term hospital, the "parent" organization of a multiple provider complex, (§3008), retains the original provider number. The component hospital is assigned a number in the 0900 series following the 2-digit State code.

Hospitals certified for emergency services only, but not certified for full participation, are assigned a special number with a letter suffix, i.e., 2100E or 2100F. The first two digits are the State code. The third, fourth, and fifth digits are assigned in sequence beginning with 001 and are not related to the above 4-digit numbers.

3507.3 Query Code.—This is a 1-digit code indicating the type of action required for handling the claim. It identifies the type of query as follows:

PART A QUERY CODES

1	Original Query	Request for benefit eligibility information. When a match of the HICN is made, an admission is established and a response will be received from HCFA.
2	Delete Query	If incorrect data was transmitted in a query code 1, send query code 2 to delete it and a query code 4 with the correct data. Both queries may be transmitted on the same day. HCFA transmits disposition code 03 when the admission has been deleted; code 00 when the beneficiary cannot be identified, and code 49 whenever (1) there is no matching admission, or (2) you attempt to delete an admission created by an interim bill.
4	Requery	When an original query (Code 1) has not been answered within 7 days (see §3501 for counting days) resend it using this code. An admission will be created in HCFA's files if none exists, and a response will be sent. Use a code 4 after you have cancelled an admission with a code 2 query and are replacing the cancelled admission with a new query. This assures that the reply received reflects that HCFA has processed the code 2 deletion.
5	Status Query	Use this query to request: o Status information if the admission on the billing has not been transmitted and entitlement status is in question; o The admission has been queried and information is needed to resolve an inquiry; or o Identification of the appropriate HMO and/or its payment option is needed. Enter "000000" as the provider number if you desire hospital or SNF status information. To obtain HHA information, enter "007000." If both types of information are desired, both Type "5" queries are necessary.

6	Bill History Query	Use this query to request an HI Bill Retrieval Listing (Bill History) from HCFA to resolve a beneficiary's utilization status. The record formats for the Bill History query are in §3550, EXHIBIT 7. See also §§3830.1 and 3840.2 for location of the queried Bill History on the Batch Clearance Tape and the conditions which preclude its release.

7 **Hospice Query**

Use this query to add, terminate, change, or delete a period of Hospice election on a beneficiary's Master record. Use the information contained on the Hospice Election Form (see § 3672) when completing it. HCFA matches this query to the beneficiary's record and updates the record accordingly, or rejects the query. The reply indicates HCFA's action(s). (See §§3100ff. and 3672.) The formats for the Hospice query are in §3550, Exhibit 12. Replies are in §3513.

Each beneficiary has available 3 periods of Hospice care which must be 'elected' by the beneficiary. The start of 'election' of Hospice care must be posted to the HCFA beneficiary record. Once posted, it is not necessary to terminate a period of Hospice election unless the benficiary so chooses. Once a period is begun, HCFA automatically terminates the period; if it is the first or second period it is terminated at the end of 90 days; if it is the third period, it terminates at the end of 30 days.

A beneficiary is allowed to change to a different Hospice once during each period of Hospice care. The receiving Hospice sends you a copy of the Hospice election form, annotated with the appropriate change data. Send a query to post the change to the benficiary record. Show the date of the beneficiary's involvement with the new Hospice in the start date field. If the beneficiary elects early termination of a period of Hospice care, submit a query to record it. Use the original start date of the applicable Hospice period. A query is not necessary to record a date of death.

HCFA does not automatically start a second or third period of Hospice care. Therefore, at the end of the first and second periods of Hospice care, verify that the beneficiary is still being serviced by the Hospice. Verification may consist of a telephone contact. Upon verification, send a query to post the second and/or third period of Hospice care.

3507.4 Name.—Furnish on each query. Transmit only 11 characters of an individual's last name and one or two initials. If known, space after the surname and show: Jr, Sr, III, etc.; do not use any punctuation. Show two-word surnames as one word. HCFA uses the name information and the HICN furnished to identify the individual's utilization record.

3507.5 Claim Number.—The HICN is required for processing an admission query. This number is variable. The number can contain up to 12 characters or as few as 7. (See §3504.)

3507.6 Date of Admission.—Take this six digit number from the provider's entry on its bill. Show the month, day and year.

Show the actual date of admission even where the effective date of entitlement is later. For example, where a patient entered a general or psychiatric hospital on March 25, 1985, and became entitled to hospital insurance on April 1, 1985, show 032585.

For psychiatric hospitals with qualifying distinct parts, show the date of admission to the qualifying distinct part, even where the treatment or diagnostic procedures did not begin until a later date.

Where a patient is admitted prior to the date that the provider agreement became effective, show the effective date of the provider agreement.

In cases involving change of ownership, where participation of the facility is continuous, show only one admission, the actual date.

3507.7 Date of Birth.--Furnish the month, day and year of birth if it is available. Do not delay the query if it is not known. While the date of birth is useful as identification and should be shown when available, the admission query will be processed without it.

An individual is considered to attain age 65 the day before his birth date. For example, if his 65th birthday is November 1, 1985, he "attained" age 65 October 31, 1985, and is entitled to hospital insurance benefits October 1, 1985.

3510. HCFA REPLY TO ADMISSION QUERY.

3510.1 Timeliness of HCFA Reply and Requery Guidelines.--HCFA prepares a reply for each admission query received. Any query received by HCFA prior to 7 PM is processed that night. Where more than one admission query for the same individual is processed on the same day, HCFA sorts first by dates of admission and then by query code.

When HCFA is unable to send a definitive reply immediately, it sends a message acknowledging receipt. Consequently, you always receive a reply within one or two days, even if the reply is merely an acknowledgment.

Requery when no reply has been received after 7 working days have elapsed (allowing for scheduled down-time). This should be necessary only occasionally since only a "read" or "write" error within the HCFA EDP system or a malfunction of the communications system can cause this.

NOTE: HCFA's policy of scheduled down-time for Federal holidays is as follows: The central computer and related facilities close at midnight (Eastern Time) on the last workday (Monday through Friday) prior to the holiday and open at 12:01 AM (Eastern Time) on the first regular workday (Monday through Friday) following. The holidays are: New Year's Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Columbus Day, Veteran's Day, Thanksgiving, Christmas, and as of 1986, Martin Luther King Jr., Birthday.

Upon receipt of Part A reply disposition codes 00, 52, 60, 65, 90, you may requery if and when, corrected or additional data is available. (See S3512.7.) Obtain corrected data by checking the HICN against CAST, or by contacting the provider, and if necessary, the beneficiary.

After any query has been pending HCFA investigation for 75 days, a reject disposition code 54 is returned unless an earlier reply showed disposition code 09 as the status. If reply code 90 preceded the reply code 54 reject, the case may have been referred to the appropriate program service center, but was rejected by HCFA due to the 75 day limitation on retaining queries. (The 75 day time frame for a definitive reply by HCFA does not apply to disposition code 09.) See S 3536 concerning requery guidelines for Part B queries.

3510.2 Updating Eligibility Information Furnished in HCFA Reply.--The HCFA reply to an admission query shows benefit days remaining and deductibles to be met as of:

- The last recorded date of discharge, or

- The date of the last action, in the event an admission exists for which a partial billing has been processed.

The HCFA reply shows benefit days and deductibles remaining after adjustments based upon the last interim or discharge bill. If it was an interim bill, the reply to the next query shows benefit days and deductibles remaining after the record is updated. The date of discharge field shows if that date is more recent than the last discharge date.

Since HCFA has no knowledge of days used or deductibles met on any unreported items, it is important to determine from your' records the remaining eligibility. To determine available days, consider the information obtained by the provider from the beneficiary regarding any prior stays.

When development establishes that the beneficiary has not been an inpatient for 60 consecutive days, begin a new spell of illness and apply the proper inpatient deductible amount.

The examples below illustrate methods of updating eligibility.

Example 1 - Current Admission Begins a New Spell of Illness

A type 1 hospital query is sent to HCFA showing a January 1, 1984 admission. HCFA replies that the last discharge date of record is May 1, 1983, 15 full and 30 coinsurance benefit days remain, and inpatient and blood deductibles met. The 2-digit field showing the year the benefit period began contains "83."

Since more than 60 days have elapsed from the last discharge of record, begin a new spell of illness unless the hospital; or your records show a prior stay within the past 60 days. Make certain that the inpatient deductible is applied and that program payment is not made for days beyond those allowed.

Example 2 - Open Admission Begins a New Spell of Illness

A type 1 hospital query is sent to HCFA showing a March 2, 1984 admission. HCFA replies that the last discharge date is July 1, 1983, 30 full and 30 coinsurance days remain, the inpatient deductible is met, two pints towards the three blood pints remain to be met, and "83" as the year the benefit period began. A hospital open admission exists (no bill accepted) for a December 1, 1983, admission. Apply days and deductibles based upon query response unless your files show information regarding the December 1, 1983 admission. If beginning a benefit period as of March 2, 1984, make certain that the $356.00 inpatient deductible is applied to the bill and that program payment is not made for days beyond those allowed.

Example 3 - Current Admission Continues Spell of Illness

A type 1 hospital query is sent to HCFA showing a January 11, 1984 admission. HCFA replies that the last discharge date of record is October 15, 1983, 10 full and 30 coinsurance days remain, inpatient deductible met, 2 pints needed to satisfy blood deductible, and "83" as the year the benefit period began. A hospital open admission exists for December 1, 1983.

Although no open admission data is given by HCFA, you find that the discharge for the December 1, 1983, admission occurred on December 15, 1983, and that one pint of blood was furnished. Since fewer than 60 days elapsed between the discharge date shown by HCFA and the December admission date and between the December earlier stay discharge date and the current admission date, the patient is in the same benefit period. Reduce the number of days remaining and blood deductible to be met shown in the HCFA reply, by the amounts in the earlier stay which have not been reported to HCFA.

Example 4 - Interim Bill Posted for an Admission

A type 1 hospital query is sent to HCFA showing January 20, 1984. HCFA replies that the last discharge date of record is November 30, 1983, 15 full and 30 coinsurance days remain, inpatient deductible met, 2 pints needed to satisfy blood deductible, and "83" as the year the benefit period began. A partial, non-PPS (interim) bill is posted for a November 15, 1983, admission with a last interim date of November 30, 1983.

You find that the discharge for the November 15, 1983, admission occurred on December 16, 1983, (total stay of 31 inpatient days including 16 days already posted by HCFA, and that 2 pints of blood had been furnished (1 pint posted from interim bill).

The inpatient deductible is zero. Make certain no full days, no more than 30 coinsurance and 60 lifetime reserve days have been applied, and no more than 1 blood pint is applied for the January 20, 1984, admission.

3510.3 Updating Eligibility When Psychiatric Inpatient Services are Involved.--An inpatient of a psychiatric hospital on the first day of entitlement to hospital benefits is subject to a reduction of inpatient days available in the first spell of illness. Any inpatient days in a psychiatric hospital (participating as of the beneficiary's first day of entitlement) in the 150-day period preceding entitlement reduce the 150 days available in the first spell of illness. The reduction of days could also apply to a subsequent general hospital stay, but only if that admission is primarily for the treatment or diagnosis of mental illness.

Determine if a reduction applies as well as the amount of the reduction. Investigate only if the current admission is to a psychiatric hospital or to a general hospital primarily for the treatment or diagnosis of mental illness.

When it is the first admission, investigate the amount of any utilization in the 150-day period before entitlement. To alert you to this need on subsequent admissions, the query reply includes disposition code 28. This code is furnished where HCFA's records indicate that the patient may still be in the first spell of illness, the first stay admission was to a psychiatric hospital, and because of an inpatient stay in a psychiatric hospital prior to entitlement, benefit days had been reduced.

See §3104 for determining days available when the reduction applies.

3511. PART A AND PART B AUTOMATIC NOTICES FROM HCFA

HCFA automatically reports certain events that affect the beneficiary's current and/or future status and the processing of claims. They are sent under Part A to intermediaries who have open admissions, and under Part B to intermediaries which have submitted Part B queries.

The automatic notices are Type 7 replies. Each reported event has an assigned disposition code which is given in the notice. For Part A, the assigned disposition codes are 39, 78, and 79. (See §3512.7.) For Part B outpatient claims, the disposition codes are 36, 39, 70, 71, 72, 77, and 79. (See §3535.)

Upon receipt of an automatic notice, take the action indicated by the disposition code given.

3512. CONTENTS OF THE HCFA REPLY TO THE ADMISSION QUERY.

The first character in the reply to is the reply code. It is either a 1, 3, 4, or 7.

Type 1 - Is a reply to an admission from a hospital or SNF and furnishes eligibility data.

Type 3 - Is an acknowledgment, it furnishes no eligibility data. (Where type 3 contains disposition code 49, the data submitted is shown.)

Type 4 - Is a rejection and signifies that the admission could not be processed because it failed the initial EDP edit.

Type 7 - Is an automatic notice to let you know, if your open admission is on record at the time of a change in the beneficiary's status. It has a special disposition code identifying the event. (See §3512.7.)

3512.1 Beneficiary Identification.--The HICN sent with the claim always appears. Where either the name or HICN for the admission is different from that in HCFA's records, a corrected name or number appears in a special field. Change the information on the billing form to reflect the information furnished in the reply.

3512.2 Date of Admission.--The date of admission appears as that on the bill unless it is an impossible date, in which case, HCFA's processing date appears.

3512.3 Part A Data.--

A. The Effective Date.--This shows the first month of entitlement to benefits. No payment can be made for Part A services furnished before the first day of that month. If the patient is not entitled, either no entry (blanks) or zeros (BCA system involved) appear.

B. Date of Last Discharge.--If HCFA processed a final bill for a prior inpatient hospital or SNF stay, the date of last discharge is shown or, if HCFA processed an interim bill covering a period later than the discharge, the last covered date of the interim billing period is shown. (For code 25 replies, the date of discharge can be from an unposted bill.)

3512.4 Part A Benefits Available.--This shows inpatient benefit days remaining and deductible to be met as of the date of last discharge, or billing through date, of an interim bill. It also shows the amount of the blood deductible and inpatient deductible yet to be satisfied, as well as inpatient full payment days, coinsurance days and psychiatric days remaining. Up to 90 inpatient benefit days are shown. HCFA maintains a record of the additional 60 days of lifetime reserve of inpatient hospitals days for each individual. The reply to the admission includes the number of lifetime reserve days only if there are fewer than 60 remaining. (See Addendum A, §7 (ARS).)

A. Selecting Correct Part A Deductible and Coinsurance Rates.--The applicable coinsurance and deductible rates depend upon when the benefit period began. Use the chart in §3211 to determine them. A 2-digit field indicating the year the benefit period began is in the query reply following the Part B effective date and preceding any trailer codes. The year is in the fixed part of the HCFA query reply. Where there has been no reduction in benefits on HCFA's records, i.e., no prior utilization has been recorded, the year shown is a presumed year.

B. Determining Blood Deductible.—The blood deductible to be satisfied is indicated by numeric code. The following identifies each code:

CODE	EXPLANATION
0	Blood deductible satisfied (on code 42, 49, 50, 51, and 52 replies, 0 does not mean the deductible has been satisfied).
1	Blood deductible to be satisfied is 1 pint.
2	Blood deductible to be satisfied is 2 pints.
3	Blood deductible to be satisfied is 3 pints.

3512.5 Part A Intermediary Number.—Your identification number assigned by HCFA.

3512.6 Part B Data.—

A. Part B Cash Deductible.—A "1" or "2" means that the deductible is, or is not met, respectively. An "0" means there is no Part B entitlement.

B. Part B effective Date.—If the individual had Part B coverage as of the date of admission, the month and year of Part B coverage are furnished. TERM appears in the Part B Effective Date field to reflect a termination of Part B benefits. If the beneficiary has never been entitled to Part B benefits, the Part B Effective Date field is blank.

Reimbursement for services of radiologists and pathologists to hospital inpatients is made under Part B for 80 percent of the reasonable charge and can be billed on HCFA-1450. (See §3604.) When the reply to the admission indicates that the individual had Part B coverage at admission, assume Part B coverage through the end of the hospital stay or until Part A benefits are exhausted, whichever is earlier.

3512.7 Disposition Code.--This describes the reply. It may encompass caution signals, no record indications, questionable items, errors, etc.

Listed below are the identifications and explanation:

DISPOSITION CODES - PART A

Disposition Code	Admission Established	Condition
00	No	HCFA acknowledges receipt of the query, but a reply is delayed. The name and/or HICN does not match a record on the HI master file. HCFA will send a definitive reply within 75 days if the individual is identified, or a code 52 if not. If you determine that the original admission contained an incorrect HICN or surname, requery immediately using the corrected data and delete the original. If a definitive or disposition code 90 reply is not received within 30 days, requery using the same information submitted in the original. Do not refer 00 replies to the Social Security Office. Approximately 55 percent of these cases are resolved by HCFA within 5 days.
01	Yes	Approval. The beneficiary has never used Part A services. This is an initial admission for this beneficiary.
02	Yes	Approval. Some prior Part A utilization. Last recorded date of discharge is within 60 days of this date of admission and there are no query-related open items on HCFA's records.
03	No	Acknowledgment. HCFA has processed a query code 2 (cancel) and deleted the admission.
09	No	Acknowledgment. This acknowledges receipt of the query. However, a definitive reply cannot be furnished at this time due to adjustment, cross-referencing, or clerical correction actions currently being taken. If a definitive reply is not received within 60 days, forward a letter including the HICN and name of the beneficiary to: Health Care Financing Administration Correspondence Services Branch, OMB 6325 Security Blvd. Baltimore, MD 21207

Disposition Code	Admission Established	Condition
		If a final reply is not received from HCFA within 45 additional days, refer the case to the RO under the critical case procedure in §3538.1. NOTE: The 75 day time limit for a definitive reply by HCFA does not apply to disposition code 09.
22	Yes	Qualified Approval. Admission date precedes date of entitlement to Part A. A trailer code of T and/or P may be appended. The T trailer gives the date of termination. A P trailer gives the dates of an earlier period of entitlement if the date of admission in the query is before the earlier period of entitlement.
23	Yes	Qualified Approval. Previously reported deceased. The admission date is in, or prior to, the month of death.
25	Yes	Qualified Approval. An admission date was received for this beneficiary prior to the current query, and the date of the current admission is 60 days or more after the last discharge date from a posted bill. According to HCFA's records, the current admission starts a new benefit period. The remaining Part A benefits given in the code 25 are always as of the last bill posted. There may be an earlier or later stay(s) for which no bill has been accepted. Make any needed development of nonrenewable days (lifetime reserve or psychiatric) remaining and determine if any noncovered stays continue a benefit period through the current admission.
26	Yes	Qualified Approval.—Alien nonpayment provision may apply. No payment may be made until HCFA reports in writing that payment is not barred. (See §3716 for explanation of this provision and development of these cases.)

Disposition Code	Admission Established	
27	Yes	Qualified Approval. The admission date on the current query precedes the last recorded discharge date or the date on the last processed interim bill shown on HCFA's records. This reply shows the utilization remaining as of the date of last billing action. Determine if your admission falls within the current benefit period, a prior benefit period, or links two benefit periods. This may require a code 6 query (§3507.3) to obtain a Bill Retrieval Listing (Bill History). Apply the utilization remaining within the applicable benefit period to your current admission.
28	Yes	Qualified Approval. The beneficiary appears to be in an initial spell of illness, first admission was to a psychiatric hospital, and a reduction in days was applied. Investigate the 150 day preentitlement period if the current admission is to a psychiatric hospital or to a general hospital primarily for the treatment or diagnosis of mental illness and the beneficiary is still in his first spell of illness. Code 28 does not apply to SNFs. (See §§ 3510.3 and 3104.)
38	No	Rejected. An admission query has been received which: 1. Contains the HICN and surname of a deceased beneficiary whose record has been placed on the inactive file, i.e., the beneficiary has been deceased more than 1 year without any query or billing activity. The query, however, failed to match on all personal characteristics, i.e., initial and date of birth. OR

Disposition Code	Open Item Established	
38(Cont.)		2. Perfectly matched an inactive record of a deceased beneficiary.

Information furnished in this reply includes:

- o HICN
- o Surname (6 positions)
- o Initials
- o Date of birth (month and year)
- o Date of death (month, day, and year)
- o Sex code (1=male; 2=female)
- o Admission date (month, day, and year) as shown in the admission query
- o Provider number as shown in the admission query.

Review the data in your admission query and, if the admission was for a different beneficiary, develop the appropriate data and resubmit a type 1 query. If the original admission was for the beneficiary identified in the reply and the date of death is correct on the HI record, use the data to submit a corrected query. A code 09 reply will be generated immediately and within 30 days a definitive reply will follow once the inactive record has been retrieved.

If the admission was for the beneficiary identified in this reply and the date of death is incorrect, refer the case to the SSO via form HCFA-1980, Carrier or Intermediary Request for SSA Assistance, (or a locally agreed upon form).

Include the following information:

Disposition Code	Admission Established	
38(Cont.)		o HICN; o Name and full address on the claim form; o Part A disposition code 38; o Date of death as shown on the admission reply; o Date of death, (if any) indicated on billing form; o A statement that the case is forwarded for date of death investigation and/or correction; o Signature and title of person completing the request form; o Your return address; and o Copies of any documentation pertaining to the case at your disposal. The SSO investigates the date of death issue and when necessary, initiates corrective action. The SSO notifies you of any action taken by HCFA by completing and returning part II of form HCFA-1980 or the reply portion of a locally agreed upon form. (If the SSO reply is delayed, use regional guidelines for followups. If there is no reply after 90 days, refer the case to the RO.)

Disposition Code	Admission Established	
39		(See page 112.1, disposition codes for automatic notices.)
41	Yes	Qualified Approval. Query-related benefit including 60-day lifetime reserve for inpatient hospital stays is exhausted. No benefits are available unless this stay begins a new spell of illness or home health service are involved.
42	No	Disallowed. No entitlement to Part A, but entitled to Part B. Submit a Part B bill.
43	Yes	Qualified Approval. The beneficiary was previously reported deceased on a billing form or similar document and the date of this admission is after the month of death indicated on the HI Master Record. The date of death is indicated in a six-digit month-day-year format after trailer record Code "U" (see §3512.8). If the actual day is not available "OO" appears in the day field (e.g., 010085). When you receive a disposition code 43: Verify whether the patient is the same individual previously reported deceased, and check the accuracy of the HICN and service dates. For example: review the original bill for consistency of identification data (name, sex, date of birth); check the beneficiary's full name, address, sex, and HICN (including suffix) against the CAST; compare the admission dates with those contained in the query. If the review shows the date of death is correct, send a code 2 query to delete the admission.

Disposition Code	Admission Established	
43(Cont.)		If the review shows the date of death must be investigated by HCFA, inform the provider that bill processing will be delayed pending HCFA's resolution of the date of death discrepancy. (You need only insure that the correct data has been queried. No additional date of death investigation is necessary before referring the case to the SSO.)

To have the date of death verified or corrected on HCFA's records, refer the case to the SSO via Form HCFA-1980 (Carrier or Intermediary Request for Assistance, see §3706) or other locally agreed upon form.

Include the following information:

- o HICN;
- o Name and full address on the claim form;
- o Part A dispositon code (43) (show 52II for RTIs);
- o Date of death (if any) indicated on bill;
- o Provider's name;
- o A statement that the case is forwarded for date of death investigation and/or correction;
- o Signature and title of person completing Form HCFA-1980;
- o Your return address; and
- o Copies of any documentation pertaining to the case that is at your immediate disposal.

The SSO investigates the date of death issue, and where necesssary, initiates corrective action. The SSO notifies you of the action taken by completing and returning part II of Form HCFA-1980 or the reply portion of a locally agreed upon form. (If the SSO reply is delayed, use regional guidelines for followups. However, if there is no reply after 90 days, refer the case to the RO.)

Disposition Code	Admission Established	
43(Cont.)		Upon receipt of the SSO findings process the bill accordingly. Keep the SSO reply on hand until the bill is processed. If the bill becomes a 5211 RTI (see §3828.1), use the SSO reply for immediate resolution. Do not refer date of death discrepancies involving railroad beneficiaries to the SSO. Instead, send completed HCFA-1980s to: Railroad Retirement Board Health Insurance Operations 844 Rush St. Chicago, Il 60611 The RRB will investigate, initiate corrective action, and provide notification in the same manner as the SSO.

Disposition Code	Admission Established	
44	No	Rejected.--Entitlement to Part A benefits has terminated and the date of admission is subsequent to that date. Reasons for termination: o The beneficiary is no longer considered disabled; o Twelve months have passed since renal transplant; o Twelve months have passed since course of dialysis was terminated; o Withdrawal (by desire) of premium paying beneficiary; o Nonpayment of Part A premium for a premium paying beneficiary; o Entitlement as a Part A qualified uninsured beneficiary is terminated because Part B entitlement terminated; or o An insured beneficiary is no longer entitled to monthly benefits.
46	Yes	Qualified Approval.--A reply with code 46 means that the individual had a prior admission to a Christian Science SNF and the current admission is to a regular SNF, or he had a prior admission to a regular SNF and the current admission is to a Christian Science SNF, and both admissions may be in the same spell of illness. After an individual has received covered extended care services in a Christian Science sanatorium, he cannot, during the same spell of illness, receive covered extended care services in a regular SNF. Also, after he has received covered extended care services in a regular SNF, he cannot, during the same spell of illness, receive covered extended care services in a Christian Science sanatorium.

Disposition Code	Admission Established	
		Upon receipt of a code 46 reply, investigate any prior stay SNF and determine whether the current admission continues the benefit period or whether a new benefit period has begun. If a new benefit period has begun or the prior SNF stay was noncovered, pay for the current stay. If the current stay is noncovered, submit a no-payment bill. (See §3610.)
47	No	Reply to Duplicate Admission Query. HCFA replied based upon a prior query. There is only one admission on HCFA's records. Treat as any other approval. An "L" trailer code containing the original disposition code is furnished.
48	No	Rejection. Not entitled to Part A or Part B benefits.
49	No	Rejection. HCFA cannot delete the admission because there is no matching admission on the file and an interim bill has been posted. The data submitted are shown on the reply.
50	No	Rejection. The name, HICN, and personal characteristics furnished in the query match the non-HI records. However, HCFA determined that the individual has not filed for HI entitlement. This is authorization to deny the claim. Referral of the claim to the SSO is not required, but the denial must refer the individual to the local SSO if the individual disagrees with the denial.
51	No	Rejection. The name, HICN, and personal characteristics furnished in the query match the non-HI records. However, HCFA determined the individual is not eligible for HI benefits. This applies also to individuals receiving SSI benefits, but under

Disposition Code	Admission Established	Explanation
		the age of 65 and not eligible for HI benefits. Since most of these cases are disallowed for failure to establish proof of age or residence requirements, the individual may become eligible at a later date.
52	No	Rejection. The claim number furnished is not assigned to the surname furnished in the query. This code indicates the surname and/or HICN given in the query is incorrect or, in some cases, that the HI master record is incorrect. Check the surname and number against the claim. If they agree, check the CAST/CASF (§3505) for another spelling of the surname or a difference in the claim number. If this does not resolve the issue, follow §3504. Requery when you obtain the correct name and HICN.

Dispostion Code	Admission Established	Explanation
54	No	Reject. The surname, HICN, and initial or date of birth furnished in the query match HCFA's non-HI records, but HCFA is unable to resolve the exception item within a 75 day time limit. Initiate the following actions: o Seek the correct HICN on the Carrier Alphabetic State File (CASF microfiche). (See §§3505ff.) An appreciable number of Code 54s involve individuals entitled under another claim number. o Ascertain whether another claim for the same individual has been cleared on receipt of corrected claim data. o Review the source document with the data input to the automatic claims processing system for errors. o Review the claims history file, if maintained and readily accessible. o If the claim number is obtained, requery as appropriate. If the data cannot be resolved deny the claim. Referral of the claim to the SSO is not required but the denial must refer the individual to the local SSO if the individual disagrees with the denial.

Disposition Code	Admission Established	
57	No	Individual Is Eligible for HI Benefits But Has Not Filed a Claim Refer to SSO. The name, HICN, and personal characteristics furnished in the query match HCFA's non-HI records and indicate that the individual is eligible for HI benefits but has not filed a claim. Check the name against the Carrier Alphabetic State File (CASF) microfiche before proceeding with regional instructions for referring the claim to the parallel SSO for resolution. The parallel SSO will undertake the necessary development and advise you when to requery.

NOTE: "Status" indicated in the following Disposition Codes is related to replies to queries transmitted under Query Code "5."

Disposition Code	Admission Established	
60	No	Status. Investigation action is being taken to check the name and/or HICN. If HCFA is unble to locate the record or reconcile the name differences, a reply with a disposition code "65" will be sent within 75 days. Requery, if and when, corrected or additional data is obtained.
61	No	Status. No Prior Part A utilization.
62	No	Status. Eligibility has been reduced by prior utilization.
63	No	Status. Previously reported deceased on a billing form.
64	No	Status.—Entitlement to Part A benefits has terminated and the date of admission is subsequent to that date.

Disposition Code	Admission Established	
65	No	Status.--Unable to identify the beneficiary under HICN furnished in the query. Recheck the HICN and name. If necessary, contact the SSO. (A previous reply was sent under code "60.") Requery if, and when, corrected or additional data is available.
66	No	Status.--No entitlement to Part A, but entitled to Part B.
67	No	Status.--No entitlement to Part A or Part B.
68	No	Status.--The beneficiary appears to be in his initial spell of illness, the first admission was to a psychiatric hospital, and a reduction in days was applied. This code does not apply to SNFs or HHAs.
69	No	Acknowledgment.--This acknowledges receipt of the query. However, a definitive reply cannot be furnished due to adjustment, cross-referencing, or clerical correction actions being taken. If a definitive reply is not received within 60 days, forward a letter, including the HICN and name of the beneficiary to: Health Care Financing Administration Correspondence Services Branch, OMB 6325 Security Blvd. Baltimore, MD 21207 The 75 day time frame for a definitive reply from HCFA does not apply to disposition code 69.

Disposition Code	Admission Established	
90	No	Acknowledgment.--The name, HICN, and personal characteristics furnished in the query matched a non-HI record. The individual has filed a claim, but the entitlement is not presently reflected in the HI Master. Development has been initiated to resolve the situation. If the HI record can be established within the 75 day time limit, an appropriate response will be provided. If the 75 day time limit expires, a code 54 is generated. Requery if and when additional or corrected data is available before the 75 days expire.

Disposition Codes for Automatic Notices

NOTE: Part A automatic notices consist of the following disposition codes:

39	Notice of Chronic Renal Disease.--This indicates the beneficiary has ESRD. The specific reason for coverage is appended in an S trailer. The notice is sent to all intermediaries who have current admissions (open) on the HI Master for this individual.
78	A Change in Part A Entitlement.--This notice is sent to all intermediaries who have current admissions (open) on the HI Master for this person. The entitlement of the beneficiary to Part A benefits has changed (i.e., entitlement is terminated or is reinstated after termination). The notice alerts you to a possible change in utilization which may be required for billings occurring during a period of termination or reinstatement. Where entitlement terminated, the notice gives the month and year. Payment cannot be made for services provided after the last day of the month indicated. Where entitlement is reinstated, the termination date field is blank.

Disposition Code	Admission Established	
		Review all pertinent bills in process or submitted to HCFA for processing, and notify the appropriate provider(s) of the notice. If coverage was denied for the period of nonentitlement and is now permitted because of reinstatement, new bills may be required. If the bills have not been submitted to HCFA submit them. If the bills have been submitted to HCFA and accepted, debit/credit adjustments may be required to show the data changed. (See disposition code 44 for reasons for termination.)
79		Enrollment in or Disenrollment from an HMO, or Change in HMO Option.--This notice is given when the beneficiary enrolls, disenrolls from, or his option in an HMO is changed. Annotate your records and process claims in accordance with the information in the notice. See §§3512.8 and 3512.9 for information about queries regarding HMO members. The data content given in an R trailer (see §3535.1) is also given.

3512.8 Explanation of Part A Trailer Codes.--The trailer code is a 1-position alpha code which identifies the contents of the following data. HCFA may include one or more trailers in a reply. A trailer supplies information not contained in the main body of the reply. Descriptions of the Part A trailer codes follow: (See Addendum A, §7, for ARS formats.)

Trailer Code	Data Furnished
B	Corrected Surname.--This field is used only if the name in the query is not consistent with HCFA's records. If your investigation indicates HCFA has an incorrect name, process the claim and supply all pertinent documentation including the data contained in the B trailer as well as the correct data via a HCFA-1980 to the SSO for correction.
NOTE:	The B record code will not be generated if there is only a one position error in other than the first letter of the first six positions of the surname.

Trailer Code	Data Furnished
C	Corrected HICN.--The corrected number is included only if the HICN submitted is incorrect.
G	Lifetime Reserve Benefit Days.--This trailer is furnished when the number of lifetime reserve benefit days remaining are fewer than 60 as of the last recorded date of discharge or interim bill. It is given only when one or more lifetime reserve days have been used.
K	Cross-Referred HICN.--HCFA transmits this information whenever a beneficiary's HICN is cross-referred to another. Process the beneficiary's current claim(s) using the new number, and cross-refer any beneficiary files you maintain. On subsequent claims use the claim number given on the K trailer.
L	Original Disposition Code.—This trailer is furnished with a disposition code 47 reply (which is a reply to a duplicate admission). The purpose of the L trailer is to give the disposition code that was furnished in the original response.
M	State Buy-In.—HCFA transmits this information whenever the HI records indicate current involvement with State buy-in. This individual

Trailer Code		Data Furnished
(S Cont.)	3	The individual has, or had, ESRD but is currently covered by the disability provision. (See §3687 for required development.)
	4	The individual is age 65 or over and is covered by Medicare as an uninsured or old-age or survivor insured, and has ESRD.
	8	The individual has ESRD and is covered under the Part A premium payment provision.
	9	The individual is covered under the Part A premium payment provision.

NOTE 1: Five extra positions are added to show the reimbursement method and effective date for ESRD beneficiaries receiving home dialysis. When this applies, we follow the regular trailer code with 1 to show that the beneficiary elected Method I, or 2 for Method II. Following the method is the effective date (MMYY) of the election that applies to the service period shown in the query.

NOTE 2: Codes 2, 3, 4, and 8 apply for the reporting of ESRD cases as required by HCFA. Refer to §§3644ff. for procedures concerning the submission of ESRD bills.

All claims for services received by beneficiaries are entitled based upon disability, ESRD, or who are Part A Premium Payers subject to special workload reporting. For workload and financial reporting:

Codes 1 and 3 cover Disability
Code 2 covers ESRD
Codes 8 and 9 cover Part A Premium Payers

T — Termination of Current Period of Part A Entitlement.--This gives the month and year of termination for reasons other than death. It may be transmitted with any approval or qualified approval reply. A T trailer is always transmitted with disposition Code 44 which furnishes the reason for termination.

U — Date of Death.--This gives the month, day and year of death as recorded in the HI Master.

It may be transmitted with any approval or qualified approval reply. It is always transmitted with disposition codes 23, 43, and 63. The description for disposition code 23 includes a previously reported deceased beneficiary where the admission date is prior to the month of death. The description for disposition code 43 furnishes you necessary action in resolving date of death problems. A disposition code 63 is the corresponding status reply. If the actual day is not available, "00" appears in the day field (i.e., 010084).

Trailer Code

Y Other Program Involvement.--This indicates that some other insurance program may be the primary payer. It is possible to receive multiple Y trailers. Their number depends upon the number of Other Program annotations present on the beneficiary's record. In all cases, annotate your records and proceed in accordance with the following instructions. (See §3550, Exhibit 16 for trailer format.)

The Other Program Code indicates the other federal program or other type of insurance that may be the primary payer for claims submitted by/for this beneficiary. Possible codes are:

Code 1.This is furnished when the HI Master indicates that this beneficiary has WC coverage. Check the diagnosis on the claim. If it appears that the services may have been necessitated by an accident, or if it consists of an occupational disease, withhold payment until you determine that the services for which payment is claimed are not covered by WC. Fully develop the issue in accordance with §§3415ff. Contact the State Workers' Compensation Agency (§3599, Exhibit 10) of the beneficiary's State of residence to obtain information about this WC award. If his home State is not the award State, obtain the appropriate address by writing to:

Health Care Financing Administration
Office of Management and Budget, DMOS
P. O. Box 17078
Baltimore, MD 21203

Code 2.This is furnished when HI Master BL indicates that this beneficiary is on the Department of Labor's (DOL) beneficiary rolls. Enter the annotation "BLACK LUNG" on your reply to the notice of admission. Check the diagnosis on the claim. If it appears from the diagnosis or the services performed (see §3415.3 E and F) that all or part of the inpatient services on the claim were attributable to BL disease, deny the claim. (See §3722.4 MISC-15 for denial paragraph.)

NOTE: For the following codes, annotate your records and use them as alerts if you receive improperly completed claims. In addition, annotate your reply to the notice of admission indicating the type of potential other payer involvement. These codes are an indication that Medicare was determined not to be the primary payer on at least one previous claim. In addition, Code A also includes individuals whose SSA record shows the presence of a S2 LAF code.

Code A.Medicare was not primary because the beneficiary was a 'working aged' beneficiary or spouse covered by an EGHP based on a prior claim or the beneficiary's record shows the presence of an S2 LAF code. An S2 LAF code indicates the beneficiary is in suspended benefit payment status because of earned income and could be a potential "working aged." (See §3686 for development.)

Trailer Code	Data Furnished
	Code B. Medicare was not primary because this beneficiary was determined to be an ESRD beneficiary in the 12 month coordination period and was covered by an EGHP. (See §§3491ff.) Code C. Medicare has made a conditional payment on a claim until a final resolution (of the claim) is decided. One type of conditional payment is where there is/was a pending liability claim. (See §§3419ff.) Code D. Medicare was not primary because of automobile medical, no-fault, or other liability insurance involvement. (See §§3419ff. and 3489ff.) Code E. Medicare was not primary because of WC. (See §§3407ff.) Code F. Medicare was not primary because the beneficiary was entitled to coverage by the PHS or other Federal agency program. (See §3153.) Code G. Medicare was not primary because the beneficiary was a disabled beneficiary covered by a LGHP. (See SIM 3492.) Code H. Medicare was not primary because of BL coverage. (See §3414.2.) Code I. Medicare was not primary because the beneficiary was involved in the VA program. (See §3153.2.) The effective date contained in this trailer indicates: For codes 1 and 2 the effective (entitlement) date of the applicable program involvement. For codes A, B, C, D, E, F, G, H, and I the earliest date on record indicating actual (from prior claim) or potential (from SSA LAF code) Medicare coverage as secondary. See §3686 for development instructions upon receipt of any of these Y trailer codes.
Z	Hospice Involvement.—This trailer is given when the beneficiary's record indicates one or more periods of Hospice involvement. Only the applicable period of Hospice is included. Once a beneficiary elects Hospice care, all care for the terminal condition must be under the auspices of the Hospice. Contact the servicing intermediary identified in the trailer (see §3550, Exhibit 17) to determine if the claim is for services related to the Hospice care. If it is, deny payment. (See §§3100ff.) If the claim is not for services related to the Hospice care make payment if they are otherwise covered. See §3550, Exhibit 14 for the record format of the Z trailer.

3512.9 Explanation of the HMO Identification Code.--When a beneficiary has HMO involvement, explanatory information, including an identification code, is furnished in an R trailer appended to the reply to the admission or start of care notice. (See §3512.8.) The code is a five-position alpha numeric which identifies each HMO within a State. The first position is always an H. The second and third positions give the applicable State Code. The fourth and fifth positions give the serial number (01 through 99) assigned to the particular HMO within the State.

3513. HCFA REPLY TO HOSPICE QUERY

HCFA responds to each Hospice query received. If no response is received within 7 working days (not including holidays, Saturdays or Sundays) retransmit the query using the same information. The HCFA response indicates the results of your query after it has been processed to the beneficiary record.

3513.1 Types of Replies in Response to Hospice Queries.—HCFA responds to the Hospice query using one of the following replies:

Edit Reject - Type 4
If HCFA cannot process the query because it failed the initial EDP edits, a Type 4 reply is returned. The reply contains an indication of which data element was in error. (See §3550, Exhibit 13 for record format.)

Acknowledgement - Type 3
If the query passes the initial EDP edits, but HCFA is unable to process the query to a beneficiary record, a Type 3 reply is returned. (See §3550, Exhibit 13.) The reply contains one of the following disposition codes:

Disposition Code	Meaning
00	See §3512.7, disposition code 00.
09	See §3512.7, disposition code 09.

Definitive - Type 5
A definitive reply is returned by HCFA when the record is processed against a beneficiary record, or if no matching beneficiary record can be located. The reply contains an indication of the action taken by HCFA. In addition, a Z (Hospice) trailer is appended (except codes 38 and 52). It shows how the applicable Hospice period appears on the beneficiary record. (See §3550, Exhibit 13.) The reply contains one of the following codes:

Disposition Code	Meaning
10	A Hospice query has been received by HCFA and the applicable start, termination, change or void was accepted and posted to the beneficiary record. The attached Z (Hospice) trailer shows

Disposition Code	Meaning
	the applicable Hospice period after your query was applied. A Z trailer containing all blanks, returned on a response to a void query, indicates that the query voided the only period of Hospice on the beneficiary record.
11	A Hospice query has been received by HCFA and the applicable start, termination, change or void was not accepted because: o There is a Hospice period already in progress and your start date falls within the applicable 90 or 30 day period; o The start date submitted on a termination action does not match a start date on the beneficiary record; o You are attempting to void (cancel) a period of Hospice but one or both of the start and/or termination dates do not match a period of Hospice on the beneficiary record; o You are attempting to change the intermediary and/or Hospice number in an existing period of Hospice but the appropriate period has already been changed (only one change per period is allowed); o You are attempting to add a new period of Hospice but the beneficiary has already used the three allowable periods; or o You are attempting to delete a period of Hospice for which Hospice bills have been received. The attached Z (Hospice) trailer shows the applicable Hospice period as it appears on the beneficiary record.
38	See §3512.7, disposition code 38.
42	See §3512.7, disposition code 42.
43	See §3512.7, disposition code 43.
44	See §3512.7, disposition code 44.
48	See §3512.7, disposition code 48.
52	See §3512.7, disposition code 52.

3518. INTERMEDIARY ACTION ON HCFA REPLIES

Examine the HCFA reply, and on the basis of the disposition code, date of last discharge or last action, compute the remaining eligibility. Take into consideration any bills paid but not recorded by HCFA.

Determine the days available, the applicable coinsurance and deductible rates, and the amount of the deductible, if any, to be met as of the date of admission on the current bill. In order to do this, review the query reply and check your records for any admissions where HCFA has not posted a bill. (See §3512.7.) Use any unreported hospital stays that come to your attention.

If the bill submitted by the provider is incorrect according to your calculations, correct the bill and process accordingly. Apply the guarantee of payment provision, if the provider justifies payment under that rule. (See §3714.)

3520. VERIFICATION OF PRIOR INPATIENT STAY

A noncovered or unreported stay in Item 33 of the HCFA-1450 may affect the patient's eligibility and deductible and/or coinsurance liabilities. Inpatient benefits, except for lifetime reserve days, are related to a spell of illness. Once begun, a spell of illness cannot end until the individual has not been an inpatient of a hospital or SNF, for 60 consecutive days, starting with the date of last discharge.

An individual's benefit days are subject to reduction if he was an inpatient in a participating psychiatric hospital on the first day of entitlement and also received inpatient psychiatric services during the 150 days before entitlement in a psychiatric or a general hospital that was participating as of the first day of entitlement. (See §§3104 and 3510.3 for necessary development.)

3520.1 Prior Stay Institution Is a Participating Provider.—The HCFA reply shows the date of last discharge or last covered date reported on an interim bill. If this is consistent with the prior stay allegation on the current admission and other hospital transfer information, (see §3520.3), no further action is required. If it is not, consult your records and where necessary contact the prior stay provider or servicing intermediary to verify the entry and to obtain a claim if appropriate. Providers are to maintain the name and address of a prior stay facility indicated by the beneficiary. Where such contacts are necessary, resolve the issue of potential waiver in accordance with §3520.3.

3520.2 Prior Stay Institution is Not a Participating Provider.—When the HCFA reply shows a date of last discharge that is more than 60 days before the date of the current admission, the current admission usually begins a new spell of illness. Verify prior stay dates only if your records and/or a reply from HCFA indicates that the prior stay may not be valid. There is no need to contact a prior-stay nonparticipating provider where the HCFA reply shows that there are fewer than 60 days between the date of last discharge or the last date billed on a partial bill and the current admission, since the current stay continues the spell of illness.

If no date of last discharge or interim bill date is shown on the HCFA reply, no further development is necessary.

Where the stay was in a hospital outside of the United States, accept the patient's allegation of a prior stay without verification (in the absence of contrary evidence), and assume that a stay of 1 or more days prolonged the spell of illness. (See §3035.)

Where the institution listed in Item 33 is an emergency hospital, see §3035 for spell of illness implications.

From the dates of stay, determine:

- o Whether the stay in the nonparticipating portion prolonged the benefit period, or
- o Whether 60 days elapsed from the date of discharge to the present admission.

3520.3 Verifying 3-Day Prior Stay and the Transfer Requirement for SNF Admission.—The 3-day prior stay hospital admission and discharge dates are entered on the bill by the SNF in Item 33. The names and addresses of any SNFs and the name and address of any hospital in which intervening stays occurred (regardless of length) is maintained by the provider. (Institutional stays in the 60-day period prior to the 3-day hospital stay are shown last.

In counting days for a qualifying 3-day hospital stay, count the day of admission as a day, but not the day of discharge. In counting days for the 30-day transfer requirement, do not include the day of discharge from the prior hospital stay.

Rely on information in Items 15 and 33 of the HCFA-1450 in determining whether the 3-day hospital stay and 30-day transfer requirements are met. When an HMO has jurisdication over processing a bill, return the bill to the provider with instructions to send documentation with the bill sufficient for the HMO to determine if the 3-day hospital stay and 30-day transfer requirements are met.

The SNF completes Item 33 from information given on the hospital transfer form or shown in a written SNF record of a telephone coversation with the transferring hospital.

If the prior-stay hospital is not a participating hospital, psychiatric hospital, or a participating distinct part of a psychiatric hospital, it may satisfy the prior-stay requirements if it meets at least the definition of hospital described in §§3010A, E, and G.

If an intervening stay occurred between the 3-day hospital stay and the current SNF admission, the SNF attaches a detailed explanation to the billing form. You or the HMO, depending upon jurisdiction, determine whether such intervening stay extended the 30-day transfer period.

Part B Queries and Replies

3525. QUERYING FOR PART B SERVICES OF PROVIDERS.

Part B deductibles are recorded from queries. (See §3510J for HCFA's policy of scheduled down-time for Federal holidays relative to Part B query replies.)

Query your first Part B claim for an individual in a calendar year to determine if the individual is eligible and whether or not the Part B cash deductible has been met.

Routinely send a Part B query if the waiver of liability provision is applicable and the beneficiary is not at fault. (This includes cases where the provider is at fault and potential indemnification exists--see §3446.) These queries serve to update the deductible in HCFA's HI Master.

Send a Part B status query if the waiver of liability provisions are considered, but the beneficiary is found to be at fault. Status queries do not update the deductible, but their replies contain eligiblity information needed to send the proper denial notice.

When the time limitation expires before the provider files a claim for payment, the following rules control assessment of the Part B deductibles:

o If the provider was responsible, send a Part B expense query to update the deductible.

o If the beneficiary was responsible, the deductible and coinsurance are not assessed. Instead of a Part B expense query, submit a status query to determine Part B entitlement and the type of denial letter to send.

3525.1 Part B Deductible Has Been Met.--

If a query reply is for other than a status query and indicates that the deductible was met, and the current request does not involve Part B blood, process the claim without querying HCFA.

Exception 1: Subsequent Year.--The above applies only within one calendar year. When HCFA has received queries from other contractors it notifies you of certain events as indicated in §3511. Query HCFA for deductible status in the new calendar year in the same manner as the prior year; i.e., until a HCFA reply is received indicating that the current year's deductible has been met or that the Part B blood deductible has been met.

Exception 2: Deductible Information Not Available In File.--Query for each Part B claim processed.

Exception 3: Purchase of Durable Medical Equipment.--Submit a status Z query to HCFA before making a periodic payment for the purchase of DME, except when medical necessity is being reevaluated. (See §3113.7E.) This query is necessary to insure against overpayments when the updated record indicates benefits terminated due to death, nonpayment of premiums, or withdrawal.

3525.2 Deductible Has Not Been Met.—If your records do not show that the deductible has been met, submit a Part B expense query.

3525.3 First In - First Out.—Before payment can be made for covered expenses in the calendar year, the individual must meet the Part B cash deductible. Apply expenses toward the deductible in the same order that the bills are received, regardless of the dates expenses were incurred. (If bills are received simultaneously, apply the deductible on the basis of the earlier incurred dates. If two or more bills involving one beneficiary are received from different sources on the same day, with the same incurred date, prorate the deductible.)

Total benefits paid must be the same regardless of the order in which the bills are received and paid.

3525.4 Expenses for Radiology and Pathology Services.—Reimbursement for professional services of radiologists and pathologists is made by the carrier under Part B. These expenses do not count as incurred expenses toward the cash deductible on the bill you process; therefore, never include them in the Part B expense query. The reply to the Part A admission query furnishes the effective date of Part B coverage. (See §3512.6B.) Use a Part B status query when necessary.

3525.5 Querying Expenses for Part B Provider Services.—Where Part B inpatient and outpatient SNF services (see §3640.3) are furnished, transmit a Part B query to HCFA reporting billed charges.

3525.6 Reporting Allowable Monthly Charges for Purchase of DME.—Payments may be made for the purchase as well as the rental of DME. Where the equipment costs more than $50, or it is decided that a payment for equipment costing $50 or less will not be made in a lump sum, set up a diary for continuing payment. Until the deductible is met, send a separate Part B query for each monthly allowed charges based upon the rental value of the equipment. (See §3113.7B for the date expenses for DME are incurred.) After the deductible has been met, transmit Z status queries.

3525.7 Retention of Part B Deductible Data by HCFA.—HCFA retains deductible status in its HI Master for a maximum of 5 years and a minimum of 1 year.

3526. PART B QUERY PROCEDURES FOR THE BLOOD DEDUCTIBLE

There is a separate Part B blood deductible equal to the charge for the first three pints of blood furnished an individual in a calendar year. (See §3235.2.) When blood deductible data is shown on a query, it is recorded on the utilization record. The query need not show whether the blood was replaced or unreplaced since the blood deductible is on an incurred basis. Report blood in terms of complete pints, rounded upwards, i.e., if a beneficiary receives 1 1/2 pints of blood, report 2 pints.

3526.1 When to Query.—When a claim involves blood and you have information in file that:

o Both the cash deductible and blood deductible are met, no query is necessary.

o The cash deductible is met but the blood deductible is not met; your query should show in the sex/blood field pints of blood furnished up to a maximum of three.

o The cash deductible is not met and the blood deductible is met; your query should show as reasonable charges total Part B expenses including covered charges for blood. Expenses for which Medicare reimbursement is not due because of the blood deductible cannot be applied toward the annual cash deductible.

o Neither the cash deductible nor the blood deductible is met; your query should show as reasonable charges all covered expenses, basing the computation of noncovered expenses for blood on the deductible pints remaining as shown on the last query response shown. Show the pints of blood furnished, up to a maximum of three, in the sex/blood field.

If reasonable charges for blood included in the query prove incorrect based upon HCFA's reply, send a type A or I reply, as appropriate, to correct the record.

EXAMPLE: Four pints of blood were furnished at $10 per pint = $40, and $10 for blood administration. Your record for the beneficiary shows none of the cash deductible is met and one pint of the blood deductible is met. Send a Part B query showing reasonable charges of $30 ($20 for blood and $10 for administration) and three pints of blood furnished.

If the reply shows that two pints of the blood deductible remain to be met, no requery is necessary. If the reply shows that one pint remains to be met, submit a type I query showing $10. This increases the money amount in the cash deductible record to the correct amount of $40.

3527. DATA FURNISHED TO HCFA IN THE PART B QUERY

A. Intermediary Number.—Enter your number on each request so that HCFA knows where to send the reply. Errors in furnishing this information result in the request not being processed or in routing the reply to the wrong intermediary. If you have both an A and B intermediary number, use the A intermediary number when processing Part B queries for "provider" claims (outpatient claims, for example).

B. Intermediary Control Number.—This number is a processing or identification number you assign. It may contain up to 10 alphanumeric characters.

Assign a control number to each query to identify the query (except it is not necessary to assign one to a Z query).

Each new query for an individual must have a different control number, except when it is a followup. When you followup because HCFA has not responded, send an exact duplicate of the initial query using the same intermediary control number used in the initial query. When retransmitting a previously rejected query, however, you may use the same or a different control number. By following this procedure, you enable HCFA to prevent duplicate posting of the same bill. For a period of 75 days HCFA maintains sufficient query identification data on the beneficiary's record to enable detection of duplicate queries. The query identification data includes the control number and is maintained for accepted Part B queries only.

Since identical control numbers are HCFA's only method of detecting duplicate queries for outpatient services (which may represent duplicate bills or potential duplicate payments), exercise control to insure: Your responsible personnel are fully trained in the recognition and handling of duplicate query responses; bills are not routinely requeried beyond the 75-day HCFA control number retention period and that control numbers are not changed to negate HCFA's duplicate detection screens

If HCFA determines that the control number in the query matches the control number of a previous query, the expenses are not posted. HCFA transmits a reply containing disposition code 03, 04, 07, 08, 23, or 28, as applicable. This indicates the reply is a duplicate of a previous reply that was transmitted with a disposition code 01, 02, 05, 06, 21, or 26.

When sending an A-coded query (to adjust or cancel), use a different intermediary control number than the one used in the I-coded query that is being canceled or adjusted. When an A-coded query generates a reply with disposition code 03, 04, 07, 08, or 28, it indicates that the A query contained the same intermediary control number as a previously submitted I query and that the Medicare Bureau has not posted the cancellation/adjustment. Retransmit the A-coded query using a different intermediary control number.

When you transmit an I query and the Medicare Bureau rejects it with a disposition code 23, it indicates the I query contained the same intermediary control number as an earlier A query. The individual's record has not been updated and you should retransmit the I query using a different intermediary control number.

When you transmit a query which does not contain an intermediary control number, the Medicare Bureau transmits a type 4 "reject" reply. The reason for the rejection is indicated by the inclusion of the intermediary control number trailer record code "A," preceding the word "OMITTED." An asterisk is shown at the end of the field, the usual procedure to indicate that this is the field that was incorrect in the query.

C. Explanation of Query Code.--This tells the EDP system what type of action to take as a result of the query. The Part B query codes, A through D and G through Z, are listed below with an explanation of when each is used.

Establish controls to assure that initial queries are not inadvertently sent twice, since this could result in double processing and incorrect updating of the deductible and/or noninpatient psychiatric expense amounts. Each Part B query code, except Z, has a companion code to be used for sending a second request. Second requests may be made if no reply has been received after 7 days (not including Saturdays, Sundays, and legal Federal holidays).

If you follow these instructions, you will rarely, if ever, receive duplicate replies. However, if second requests are sent prematurely, it is quite possible that two replies will be received.

When you send a second request on a Part B query, establish a control to assure that only one reply is received for the item. If two replies are received and the disposition code of one of the replies does not indicate that the reply is a duplicate of a previous reply, cancel the followup query by sending a message using query code A. Otherwise the Medicare Bureau processes the data twice and incorrectly updates the deductible status for an individual.

Use Query Code:	To Followup on Prior Query Code:
B	A or B
D	C or D
H	G or H
J	I or J
Z	Z

NOTE: Query codes A, B, C, and D are adjustment query codes. None of these coded queries should be sent until a reply has been received indicating that the Medicare Bureau has recorded the query to which the adjustment is directed. Also, it is not necessary to cancel a query if the Medicare Bureau has rejected it--see disposition codes in § 3535.

Query Code	Explanation
A	Void or Credit Query. When a previously sent query is to be canceled, whether or not it is replaced, cancel it by retransmitting the prior query data using an A or B query code (and a new intermediary control number). When the canceled query is to be replaced, transmit the corrected query using an I or J query code. It is also permissible to use an A- or B-coded query to reduce the money amount. Retransmit the prior query showing the amount by which the previously reported expenses are to be reduced.

To increase the money amount, it is also permissible to use a new I- or J-coded query to transmit the difference between the amount in the previous query and the larger, correct amount.

Use query code B to retransmit a query coded A when no response has been received.

C Void or Credit Query - Termination or Prior Period of Entitlement Involved. Use this code to cancel a query sent with query code G or H. Retransmit the earlier query using a C (D) query code and a new intermediary number. It is also permissible to use a C- or D-coded query to reduce the money amount. Retransmit the earlier query showing the amount by which the previously reported expenses are to be reduced.

The intermediary should also use a C (or D) query code to cancel medical expenses that were posted to the HCFA record in error; i.e., where HCFA sent an approval reply to a query and later sends a notice of termination, nonentitlement, or special intermediary involvement, or that the beneficiary is in a lock-in status in a Health Maintenance Organization (HMO). When such medical expenses are removed from the HCFA record in reply to a C or D query, HCFA sends a disposition code 21 or 23 reply in which the entitlement field is blank. (See § 3535.) Use query code D to retransmit a query coded C when no response has been received.

G Routine Claim Query - Termination Involved. Use this code to retransmit expenses that were previously transmitted in an I or J query, for a period during which the beneficiary was entitled to Part B, but only after HCFA has furnished a reply to a previous I or J query showing any of the following disposition codes:

40, 44, 45, 48 (see § 3535 for explanation of codes).

The use of a G (or H) query is positive indication that the intermediary has reviewed and considered the HMO lock-in, termination, or prior period of entitlement.

Use a query code H to retransmit a query code G when no response has been received.

I Routine Part B Query. Code I indicates a claim has been received and furnishes amounts of incurred reasonable charges and blood furnished. Use these codes to request status when a claim is pending. HCFA updates deductible and psychiatric care totals on the basis of this type of query. Use a query code J to retransmit a query coded I when no response has been received.

Z Part B Entitlement Status Query. Use the Z query code to request status. It is used when the intermediary needs information from HCFA's records to process correspondence, to assist in resolving questionable items prior to submitting a routine claims inquiry, or to make periodic payments for the purchase of durable medical equipment (§ 3525.2, Exception 3). A code Z query must have the year for which status is requested in the "Date First Incurred" field. The month may be an actual month of expense. The subsequent money fields must be zero fill. HCFA does not update on the basis of this type of query; however, an "approval" reply (see disposition codes in § 3535) to a Z query will include deductible information.

Services of radiologists and pathologists to hospital inpatients are covered under Part B with no deductible or coinsurance. When the intermediary's file indicates the individual has Part B coverage and the intermediary has been placed on an automatic notification listing in accordance with § 3511, no Part B query is necessary before processing a claim involving these services. However, when these conditions are not met, a Z status query must be submitted. (See § 3525.5.)

A code Z query may be used to follow up on a prior code Z query.

NOTE: In processing replies to I, J, and Z queries, intermediaries are cautioned to verify that the dates of expense do not fall outside a period of coverage. To facilitate this verification an I trailer will be furnished in the query reply if HCFA records indicate that a beneficiary has had a prior period of coverage.

D. Health Insurance Claim Number.--See § 3504 for discussion of this item.

E. Name.--See § 3507.4 for discussion of this item.

F. Sex and Blood Deductible.--The sex code in the Part B query includes pints of blood furnished, if any, as well as sex. (See

§ 3526.) Take the sex from the claims form, e.g., the SSA-1483. Select the sex/blood code from this chart:

Pints of Blood Furnished:		0	1	2	3
SEX	Male	1	C	E	G
	Female	2	L	N	P

C. Incurred Expenses.—The amount of the "reasonable charge" for Part B services is reported on the Part B query. Expenses incurred in the last three months of a calendar year which apply toward the Part B cash deductible for that year also apply toward the Part B deductible for the following year. (See § 3525.1.) SSA maintains a record of this; therefore, when querying SSA, the intermediary reports the "First Incurred Dates" and "Reasonable Charges" during the first nine months, and those during the last three months separately.

3531. SSA RECORD MAINTENANCE AND REPLIES

SSA maintains an up-to-date record of each beneficiary's status using expenses reported in queries received from the intermediary to update the deductible amount on the SSA tape record. The record includes separate totals for outpatient psychiatric and other medical expenses. SSA also maintains the amount of any carryover deductible. Upon receipt of each new inquiry, SSA notifies the current inquirer of the amount of the deductible that still has not been satisfied. Where more than one inquiry for the same individual is processed on the same day, SSA sorts the queries for that person in sequence alphabetically by query codes and then by dates of incurred expenses.

SSA's reply gives the status prior to receipt of the current inquiry and enables the intermediary to determine whether he can make a payment EXCEPTION: Replies containing disposition code "21" furnish status after adjustments have been made based on the current inquiry. (See query codes A and C, § 3527C.)

SSA will not furnish a deductible status in reply to an intermediary when:

A. The reported incurred date precedes the month of the beneficiary's entitlement to Part B, or

B. His entitlement to Part B had terminated for a reason other than death.

C. The beneficiary is in an HMO lock-in status.

There is an exception to A, B, and C. SSA will reply when the intermediary uses a query code of G or H indicating that he is aware of the prior period of entitlement, termination, or the HMO lock-in, but is reporting expenses incurred prior to that. A code 41 or 44 reply will be received for a G query if the first date is not during a period of Part B entitlement. A code 40 reply will be received for a G query if the first date of expense falls within a lock-in period.

3532. INTERRUPTED PERIOD OF ENTITLEMENT UNDER PART B

There are individuals currently enrolled under supplementary medical insurance who have had an interrupted period of entitlement. For example, a beneficiary's coverage was terminated and he enrolled during a general enrollment period, or he was re-enrolled by a State under a State buy-in agreement.

SSA takes these actions concerning terminations:

1. Disposition Code 41.--SSA transmits a disposition code 41 reject reply in response to an A, B, I, or J query which contains a date of first expense prior to current entitlement date and SSA has no indication of a termination date nor a prior period of entitlement. (See § 3535 for the alternate meaning of code 41 when it is received in reply to a G or H query.)

2. Code 44 With F Trailer.--When an A, B, I, or J query is received for a beneficiary whose latest period of entitlement has terminated, SSA sents a reject reply with disposition code 44. The code 44 reply format is the same as the disposition code 41 format except F trailer code is added to furnish the date of termination. (See § 3535 for the alternate meaning of code 44 when it is received in reply to a G or H query.)

3. Code 48 With I Trailer.--When the intermediary's query contains a date of first expense that is prior to the current entitlement date and the SSA record indicates there was a prior period of entitlement , SSA sends a reject reply using disposition code 48. The code 48 reply format is the same as the code 41 format except an I trailer code is added. The field following this trailer code will show the entitlement date and termination date of the earlier period of coverage; e.g., I.0766 1266.

If the intermediary determines that some or all expenses fall within an entitlement period, he should send a query coded G, including only expenses incurred during a period that the individual was entitled. The intermediary is cautioned to compute payment on the basis only of expenses incurred during a period of titlement. Query code C (with a D followup) should be used to cancel or adjust expenses reported in a G or H-coded query.

3534. CROSS REFERRING HEALTH INSURANCE CLAIM NUMBERS

When a beneficiary's entitlement to Medicare benefits has been transferred from one health insurance claim number to another, SSA will cross-refer the old number to the new number. Where there has been utilization of benefits under each number, this data will be combined under the new claim number. Through this combination of data, SSA may find that an improper deductible reply was given for this beneficiary which has resulted in a potential overpayment/underpayment. If this is the case, SSA transmits this information by form letter SSA-L495 (§ 3550, exhibit 6) to either the intermediary who received the improper deductible reply or to the intermediary receiving the latest query reply indicating deductible to be satisfied. Take the appropriate steps to either refund the underpayment or collect the overpayment. (Any requests for assistance to SSA regarding form letter SSA-L495 should be accompanied by a copy of this letter.)

In developing the overpayment and underpayment information, HCFA adjusts the latest query reply to show the deductible to be met, not necessarily the query reply which gave the wrong deductible status. This is done to simplify adjustment actions. For example, if a query reply prepared in 1979 is found to contain an erroneous deductible status, HCFA may adjust the reply to a query submitted in 1984. This could save the time and effort required to obtain the original claim information from the Federal Archives and Records Center.

3535. DATA FURNISHED IN THE PART B REPLY.

There are four reply codes representing different types of Part B reply messages.

Type 3--is an acknowledgment. HCFA is either unable to locate the beneficiary's record on the basis of the HI claim number and/or name furnished in the query, or is processing an adjustment to the beneficiary's record which may affect the current utilization data. HCFA is investigating and will send a type 6 reply when the investigation is completed.

Type 4--is a reply indicating that a query has been rejected due to edit errors.

Type 6--is a routine reply to a Part B query

Type 7--is an automatic notification of a change in beneficiary status. This type of message has a "reply" code; however, it is generated automatically by a certain event; not in response to a query. (See § 3511.)

All Part B replies contain a reply code, an intermediary number, the HI claim number, and (except type 4), a disposition code.

A. Intermediary Number.-- This is a 5-digit number assigned by HCFA.

B. HI Claim Number.-- This is the beneficiary's claim number which may vary from 7 to 12 positions. The field is 12 position; any unused positions following the seventh position are blank.

C. Disposition Code.-- This is a 2-digit number that describes a condition on the HCFA's utilization records for the individual:

Disposition Code — CONDITION

00 HCFA acknowledges receipt of the query, but information is delayed. The name and/or HI claim number does match a record on the HI master file. HCFA will send a definitive reply within 75 days if the individual is identified, or a code 52 if not.

If you determine that the original query contained an incorrect HI claim number or surname, requery immediately using the corrected data and your control number of the original query.

If a definitive reply or disposition code 90 reply is not received within 30 days, requery using the same information submitted in the original. Do not refer 00 replies to the Social Security Office.

Approximately 55 percent of these cases are resolved by HCFA within 5 days.

NOTE: When you receive a query response containing disposition codes 01, 02, 03, 04, 05, 06, 07, or 08 and it contains an H trailer, you must take the action indicated under the H trailer (S 3535.1) before you make payment.

01 Approval.-- This is an unqualified reply containing data requested in the query.

02 Qualified Approval.-- The beneficiary's entitlement to Part B has terminated because of death. A code 02 reply is given any time a date of death appears on the HI master record, regardless of the date of expense. The date of death is indicated by a six-digit month-day-year format after a trailer record code "U." (See S 3535.1.) When the month, day and year of expense are not subsequent to the date of death in the "U" trailer, process the claim to completion with no verification of the date of death. Also, if the "U" trailer contains "OO" as the day of death, process the claim without verification of date of death as long as the month and year of expense are not subsequent to that in the "U" trailer.

When the date of death in the "U" trailer is prior to the last date of expense in the claim, take the following actions:

1. Verify that the patient is the same individual previously reported deceased and the accuracy of the service dates. For example: review the original claim form for consistency of identity data (name, sex); check the beneficiary's full name, address, and HICN (including suffix) against the CASF; compare the service dates with those contained in the query.

2. If this review reveals a discrepancy in your queried data, i.e., query submitted under an incorrect HICN or erroneous dates of expense, submit a void (A) query to remove the incorrect data and requery the charges with the correct date (HICN and/or dates of expense) using an I or J query code.

3. If the review reveals that the queried data agrees with the claim data, contact the physician/provider to verify the dates of expense. Where this contact reveals that the dates of expense on the claim form are incorrect, submit a void query to remove the incorrect data and requery the correct data.

4. Where contact with the physician/provider verifies the date of expense on the claim form, the intermediary should suspend the claim and take necessary action to have the date or fact of death verified or corrected on the HI record. To accomplish this, the case will be referred to the SSO via Form SSA-1980, Carrier or. Intermediary Request for SSA Assistance. (or a locally agreed upon form) (See § 3706)

   Include the following information:

   a. HI claim number (including suffix);
   b. Name and full address on the claims form;
   c. Part B (outpatient) disposition code (02);
   d. Date of death as shown on the query reply:
   e. Date of death, if any indicated on payment request;
   f. A statement that the case is being forwarded for date of death investigation and/or correction;
   g. Signature and title of person completing the request form;
   h. Intermediary's return address;
   i. Copies of any documentation pertaining to the case that is at your immediate disposal.

   The SSO investigates the date of death issue, and where necessary, initiates corrective action. The SSO notifes the intermediary of SSA action taken by completing and returning Part II of Form SSA-1980 or the reply portion of other locally agreed upon forms. (If the SSO reply is delayed, use regional guidelines for followups. However, if there is no reply after 90 days, refer the case to the Medicare RO

5. Upon receipt of the SSO's findings, initiate payment or denial action accordingly.

6. Keep the SSO reply on file until the bill processes. In the event the bill rejects with a code 5211 (see § 3828.1), use the SSO reply for immediate resolution.

7. When the disposition code 02 (for outpatient queries) is received in conjunction with a railroad claim (indicated by a prefixed claim number such as A123456, WA123456789, etc.), follow the above guidelines. This instruction also applies when the query response indicates a cross-referred railroad number. However, do not refer date of death discrepancies involving railroad beneficiaries to the SSO. Instead, send completed SSA-1980s for such cases to:

Railroad Retirement Board
Health Insurance Operations
844 Rush Street
Chicago, Illinois 60611

The RRB will investigate, initiate corrective action, and provide notification in the same manner as the SSO.

NOTE: Where the expenses reported are for rental of durable medical equipment, investigation of discrepant dates of death will not be required for the period of rental in which death occurs. For example, a beneficiary rents a hospital bed on July 12, 1978, and the rental period extends through August 9, 1978. If the beneficiary dies at any time prior to August 10, 1978, no investigation is required.

Disposition Code	Condition
03	Rejected.--Duplicate SSA reply of a previously approved reply sent with disposition code 01.

NOTE: Receipt of an 03 reply usually means that an 01 reply was previously received. The intermediary should be sure that the same claim is not paid twice.

In some instances the intermediary sends an I query, receives an 01 reply, then sends an A query, inadvertently using the same control number as in the I query. In response, SSA transmits an 03 disposition code. This code should alert the intermediary that he has not deleted the expenses or blood information as he intended.

Disposition Code	Condition
04	Rejected. Duplicate SSA reply of a previously approved reply sent with disposition code 02. (The Note above also applies to an 04 code reply situation.)
05	Unqualified Approval. This code corresponds to disposition code 01, except that the deductible to be met is adjusted to correct an erroneous carryover. Since this query was for less than the cash deductible, any subsequent claim for medical expenses incurred in the same year must be required. The intermediary must query SSA for deductible information until at least the cash deductible has been met for that year.
06	Qualified Approval. This corresponds to code 02 (beneficiary's entitlement has terminated because of death) except the deductible to be met is adjusted to correct an erroneous carryover. A reply with an 06 code indicating the deductible has been satisfied is not sufficient to process subsequent bills without an additional query. (See Note in code 05.)
07	Rejected. Duplicate SSA reply of a previously approved reply sent with disposition code 05.
08	Rejected. Duplicate SSA reply of a previously approved reply sent with disposition code 06.
09	Acknowledgment. This acknowledges receipt of the query. However, a definitive reply cannot be furnished at this time due to an adjustment, cross-referencing, or clerical correction action currently being taken by SSA. If a definitive reply is not received within 60 days, forward a letter, including the HI claim number and name of the beneficiary to: Social Security Administration Health Insurance Bill Processing Methods Branch, BDP 2-G3 Dogwood East Building Baltimore, Maryland 21235 If a final reply is not received from BDP within 45 additional days, the case should be referred to the Regional Officer Under the critical case procedure outlined in § 3537. The 75 day time frame for a definitive reply by SSA does not apply to disposition code 09.
21	Acknowledgment. Query code A or C (void/credit) or the companion follow-up code B or D has been received and posted. This reply furnishes status after adjustment has been made based on the current query.

NOTE: Upon receipt of a response to an A, B, C, or D query bearing disposition code 21 (or duplicate reply code 23), compare the deductible status shown in this response to the original query reply.

If the original query reply indicated deductible remaining, this should alert the intermediary to the fact that the medical expenses cancelled were used to satisfy part or all of the deductible and the cancellation of these expenses may have created an overpayment.

Where the deductible remaining in the reply to the cancel query is equal to or greater than that shown in the original query reply, there is no possibility of an overpayment, therefore no further review is required. For example:

(1) Intermediary #1 queries for $50, gets an 01 response and $50 deductible remaining. Later he cancels the entire $50 and gets a 21 response again with $50 remaining. No action required.

Also, if the amount shown as the deductible remaining in the reply to the cancel query is less than that shown in the original query reply but the figures can be reconciled, no further action is required. For example:

(2) Intermediary #1 queries for $60, gets an 01 response showing $50 deductible remaining. Later he cancels $50 and gets a 21 response with $40 deductible remaining. These figures are reconcilable by the intermediary since he knows he still has $10 posted to the beneficiary's account and the deductible remaining is $40. No further review is required; however, any overpayment based on the original query reply must be recovered.

If the deductible remaining shown in the reply to the cancel query is less than that shown in the original query reply and the figures cannot be reconciled, there is a definite possibility of an overpayment. The intermediary should document the available facts in the case and forward them for reconciliation to: Social Security Administration, Division of Systems, BHI, Part B Systems Branch, Baltimore, Maryland 21235. Examples:

(3) Intermediary #1 queries for $40, gets an 01 response and $50 deductible remaining. Intermediary #2 queries for $10, gets an 01 response and $10 deductible remaining. Later, intermediary #1 cancels $20, gets a 21 response with $20 deductible remaining. These figures are not reconcilable by Intermediary #1, therefore the case should be documented and forwarded to BHI.

(4) Intermediary #1 queries for $40, gets an 01 response and $50 deductible remaining. Intermediary #2 queries for $50, gets an 01 response with $10 deductible remaining. Intermediary #2 pays 80% of $40. Later intermediary #1 cancels the $40, gets a 21 response with $0 deductible remaining. This means there was a definite overpayment. The case should be documented by Intermediary #1.

Disposition Code — Condition

23 Rejected. Duplicate HCFA reply of a previous reply sent with disposition code 21. (See Note in code 21.)

NOTE: In some instances the intermediary sends an A query, receives a 21 reply, then sends an I query, inadvertently using the same control number as in the A query. In response, HCFA transmits a 23 dispsition code. This code should alert the intermediary that it has not updated the expenses or blood data as it intended.

26 Qualified Approval. Alien nonpayment provision may apply. No payment may be made under Part A or Part B until HCFA reports in writing that payment is not barred. (See § 3716 for explanation of this provision and development of these areas.)

28 Rejected. Duplicate HCFA reply of previously approved reply sent with a disposition code 26.

36 (This is an automatic notice code. See page 127.3)

38 Rejected. A query has been received which:

1. Contains the HICN and surname of a deceased beneficiary whose record has been placed on the inactive file, i.e., the beneficiary has been deceased more than 1 year without any query or payment record activity. The query, however, failed to match on all the personal characteristics, i.e., initial and sex code.

OR

2. Contained expenses subsequent to 12/31/75 and perfectly matched an inactive record of a deceased beneficiary with a date of death prior to January 1, 1976. (HCFA has purged all inactive beneficiary records containing date of death prior to January 1, 1976.)

Information furnished in this reply includes:

1. HICN
2. Surname (6 positions)
3. Initials
4. Date of Birth (Month and Year)
5. Date of Death (Month, Day and Year)
6. Sex Code (1=Male; 2=Female)
7. Query Control Number as shown in Query.

Review the data in the original claim form and, if it is determined that the claim was for a different beneficiary develop the appropriate claim data and resubmit the query. If it is determined that the original claim form was for the beneficiary identified in the query and the date of death is correct on the HI record, the data furnished in this reply will be used to submit a corrected query. A code 09 reply will be generated immediately and within 30 days a definitive reply will follow once the inactive record has been retrieved.

Disposition Code **Condition**

38 If it is determined that the original claim form was for the beneficiary identified in this code 38 reply and the date of death is incorrect on the HI record, the case will be referred to the SSO via Form HCFA-1980, Carrier or Intermediary Request for SSA Assistance, (or a locally agreed upon form).

Documentation should include the following information:

a. HI claim number (including suffix);
b. Name and full address on the claim form;
c. Part B disposition code 38;
d. Date of death as shown on the query reply;
e. Date of death, if any indication on claim form;
f. A statement that the case is being forwarded for date of death investigation and/or correction;
g. Signature and title of person completing the request form;
h. Contractors return address;
i. Copies of any documentation pertaining to the case that is at your immediate disposal.

The SSO investigates the date of death issue and when necessary, initiates corrective action. The SSO notifies you of any action taken by SSA by completing and returning part II of form HCFA-1980 or the reply portion of other locally agreed upon forms. (If the SSO reply is delayed, use regional guidelines for followups. If there is no reply after 90 days, refer the case to the HCFA RO.

Upon receipt of SSA's findings, process the claim accordingly. However, if the SSA's findings indicate that the HI claim number (including suffix) identified on the claim form belongs to the beneficiary identified on the claim form and the date of death originally returned in the code 38 reply was prior to January 1, 1976 then it is necessary to have HCFA reinstate the beneficiary record since it has been purged. To have a purged record reinstated, send the following documentation to Health Care Financing Administration, Records and Telecommunications Branch, Room 2-A-4, Meadows East Building, 6325 Security Boulevard, Baltimore, Maryland 21207:

1. Copy of completed investigation (form HCFA-1980);
2. Copy of the claim involved;
3. Statement advising HCFA to reinstate the purged record to the HI active file.

Disposition Code	Condition
39	(This is an automatic notice code. See page 127.2.)
40	Rejected. The HI master record indicates that the beneficiary is locked in to a Health Maintenance Organization (HMO) which is required to process all Part B claims, and the date of first expense was incurred before or during the period of HMO enrollment. A code 40 reply always has an R (HMO) trailer. Review the claim to determine if any of the services were outside the period of lock-in status. If all services were within the lock-in period, transfer the claim to the HMO identified in the R trailer. Where expenses were incurred outside the period of lock-in, requery using query code G. A code 40 reply can be received in response to any query except codes C and D. Where a code 40 response is received in reply to a G or H query, it means the date of expense fell within the lock-in period.
41	Rejected. HCFA transmits a code 41 when the month of first expense is prior to the entitlement month on record and there is no prior period of entitlement. Where the code 41 is in reply to a G or H query, this means that the month of incurred expense in the query is not in a period of entitlement. Review the claim and the previous related reply.
42	Rejected. HCFA records indicate the individual has never been entitled to Part B. However, contact the State to investigate eligibility under any State buy-in agreement if the intermediary and the State have an arrangement to do so and if it appears that it may be a buy-in case. The Social Security claim number should be furnished in case the State does not have the correct number on record. If the individual is not covered, the State will advise the intermediary so that the claim can be denied immediately. If the State's record indicates coverage under the agreement, it will inform the intermediary and will certify coverage to HCFA outside the normal accretion process. After HCFA has established Part B coverage in the eligibility records, HCFA will advise the intermediary by letter when to requery.

Disposition Code	Condition
43	Rejected. A query coded A (void), B (followup for A), C (credit), or D (followup for C) requested cancellation or reduction of more medical expenses or pints of blood than the amount posted to the beneficiary's record. The query cannot be processed and is rejected with disposition code 43. Determine whether the amount transmitted in the rejected query was correct. If the amount was not correct, submit a new query with the correct amount. Otherwise, send a code Z query to determine the amount posted on HCFA's record. If the HCFA reply indicates some remaining amount, compute the amount previously reported and make the necessary adjustment with a new query. However, if the status reply shows zeros (and, therefore, the posted amount is still unknown), send a memorandum outlining the desired adjustments to: Health Care Financing Administration Bureau of Support Services, OHPS Transaction Processing Branch P. O. Box 17078 Baltimore, Md 21203
44	Rejected. Beneficiary's latest period of entitlement to Part B has terminated for reasons other than death. This code indicates that the individual, according to HCFA records, has either failed to pay the SMI premium or has voluntarily withdrawn from the SMI program. A code 44 is given any time a date of termination exists, regardless of the date of expense. Since there will be delays in recording some timely premium payments, however, HCFA replies may not reflect final status. Therefore, do not disallow a claim for services rendered after the termination month shown in the

Disposition Code

Condition

reply until at least 30 days have elapsed after that month. If, in the meantime, a timely premium payment is recorded by HCFA a correction notice will be sent to the intermediary so immediate payment can be made on the claim.

A tentative or informal termination notice may be sent to the provider if it seems needed; e.g., where a provider has started services under a home health service plan and the intermediary is notified early in the month following termination that the services beyond the termination date may not be covered, informal notice to the provider would enable the provider to bill directly for expenses incurred after the termination or take other steps deemed necessary to protect his interests.

When the intermediary receives a code 44 reply, it is also possible that the individual has enrolled under a State buy-in agreement, but a code 44 reply is sent because of problems involved in identifying and matching State buy-in items. The intermediary should follow the procedures in the "Condition" for disposition code 42 above, if it has arranged with the State to do so.

Where the code 44 is in reply to a G or H query, it means that the month of incurred expense in the query is after the current month of termination on the HI record.

45 Rejected. This code indicates that, according to Medicare records, the individual has been terminated from SMI due to failure to meet the alien residency requirement, termination of DIB entitlement, or ESRD cessation. A code 45 response is given any time a date of termination exists for any or all of the above 3 reasons, regardless of the date of expense.

Disposition code 45 can be sent in reply to any query code except codes C and D. Where the code 45 is in reply to a G or H query it means that the month of incurred expense in the query is after the current month of termination on the HI record.

Do not follow the procedures for disposition code 44 as there cannot be SMI entitlement after the month of termination on the HI record. Enrollment under a State buy-in agreement is also precluded.

Disposition Code	Condition
47	Rejected. The surname agrees but the sex and first initial of the individual shown in the query do not agree with HCFA's records. HCFA will not attempt to reconcile the discrepancy. If either the sex or the first initial agrees, a code 47 will not be furnished. When a code 47 is furnished, the reply will contain a trailer code "H" showing the full name on the HCFA record. The intermediary should check the sex and the first initial queried against the claim or the CAST to determine whether the same or different individuals are involved. If the same individual is involved, requery using the initials shown on the HCFA record. If different individuals are involved, check the CAST/CASF, for another individual with the same surname using guidelines in § 3506. If this check does not resolve the issue, apply the instructions in § 3504.
48	Rejected. This code indicates that the date of first expense shown in the query is prior to the current entitlement date; however, the individual had a prior period of entitlement. The intermediary should review the claim to determine expenses incurred during a period of entitlement, then report those expenses in a query coded G. (see § 3535.)
49	Rejected. HCFA received a G or H-coded query, but there is no prior period of entitlement or termination which would require the use of a G or H query.
50	Rejected. The name, SSN, and personal characteristics furnished in the query match HCFA non-HI records, but the individual has not filed for HI entitlement. This is authorization to deny the claim for Medicare reimbursement. Referral of the claim to the social security office (SSO) is not required of the intermediary, but the denial is to contain the legend referring the individual to their local SSO if the individual disagrees with the denial.
51	Rejected. The name, SSN, and personal characteristics furnished in the query match HCFA's non-HI records. However, HCFA determined the individual is not eligible for HI benefits. This applies also to individuals receiving SSI benefits, but under the age of 65 and not eligible for HI benefits. Since most of the cases in this category are disallowed for failure to establish proof of age or residence requirements, the individual may become eligible at a later date.

Disposition Code Condition

52 Rejected. The claim number furnished in the query is not assigned to the surname furnished in the query.

This code indicates the surname and/or HI claim number given in the query is incorrect or, in some cases, that the HI master record is incorrect. Check the surname and number against the claim. If they agree, check the Carrier Alphabetic State File (CASF) microfiche (See §§ 3505ff) for another spelling of the surname or a difference in the claim number. If this check does not resolve the issue, apply the instruction in § 3504.

Requery when you obtain the correct name and HI claim number.

54 Rejected. The surname, SSN, and initial or sex furnished in the query match HCFA's non-HI records, but HCFA is unable to resolve the exception item within a specified 75 day time limit.

Resolve the rejection by initiating the following actions:

1. Seek the correct claim number on the Carrier Alphabetic State File (CASF) microfiche. (See §§ 3505ff.) An appreciable number of Code 54s involve individuals entitled under another claim number.
2. Verify that another claim for the same individual has not been cleared on receipt of corrected claim data.
3. Review the source document with the data input to the automatic claims processing system for errors.
4. Review the claims history file, if readily accessible.
5. If the claim number is obtained in any of the above processes, requery as appropriate.

If the claim cannot be resolved by any of the above actions, deny the claim. Referral of the claim to the SSO is not required but the denial must contain a legend referring the individual to the local SSO if the individual disagrees with the denial.

Disposition Code	Condition
55	SSI Recipient Not Eligible for Automatic Enrollment by HCFA in SMI Buy-In Coverage Rejected. The name, SSN, and personal characteristics furnished in the query match HCFA's non-HI records but the individual is shown to be entitled to SSI benefits only. Since this code is generated only when HCFA's records show the individual is age 65 or over, refer the claim to the appropriate SSO for resolution. The SSO will develop the claim and notify you as to entitlement status. (NOTE: If the individual is under age 65 and receiving SSI benefits only, HCFA would respond with a code 51.)
56	SSI Recipient Eligible for Automatic Enrollment by SSA in SMI Buy-In Coverage SSA is Developing a Claim for HI Benefits. The name, SSN, and personal characteristics furnished in the query match HCFA's non-HI records and the individual is shown to be eligible for SSI benefits. Diary the claim and requery HCFA in 60 days. HCFA will undertake the necessary development to secure a claim. The first code 56 is generated 10 to 15 days following the MBR search. Upon receipt of a second code 56 refer the claim to the SSO. Be sure to indicate on the form HCFA-1980 "Second Code 56 after 60 Day Diary."
90	Acknowledgement. The name, SSN, and personal characteristics furnished in the query matched a non-HI record. The individual has filed a claim, but the entitlement is not presently reflected in the master HI records. HCFA has initiated an extended development in an attempt to resolve the situation. If a 75 day time limit expires HCFA will generate a code 54. Requery using the same Intermediary Control Number as in the original query if and when you obtain corrected or additional data.

Part B Automatic Notices

NOTE: Disposition codes 36, 39, 70 through 72, 77, and 79 appear in a Part B outpatient automatic notice (type 7) reply. (See § 3511 for an explanation of the automatic notice.) For examples, see Addendum A, page A-18.1.)

Disposition Code	Condition
36	Notice of Other Program Involvement. Sent to all intermediaries of record when the beneficiary becomes entitled to WC, BL and/or VA benefits. It is also sent when HCFA receives an indication that a claim has been processed where Medicare was not the primary payer. The data parallels that contained in the Part B Y (Other Program Involvement) trailer contained in § 3535.1. Annotate your records and process all future claims in accordance with the procedures outlined in the Y trailer. (See § 3599, Exhibit for record specification.)
39	Notice of ESRD. Sent to all intermediaries that have received a valid response to a query. Insure proper financial workload reporting and submission to HCFA of all claims processed for this beneficiary.
70	Termination. Part B entitlement has terminated for a reason other than death. This includes terminations as a result of erroneous entitlement. Where the termination is due to erroneous entitlement, the "effective date" field contains xxxx. In those instances, make adjustments for claims paid under the prior approval. The code is sent to all intermediaries that have submitted queries and received approvals. Do not pay for expenses incurred after the last day of the month indicated. Do not deny other claims without querying. You may hold any pending claims for 30 days before denying them if your experience indicates a substantial number of cases where a reinstatement notice is received soon after a code 70 notice. This code is also used where entitlement is terminated because disability or renal dialysis treatment ended.
71	Reinstatement or Change in Effective Date of Entitlement. The individual's Part B entitlement has been reinstated after termination or the effective date of entitlement has been changed as a result of administrative review. Where the date of entitlement has been changed (in most instances the new date is later than the original,) determine if payments have been made for the period between the original and the new entitlement dates. Where required, initiate recoupment action.

Disposition Code	Condition
	If your records show a termination date and the date in this notice agrees with the original entitlement date, drop the termination. If there is no termination date in your records, the date contained in this notice replaces the original entitlement date. Disposition code 71 notices are sent to intermediaries which have received approval replies or disposition codes 44. Query any new claims and reprocess any which have been improperly denied.
72	Query Next Claim. Indicates that a beneficiary's deductible status for the indicated year has moved from a "met" to a "not met" status. o The individual's account has been credited; i.e., the cash or blood deductible has been adjusted from a "met" to a "not met" condition, or amounts have been adjusted that were previously applied to physical therapist expenses, or to the maximum for noninpatient psychiatric care. (See §3535.1, trailer D for maximums.); o HCFA has received a date of death or an adjustment in the date of death for this beneficiary and the HI Master indicates that the Part B deductible for the year of death had been satisfied; o HCFA has removed a date of death. When a date of death is removed the effective date field contains zeros; or, o HCFA has received notification that the beneficiary has elected a period of Hospice coverage and the Part B deductible for the year of Hospice had been satisfied. Query the next claim for the beneficiary. The correct deductible status, date of death or appropriate Hospice involvement data will be on the reply. Disposition code 72 notices are sent to all intermediaries which submitted queries and received approvals.
77	Cross-Referred HICN. This is given when a beneficiary's entitlement to Part B benefits has been transferred from one HICN to another. Annotate the beneficiary's files and use the new HICN on subsequent queries and claims.

Disposition Code	Condition
79	Enrollment in, or Disenrollment from, an HMO, or a Change in Option for an HMO. This is given to intermediaries when the beneficiary enrolls in, disenrolls from, or changes his option in an HMO. Annotate your records and process claims in accordance with the information in the notice. See §§ 3512.8 and 3512.9 for additional information. The data content of an R trailer (see § 3535.1) is given.
90	Acknowledgment. The name, SSN, and personal characteristics in the query match a non-HI record. The individual has filed a claim, but entitlement is not reflected in the HI Master. HCFA has initiated development to resolve the situation. If the 75 day time limit expires HCFA generates a code 54. Requery using the same control number as in the original if, and when, corrected or additional data is available.

D. Part B Entitlement Date.-- This is the month and year that the beneficiary became entitled to SMI payments. HCFA transmits two digits for the month and the last two digits of the year. When the month is one digit, it is preceded with an "O." Example: for September 1987, HCFA shows 0987.

E. Beneficiary's Part A Entitlement Date/Blood Deductible Remaining to be Satisfied.-- This field has six positions. The beneficiary's current Part A entitlement date has two positions each for the month and year. A period is in the fifth position and the blood deductible remaining to be satisfied (before the current query is posted) is in the sixth. If the beneficiary had Part A entitlement but it is now terminated, the word 'TERM' appears in place of the entitlement date. If the beneficiary had Part A entitlement erroneously at some time the legend 'XXXX' appears. If the beneficiary was never entitled to Part A, the field is blank. It is necessary to know if the beneficiary has Part A entitlement in order to know whether the beneficiary does or does not meet the 'Working Aged' definition of the law. (See § 3100ff.)

The following identify the blood deductible code:

CODE	EXPLANATION
0	Blood deductible satisfied (on code 41 - 44 and 47 - 52 replies, 0 does not mean the deductible has been satisfied).
1	Blood deductible to be satisfied is 1 pint.
2	Blood deductible to be satisfied is 2 pints.
3	Blood deductible to be satisfied is 3 pints.

EXAMPLE: Intermediaries using ARS:
6.50000.470389297A .01.0866.0801.3.5000.A.1234567891.

F. Part B Remaining Deductible.-- This is the amount of the deductible that has not been met prior to receipt of the present query. (See § 3531, Disposition Code 21 for exception.)

3535.1 Explanation of Part B Trailer Codes.—A trailer code is a one-position alphabetical code which identifies the content of data which immediately follows. In any Part B reply, one or more trailer records may be present. Part B trailer codes and a description of each follow.

Trailer Codes	Data Furnished
A	Intermediary Control Number.—This is a repeat of the control number that you included in your query.
B	Corrected Surname.—A corrected surname is shown only if the name of the beneficiary submitted in the query is not consistent with HCFA's records. If investigation indicates HCFA has an incorrect name, process the claim, and refer the information via a HCFA-1980 to the local SSO for correction. Supply pertinent documentation. Include the data contained in the B trailer as well as the correct data.
C	Corrected HICN.—The corrected number is included only if the one submitted is incorrect.
D	Reasonable Charges for Psychiatric Care Remaining.—These are the maximum reasonable charges for the year in which care was provided, less reasonable physician's charges for psychiatric care reported in earlier queries: $500 before 1988 $900 during 1988 $2200 after 1988
F	Part B Termination Month and Year.—HCFA transmits 2 digits for the last month covered and the last 2 digits for the year. Expenses incurred through the last day of the month shown are reimbursable.
G	Representative Payee.—When HCFA knows that someone is authorized to act on behalf of the beneficiary, the name and address appear.

Trailer Codes	Data Furnished
H	Name on Master HI Record.--In matching queries against the HI Master Record, HCFA compares the HI claim number, six positions of the surname, the first initial, and the sex code. If a query is found to match on the HI claim number, surname, and either the first initial or sex code, it is accepted, the eligibility for Part B is determined, the deductible status is updated, and a definitive reply is furnished. In addition, the query reply will include an H trailer (when either the first initial or sex code fails to agree) containing the surname, followed by one comma, then the first name, and, if applicable, the middle initial, preceded by a comma. Where the data in the H trailer does not follow this exact format, document this and submit it to the local SSO for correction. For example, if the H trailer should show the surname followed by two commas, then the first initial, this would indicate that the failure to match the query on first initial was due to the presence of the second comma. The documentation should include the data contained in the H trailer as well as the correct data. In reviewing the H trailer and the HCFA-1483, in some instances, it may be determined that the H trailer was caused by an erroneous sex code in HCFA's records. For example, the query was for Mary A Jones with sex code of 2 and the H trailer contained Jones, Mary, A. Then it would be obvious that HCFA's records did not show a sex code of 2. To correct this and also to prevent future H trailers, submit by letter, the HI claim number, the beneficiary's name, and the correct sex code to the local SSO. If the name does not take the full 25 positions, the field will be filled with blanks. This will enable the intermediary to determine whether the individual identified in the query is the same as the individual on the HCFA Master Record. If it is determined that the query was posted to the wrong record, the intermediary should take the appropriate steps to cancel the erroneous posting, determine the proper HI claim number, and requery accordingly.

Trailer Codes

Data Furnished

I Prior Period of Coverage.-- HCFA transmits this information with disposition code 48 to enable you to determine if expenses reported in a query fall within a prior period of entitlement.

K Cross-Referred HI Claim Numbers.-- HCFA transmits this information whenever a beneficiary's HI claim number is cross-referred to another HI claim number. Process the beneficiary's current claim(s) using the new number, cross-refer any beneficiary files, and on subsequent claims use the claim number given on the K trailer. When a query is transmitted using the number in the K trailer, the reply is not cross-referred to the prior number.

M State Buy-In.-- HCFA transmits this information whenever current involvement with State buy-in is indicated. This information is to alert you that referral of claims data to the title XIX State agent may be in order. The option on whether referral is to be made is up to the State agency. If it is desired, the State Medicaid agent and the intermediary servicing the State coordinate to determine the method of referral and data elements to be furnished.

The HCFA RO coordinates these activities and works with the intermediary in any aspects of implementation. At a later date, the trailer will contain the State code and the effective date of buy-in. (See § 1602 in Part I and § 3771 concerning disclosure of information for Federal grant-in-aid program purposes.)

O Beneficiary Date of Birth and Sex.— This trailer is furnished on all approval replies. The trailer contains the date of birth and sex of the beneficiary as contained in the HCFA beneficiary record. This trailer also contains a code which indicates if the date of birth reflects the current or prior century; for example, 1875 versus 1975. Assume that the date of birth contained in this trailer is correct. This data is necessary in order to know if the beneficiary meets/does not meet the working aged definition of the law. (See §§ 3100ff.) (See § 3550, Exhibit 15 for the format of the O trailer.)

R Health Maintenance Organization (HMO) Involvement.-- This data is transmitted any time a query is received for a beneficiary who is currently or had been enrolled in an HMO. The trailer gives data on the HMO Identification Code, Option Code, and Enrollment Period (explained below) for the current period of HMO enrollment and also furnishes it for the prior period.

(1) HMO Enrollment Code.-- This is a 1-position numeric code (1, 2, or 3) which indicates that the individual has had 1, 2, or more than two periods of enrollment in an HMO.

Trailer Codes — Data Furnished

R(Cont.)(2) HMO Identification Code.-- This is a 5-position code identifying a specific HMO:

Position	
1	H
2 and 3	State Code
4 and 5	HMO number within the State

(3) Option Code.-- This is a 1-position code which describes the beneficiary's relationship with the HMO:

For unrestricted use beneficiaries:

1 - Intermediary to process all (Part A and Part B) provider bills.
2 - HMO to process provider bills only for directly provided services and for services from providers with whom the HMO has effective arrangements. Intermediary to process all other bills.

For restricted use beneficiaries:

A - Intermediary to process all (Part A and Part B) provider bills.
B - HMO to process only bills for directly provided services.
C - HMO to process all bills except bills from approved dialysis facilities for dialysis and related services.

NOTE: Regardless of option, the intermediary will process all bills for dialysis and related services provided through an approved dialysis facility.

(4) Enrollment-Period.--This trailer gives the month and year of the first and last months of enrollment in an HMO.

S Reason for Entitlement.--This trailer indicates that the beneficiary is entitled because of disability (§ 3001.2), end stage renal disease (§ 3001.3), or because he has secured coverage on a voluntary basis and pays a Part A monthly premium (§ 3001.4). The codes furnished in the trailer are as follows:

Code	Definition
1	The individual is entitled because of disability.
2	The individual in entitled because of end stage renal disease.

Trailer Code		Data Furnished
S(Cont.)		
	3	The individual has, or had, ESRD, but is currently covered by the disability provision. (See §3687 for required development action.)
	4	The individual is age 65 or over and is covered by Medicare as an uninsured or old-age or survivor insured and has, or had, ESRD.
	8	The individual has, or had, ESRD and is covered under the Part A premium payment provision.
	9	The individual is covered under the Part A premium payment provision.

NOTE 1: Five extra positions are added to show the reimbursement method and effective date for ESRD beneficiaries receiving home dialysis. When this applies, we follow the regular trailer code with 1 to show that the beneficiary elected Method I, or 2 for Method II. Following the method is the effective date (MMYY) of the election that applies to the service period shown in the query.

NOTE 2:

Codes 2, 3, 4, and 8 apply for reporting ESRD cases as required by HCFA. See §§3644ff. for submitting ESRD bills.

U Date of Death.--This trailer gives the month, day, and year of death as recorded in the HI Master Record. The U trailer is always transmitted with disposition codes 02, 04, 06, 08. The description for these codes furnishes you with the necessary actions to resolve date of death problems. If the actual day is not available "00" appears in the day field (e.g., 010083).

Y Other Program Involvement.—Indicates that some other insurance program may be the primary payer. It is possible to receive multiple Y trailers. Their number depends upon the number of Other Program annotations present on the beneficiary's record. In all cases, annotate your records and proceed in accordance with the following instructions. (See §3599 Exhibit for trailer format.)

The Other Program Code indicates the other Federal program or other type of insurance that may be the primary payer. Possible codes are:

Trailer Code	Data Furnished

Code 1. Is furnished when the HCFA master indicates that this beneficiary has WC coverage. Check the diagnosis on the claim. If it appears that the services may have been necessitated by an accident, or an occupational disease, withhold payment until you determine that the services are not covered by WC. Fully develop the issue in accordance with SS3415ff. Contact the beneficiary's State Workers' Compensation Agency S3599 Exhibit 10 to obtain information about this WC award. If his home State is not the award State, get the appropriate address from:

Health Care Financing Administration
Office of Management and Budget, DMOS
P. O. Box 17078
Baltimore, MD 21203

Code 2. Is furnished when the HI Master Record indicates that this beneficiary is on the Department of Labor's (DOLs) Black Lung beneficiary rolls. Enter the annotation "BLACK LUNG" on your reply to the notice of admission. Check the diagnosis on the claim. If it appears from the diagnosis or the services performed (see S3415.3 E and F) that all or part of the inpatient services on the claim were attributable to BL disease, deny the claim. (See S3722.4 MISC-15 for denial paragraph.) In regard to outpatient services, if the primary diagnosis is not related to BL disease, reimburse the provider for the services if they are otherwise covered. (See S3415.3D.)

NOTE: For the following codes, annotate your records and use them as alerts in case you receive improperly completed claims. In addition, annotate your reply to the notice of admission indicating the type of potential other payer involvement. These codes are an indication that Medicare was determined not to be the primary payer on at least one prior claim. In addition, Code A includes individuals whose SSA record shows the presence of an S2 LAF code.

Code A. Medicare was not primary because the beneficiary was a "working aged" beneficiary or spouse covered by an EGHP plan based on a prior claim, or the beneficiary's record shows the presence of an S2 LAF code. An S2 LAF code indicates the beneficiary is in suspended benefit payment status because of earned income and could be a potential "working aged."

Code B. Medicare was not primary because the beneficiary is an ESRD beneficiary in his 12 month coordination period and was covered by an EGHP.

Trailer Code	Data Furnished

Y(Cont.)

Code C. Medicare has made a conditional payment on a claim until a final resolution (of the claim) is decided. One type of conditional payment is where there is/was a pending liability claim. (See §§3419ff.)

Code D. Medicare was not primary because of automobile medical, no-fault, or other liability insurance involvement. (See §§3419ff. and 3489ff.)

Code E. Medicare was not primary because of WC. (See §§3407ff.)

Code F. Medicare was not primary because the beneficiary was entitled to coverage by the PHS or other Federal agency program. (See §3153.)

Code G. Medicare was not primary because the beneficiary was a disabled beneficiary covered by a LGHP. (See §IM 3492.)

Code H. Medicare was not primary because of BL coverage. (See §3414.2.)

Code I. Medicare was not primary because the beneficiary was involved in the VA program. (See §3153.2.)

The effective date contained in this trailer indicates:

For codes 1, 2, and 3 the effective (entitlement) date of the applicable program involvement.

For codes A, B, C, D, E, F, G, H, and I the earliest date on record indicating actual (from prior claim) or potential (from SSA LAF code) Medicare coverage as secondary. See §3686 for development instructions upon receipt of any of these Y trailer codes.

Z Hospice Involvement.—This trailer is given when the beneficiary's record indicates one or more periods of Hospice involvement. Only the applicable period of Hospice is included in the trailer. Once a beneficiary elects Hospice care all care for the terminal condition must be under the auspices of the Hospice. Contact the servicing intermediary identified in the trailer (see §3550, Exhibit 17) to determine if the claim is for services related to the Hospice care. If it is, deny payment. (See §§3100ff.) If the claim is not for services related to the Hospice care, make payment if they are otherwise covered. See §§3550, Exhibit 14 for the record format of the Z trailer.

3536. REQUERY GUIDELINES FOR PART B QUERIES

Upon receipt of Part B reply disposition codes 00, 54, 90, you may requery (using the same Intermediary Control Number as in the original) if, and when, corrected or additional data is obtained. Corrected data may be obtained by checking the original claim form, checking the HICN against the Carrier Alphabetic State File (CASF) microfiche (see §§ 3505ff.) or by contact with the provider or beneficiary.

After any query (except one in disposition code 09 status) has been pending HCFA's investigation for 75 days, a reject disposition code 54 is returned. If reply code 90 preceded the reply code 54 reject, the case may have been referred to the appropriate program center, but was rejected by HCFA due to the 75 day limitation on retaining queries. (The 75 day limitation for a definitive reply by HCFA does not apply to disposition code 09.)

INTERMEDIARY REQUEST FOR PART B QUERY HISTORY

TO: Health Care Financing Administration
Transaction Processing Branch, OHPS
P. O. Box 17078
Baltimore, MD 21203

Date ____________________

Intermediary/Carrier Name and Number __________________

HICN __________________________________

Beneficiary Name _____________

Year(s) Involved _____________

Problem:

_____ Beneficiary Request

_____ Outpatient Bill Reject

Type of Reject ________________

_____ Disposition Code Problems

Identify ____________________

_____ Other (Explain)

Control Number of Query __________________________

Date of Query/Reply ____________________________

Address Response To:

3537. REQUESTING ASSISTANCE IN RESOLVING PROBLEM AREAS IN THE QUERY/QUERY/REPLY PROÇEDURES

In the normal course of claims processing activities, expect to encounter problems involving query/query reply procedures. The actions taken to resolve the problem depend upon the problem identified. See §§ 3538ff. for critical case procedures.

A. HCFA Central Office Assistance.—If the problem involves:

1. A complaint from a beneficiary alleging over-application of the Part B deductible. This requires the preparation of a Part B query history. Direct requests for query history should be directed to:

Health Care Financing Administration
Transaction Processing Branch, OHPS
P.O. Box 17078
Baltimore, MD 21203

The format for requesting a query history is shown on page 128.4 and may be reproduced locally. If the format cannot be adopted, all requests must contain the same basic information. The purpose of this format and the required information is to establish a standard format which furnishes the minimum information necessary for HCFA to process the requests. If a reply is not received within 45 days of mailing of the Request for Part B Query History form, forward another form clearly captioned "Second Request." Show any congressional interest by checking the "Other" block on the form letter followed by the Congressman's or Senator's name. Where the problem involves more than one query reply, report this and furnish the additional information. Round the amount of money reflected in the "Deductible To Be Met" column to the nearest dollar as this is the way it is recorded on HCFA's microfilm. If exact dollar and cent figures are required, extract the data from your files.

2. Failure on the part of HCFA to provide a definite query reply within 60 days of receipt of disposition code 90 reply, request assistance from central office. Direct these requests to:

Health Care Financing Administration
Correspondence Service Branch, BSS
P.O. Box 11979
Baltimore, MD 21207

best copy available

B. Social Security Office Assistance.—Direct the initial request for assistance to the Social Security office if the problem is caused by difficulties in determining the beneficiary's correct entitlement status. (See S3706 for details of assistance requests to Social Security offices.) Examples of situations which may require SSO assistance are:

1. Problems involving jurisdiction;

2. Evidence that a beneficiary has utilization under more than one health insurance claim number, but you are not aware of any cross-reference action taken by HCFA; or

3. The beneficiary's name, address, sex code, date of birth or date of death is incorrect on the HI master record.

In the event the Social Security office is unable to resolve the entitlement problem; (e.g., cross referencing of HI records), request assistance from central office via the RO.

C. Railroad Retirement Board Assistance.—If the problem concerns an entitlement issue involving a prefixed claim number (A123456, WA12456789, etc.), send requests for assistance via form HCFA-1980 to:

Railroad Retirement Board
Health Insurance Operations
844 Rush Street
Chicago, IL 60611

The RRB will investigate, initiate corrective action, and provide notification in the same manner as the SSO.

3537.1 HMO Related Master File Corrections.—Fully document and send to the HMO inquiries concerning problems with HMO data on the HI Master. The HMO will resolve the problem and advise you of the results.

Critical Cases

3538. CRITICAL CASE PROCEDURES—ESTABLISHING ENTITLEMENT UNDER PART A AND PART B

Use the "Critical Case" procedure to expedite processing of Part A and Part B claims delayed because of an error in the beneficiary's HI master record. The "critical case" procedure provides speedy correction of the master record and may be used where the following conditions are met.

- There is an error in the HI Master which prevents the receipt of an approval disposition code query reply. This may occur when one of the following conditions exists.

You have been unable to process a claim, even though the beneficiary apparently has entitlement because HCFA transmitted a Part A query reply with a disallowance disposition code of 42, or a reject code of 43, 44, 48, 50, 51, 52, 54, or 57; or a Part B query reply with a reject disposition code of 41, 42, 44, 47, 48, 50, 51, or 52; or

A Part A or Part B interim reply has been received with an "acknowledgement" disposition code of 00,90, or 09, but not a final reply.

- Two followups have been made to the SSO and the HI Master has not been corrected.

- At least 90 days have elapsed since correction procedures were initiated.

- A serious hardship to the beneficiary or a public relations problem has developed.

3538.1 Referral of Critical Cases to the RO.—When you identify a claim meeting the above criteria send a memorandum to the RO identifying the beneficiary by name and HICN. Specify the nature of the problem, state that the above criteria are met, and give the date of all actions in the case. If disposition code 09 is involved, indicate whether the problem concerns a hospital admission date or a Part B bill. Mark "Critical Case" on the envelope. Flag your file for special handling and expedite the claim as soon as the reply is received.

The RO provides any additional documentation needed and sends it to HCFA Central Office for processing. The RO notifies you when the claim is forwarded. Diary the case for 30 days—by that time the RO should have a response and so advise you. If you receive a positive query reply before hearing from the RO, notify the RO.

Requery where the reply to the Part A admission notice was a code 42, 44, 48, 50, 51, or 52 and you receive information that the record has been corrected. Requery where a code 41, 42, 44, 47, 48, 50, 51, 52, 54, or 57 was the problem for a Part B claim and you are informed that the record is correct.

Requery where you had received a disposition code 00, 09, or 90, and the RO receives a response from HCFA that the record is now correct. If a positive reply has not been received within 2 weeks, recontact the RO, giving the name and HICN of the beneficiary and the date the claim was originally referred.

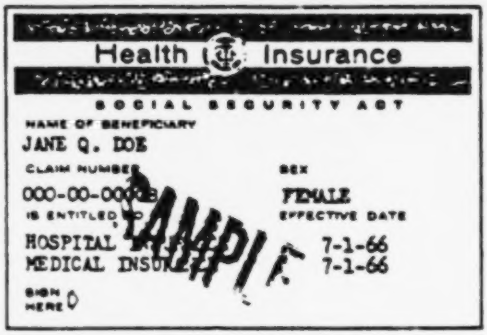
3538.2 Social Security Office Responsibility.—SSOs also process critical cases. Where both the SSOs and you are involved, the SSO is responsible for processing the case.

3550. EXHIBITS

Exhibit No. 1A	Health Insurance Cards	
Exhibit No. 1B	Temporary Notice of Medicare Eligibility	
Exhibit No. 4	Part A Disposition Codes Transmitted in Reply to Part A Queries	
Exhibit No. 5--		
	Type 1	Inpatient (Hospital or SNF) Query Reply Codes
	Type 2	Home Health Agency Query Reply Codes
	Type 3	Inpatient (General) Query Reply Codes
Exhibit No. 6	Outpatient Query Reply Codes	
Exhibit No. 7	Record Formats for the Code 6 Bill History Query	
Exhibit No. 8	Regional Map--U.S. Railroad Retirement Board	
Exhibit No. 9	Offices of the U.S. Railroad Retirement Board	
Exhibit No. 10	Workers' Compensation Directory	
Exhibit No. 11	Code 36 Automatic Notice - Record Format	
Exhibit No. 12	Type 7 (Hospice) Query - Record Format	
Exhibit No. 13	Replies To Hospice Queries - Record Format	
Exhibit No. 14	Code Z Hospice Trailer - Record Format	
Exhibit No. 15	Code O Date of Birth and Sex Trailer - Record Format	
Exhibit No. 16	Code Y Other Program Involvement Trailer - Record Format	
Exhibit No. 17	Intermediaries Servicing Hospices	

EXHIBIT 1 A

HEALTH INSURANCE CARDS



Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JANE Q. DOE

CLAIM NUMBER
000-00-00

SEX
FEMALE

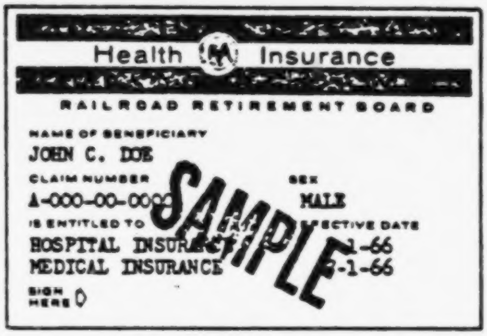
IS ENTITLED TO
HOSPITAL
MEDICAL INSU

EFFECTIVE DATE
7-1-66
7-1-66

SIGN HERE

SAMPLE

Front



Health Insurance

RAILROAD RETIREMENT BOARD

NAME OF BENEFICIARY
JOHN C. DOE

CLAIM NUMBER
A-000-00-000

SEX
MALE

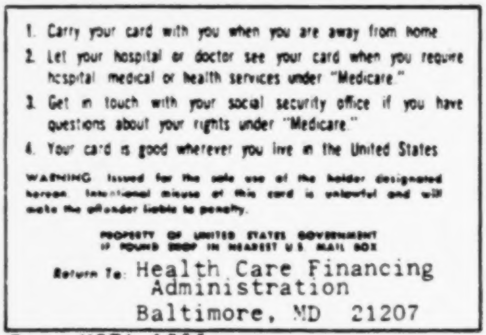
IS ENTITLED TO
HOSPITAL INSUR
MEDICAL INSURANCE

EFFECTIVE DATE
-1-66
-1-66

SIGN HERE

SAMPLE

Front



1. Carry your card with you when you are away from home
2. Let your hospital or doctor see your card when you require hospital medical or health services under "Medicare."
3. Get in touch with your social security office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States

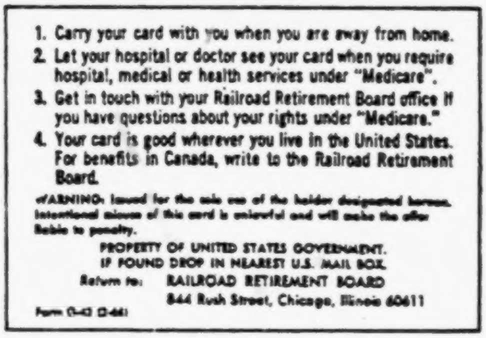
WARNING Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT
IF FOUND DROP IN NEAREST U.S. MAIL BOX

Return To: Health Care Financing
Administration
Baltimore, MD 21207

Form HCFA-1966
(8-79)

Back



1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical or health services under "Medicare".
3. Get in touch with your Railroad Retirement Board office if you have questions about your rights under "Medicare."
4. Your card is good wherever you live in the United States. For benefits in Canada, write to the Railroad Retirement Board.

WARNING: Issued for the sole use of the holder designated hereon. Intentional misuse of this card is unlawful and will make the offender liable to penalty.

PROPERTY OF UNITED STATES GOVERNMENT.
IF FOUND DROP IN NEAREST U.S. MAIL BOX.

Return to: RAILROAD RETIREMENT BOARD
844 Rush Street, Chicago, Illinois 60611

Form G-42 (2-66)

Back

Exhibit 1-B

TEMPORARY NOTICE OF MEDICARE ELIGIBILITY

District Office Address:

Date:

____
Patient's Health Insurance
Claim Number

Dear

Based on the information given to the Social Security Administration, you are (Mr. __________ was) eligible for hospital insurance beginning (mo.) (yr.) and for medical insurance beginning (mo.) (yr.). This notice will serve as evidence of your (his) eligibility for these benefits for 60 days from the date shown at the top of this notice unless you are notified otherwise during the 60-day period.

To obtain medical services (or reimbursement for medical services) before you receive a health insurance card, show this letter to your hospital or doctor but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive a health insurance card or other notice of eligibility.

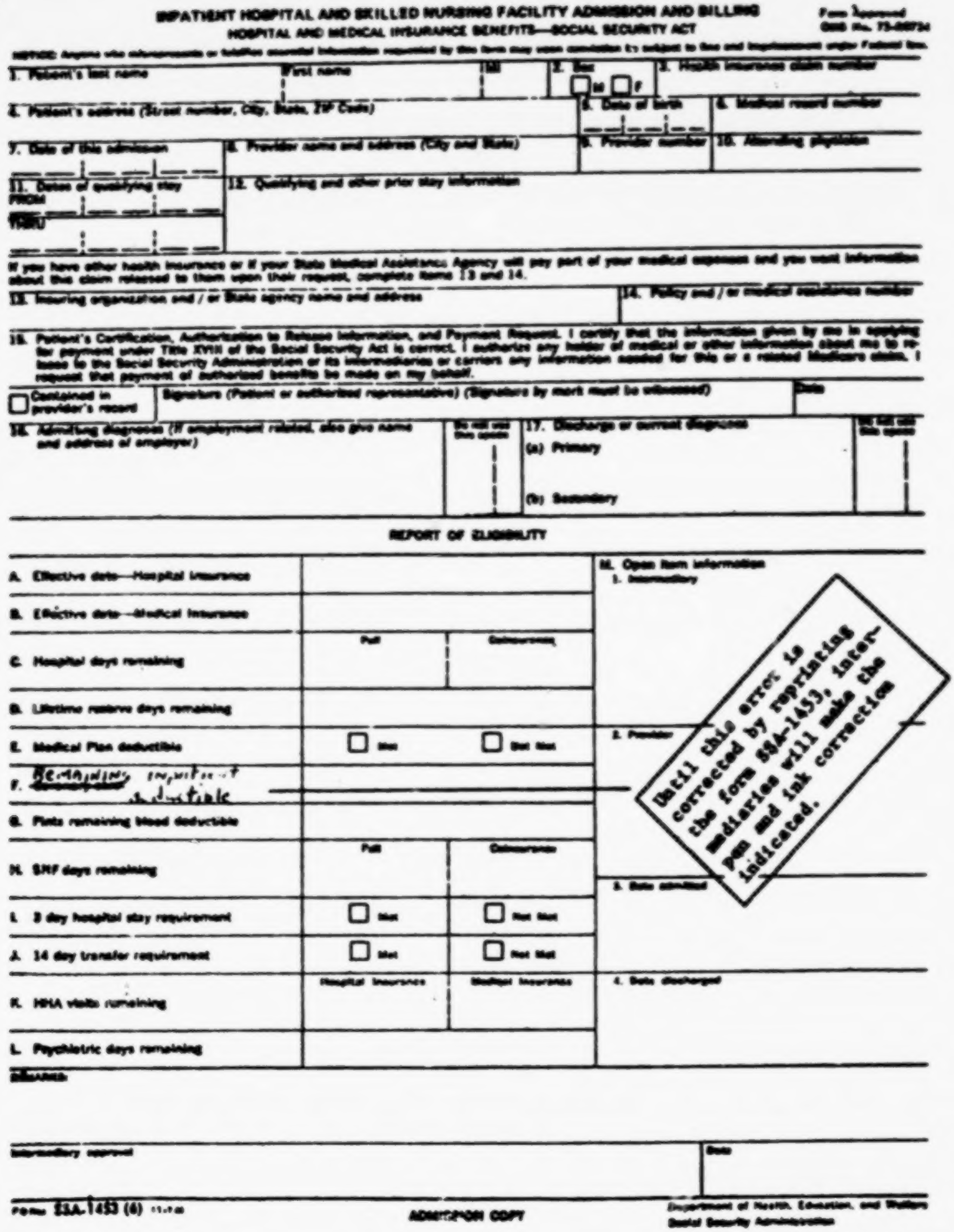
Sincerely yours,

Commissioner of Social Security

IMPORTANT

When services are provided on the basis of this notice, all bills or correspondence with an intermediary or the Social Security Administration should show the patient's health insurance claim number.

Exhibit 2



INPATIENT HOSPITAL AND SKILLED NURSING FACILITY ADMISSION AND BILLING

HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
OMB No. 72-R0734

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. Patient's last name | First name | MI
2. Sex ☐ M ☐ F
3. Health insurance claim number
4. Patient's address (Street number, City, State, ZIP Code)
5. Date of birth
6. Medical record number
7. Date of this admission
8. Provider name and address (City and State)
9. Provider number
10. Attending physician
11. Dates of qualifying stay FROM THRU
12. Qualifying and other prior stay information

If you have other health insurance or if your State Medical Assistance Agency will pay part of your medical expenses and you want information about this claim released to them upon their request, complete items 13 and 14.

13. Insuring organization and / or State agency name and address
14. Policy and / or medical assistance number

15. Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

☐ Contained in provider's record | Signature (Patient or authorized representative) (Signature by mark must be witnessed) | Date

16. Admitting diagnoses (If employment related, also give name and address of employer) | Do not use this space
17. Discharge or current diagnoses (a) Primary (b) Secondary | Do not use this space

REPORT OF ELIGIBILITY

A. Effective date—Hospital insurance		
B. Effective date—Medical insurance		
C. Hospital days remaining	Full	Coinsurance
D. Lifetime reserve days remaining		
E. Medical Plan deductible	☐ Met	☐ Not Met
F. Remaining inpatient deductible		
G. Pints remaining blood deductible		
H. SNF days remaining	Full	Coinsurance
I. 3 day hospital stay requirement	☐ Met	☐ Not Met
J. 14 day transfer requirement	☐ Met	☐ Not Met
K. HHA visits remaining	Hospital Insurance	Medical Insurance
L. Psychiatric days remaining		

M. Open item information
1. Intermediary
2. Provider
3. Date admitted
4. Date discharged

Until this error is corrected by reprinting the form SSA-1453, intermediaries will make the pen and ink correction indicated.

REMARKS

Intermediary approval | Date

Form SSA-1453 (4) [illegible]

ADMISSION COPY

Department of Health, Education, and Welfare
Social Security Administration

[illegible]

HOME HEALTH AGENCY REPORT AND BILLING
HOSPITAL AND MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

Form Approved
Budget Bureau No. 72-R730

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law.

1. PATIENT'S LAST NAME | FIRST NAME | MI
2. HEALTH INSURANCE CLAIM NUMBER
3. PATIENT'S ADDRESS (Street number, City, State, Zip Code)
4. DATE OF BIRTH
5. SEX ☐ M ☐ F
6. HOME HEALTH AGENCY NAME AND ADDRESS
7. PROVIDER NO.
8. MEDICAL RECORD NO.
9. NAME AND ADDRESS OF ATTENDING PHYSICIAN
10. DATE CARE STARTED
11. NAME AND ADDRESS OF INSTITUTION, IF ANY, CARING FOR CONDITION LATER REQUIRING HOME HEALTH SERVICES
12. VERIFIED DATES OF STAY IN ITEM 11 FROM TO
13. [illegible]
14. PAYMENT SOURCE FOR CHARGES TO PATIENT
A. ☐ [illegible] C. ☐ [illegible] E. ☐ [illegible]
B. ☐ [illegible] D. ☐ [illegible] F. ☐ OTHER (Explain)

15. PATIENT'S CERTIFICATION: AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

SIGNATURE (Patient or authorized representative) (Signature by mark must be witnessed) | DATE

16. DIAGNOSES | EMPLOYMENT RELATED A. ☐ YES B. ☐ NO (If yes, give name and address of employer.) | LEAVE BLANK

REPORT OF ELIGIBILITY

A. EFFECTIVE DATE, HOSPITAL INSURANCE
B. EFFECTIVE DATE, MEDICAL INSURANCE
C. DATE OF START OF CARE
D. HOSPITAL INSURANCE VISITS AVAILABLE
E. MEDICAL INSURANCE VISITS AVAILABLE
F. LAST DISCHARGE DATE
G. MEDICAL PLAN DEDUCTIBLE
☐ MET ☐ NOT MET
H. OUTPATIENT PSYCHIATRIC EXPENSE
☐ MET ☐ NOT MET
I. REMARKS

J. OPEN ITEM
1. INTERMEDIARY
2. PROVIDER
3. ADMITTED
4. DISCHARGED

APPROVED BY | DATE

FORM SSA-1487 (8) [illegible]

ADMISSION COPY

EXHIBIT 4

PART A
DISPOSITION CODES TRANSMITTED IN REPLY TO PART A QUERIES

QUERY CODE	DISPOSITION CODES
1	00, 01, 02, 09, 22, 23, 25, 26, 27, 28, 38, 41, 42, 43, 44, 46, 47, 48, 50, 51, 52, 54, 57, 90
2	00, 03, 09, 38, 49, 50, 51, 52, 54, 57, 90
4	00, 01, 02, 09, 22, 23, 25, 26, 27, 28, 38, 41, 42, 43, 44, 46, 47, 48, 50, 51, 52, 54, 57, 90
5	60, 61, 62, 63, 64, 65, 66, 67, 68, 69
7	00, 09, 10, 11, 38, 42, 43. 44, 48, 52

EXHIBIT 5
Type 1

INPATIENT (Hospital or SNF)
QUERY REPLY CODE TYPE 1
ASSOCIATED DISPOSITION CODES
and
POSSIBLE TRAILER CODES

Disposition Codes			Possible Trailer Codes*											
	B	C	G	K	L	M	O	P	R	S	T	U	Y	Z
01	X	X		X		X	X	X	X	X	X		X	X
02	X	X	X	X		X	X	X	X	X	X		X	X
22	X	X	X	X		X	X	X	X	X	X	X	X	X
23	X	X	X	X		X	X	X	X	X	X	X	X	X
25	X	X	X	X		X	X	X	X	X	X		X	X
26	X	X	X	X		X	X	X	X	X	X	X	X	X
27	X	X	X	X		X	X	X	X	X	X	X	X	X
28**	X	X	X	X		X	X	X	X	X	X	X	X	X
38	X	X		X										
41	X	X	X	X		X	X	X	X	X	X	X	X	X
42	X	X		X										X
43	X	X	X	X		X	X	X	X	X	X	X	X	X
44	X	X	X	X		X			X	X	X			X
46***	X	X	X	X		X	X	X	X	X	X	X	X	X
47****	X	X	X	X	X	X	X	X	X	X	X	X	X	X
48	X	X		X										X

* Trailer Codes underlined will always be shown for the corresponding Disposition Code.
** Does not apply to SNF Admissions.
*** Applies only to SNF Admissions.

EXHIBIT 5 (Cont.)
Type 1

Disposition Codes	Possible Trailer Codes*													
	B	C	G	K	L	M	O	P	R	S	T	U	Y	Z
50														
51														
52														
54														
57														
61	X	X		X		X	X̲	X	X	X		X	X	X
62	X	X	X	X		X	X̲	X	X	X	X	X	X	X
63	X	X	X	X		X	X̲	X	X	X	X	X̲	X	X
64	X	X	X	X		X	X̲	X	X	X	X̲	X	X	X
65														
66	X	X		X			X̲			X		X	X	X
67	X	X		X			X̲			X		X	X	X
68**	X	X	X	X		X	X̲	X	X	X	X	X	X	X

* Trailer Codes underlined will always be shown for the corresponding Disposition Code.

** Does not apply to SNF Admissions.

EXHIBIT 5(Cont.)
Type 2

HOME HEALTH AGENCY
QUERY REPLY AND CODE TYPE 2
and
POSSIBLE TRAILER CODES

Disposition Codes	Possible Trailer Codes*										
61	X	X	X	X	X̲	X	X	X		X	X	X
62	X	X	X	X	X̲	X	X	X	X	X	X	X
63	X	X	X	X	X̲	X	X	X	X	X̲	X	X
65												
66	X	X	X		X̲			X		X	X	X
67	X	X	X		X̲			X		X	X	X

* Trailer Codes underlined will always be shown for the corresponding Disposition Code.

EXHIBIT 5(Cont.)
Type 3

INPATIENT (GENERAL)
QUERY REPLY CODE TYPE 3
ASSOCIATED DISPOSITION CODES
and
POSSIBLE TRAILER CODES

Disposition Codes	
00	No Trailer Codes Possible
03	
09	
49	
60	
69	
90	

INPATIENT (GENERAL)
QUERY REPLY CODES TYPE 4
ASSOCIATED DISPOSITION CODES
and
POSSIBLE TRAILER CODES

No Disposition and Trailer Codes Possible

INPATIENT (GENERAL)
QUERY REPLY CODE TYPE 7
ASSOCIATED DISPOSITION CODES
and
POSSIBLE TRAILER CODES

39	No Trailer Codes Possible
78	
79	

EXHIBIT 6
Type 6

OUTPATIENT (PART A INTERMEDIARY)
QUERY REPLY CODE TYPE 6
ASSOCIATED DISPOSITION CODES
and
POSSIBLE TRAILER CODES*

Disposition Codes	Possible Trailer Codes*														
	A	B	C	D	F	G	H	K	M	O	R	S	U	Y	Z
01	X̲	X	X	X		X	X	X	X	X̲	X	X		X	X
02	X̲	X	X	X		X	X	X	X	X̲	X	X	X̲	X̲	X
03	X̲	X	X	X		X	X	X	X	X̲	X	X		X	X
04	X̲	X	X	X		X	X	X	X	X̲	X	X	X̲	X̲	X
05	X̲	X	X	X		X	X	X	X	X̲	X	X		X	X
06	X̲	X	X	X		X	X	X	X	X̲	X	X	X̲	X̲	X
07	X̲	X	X	X		X	X	X	X	X̲	X	X		X	X
08	X̲	X	X	X		X	X	X	X	X̲	X	X	X̲	X	X
21	X̲	X	X	X		X	X	X		X̲	X	X			
23	X̲	X	X	X		X	X	X	X	X̲	X	X			
26	X̲	X	X	X		X	X	X	X	X̲	X	X		X	X
28	X̲	X	X	X		X	X	X	X	X̲	X	X		X	X
38	X̲	X	X					X							
40	X̲	X	X					X		X̲	X̲	X			X
41	X̲	X	X					X		X̲	X	X			X
42	X̲	X	X					X			X	X			X
43	X̲	X	X					X			X	X			
44	X̲	X	X		X̲			X		X̲					X
45	X̲	X	X		X̲			X		X̲					X
47	X̲		X				X̲	X			X	X			

* Trailer Codes underlined will always be shown for the correspnding Disposition Code.

EXHIBIT 6 (Cont.)
Type 6

Disposition Code	Possible Trailer Codes*															
	A	B	C	D	F	G	H	I	K	M	O	R	S	U	Y	Z
48	X̲	X	X		X			X̲	X		X̲	X	X		X	X
49	X̲	X	X						X			X	X		X	X
50	X̲															
51	X̲															
52	X̲															
54																
55																
56																
57																

* Trailer Codes underlined will always be shown for the corresponding Disposition Code.

OUTPATIENT (PART A INTERMEDIARY QUERY REPLY CODE TYPE 7 ASSOCIATED DISPOSITION CODES and POSSIBLE TRAILER CODES

Disposition Codes	
36	No Trailer Codes Possible
39	
70	
71	
72	
77	
79	

OUTPATIENT (PART A INTERMEDIARY) QUERY REPLY CODE TYPE 3 ASSOCIATED DISPOSITION CODES and POSSIBLE TRAILER CODES

Disposition Codes	Possible Trailer Codes*
00	A
09	A
90	A

* Those Trailer Codes underlined will always be shown for the corresponding Disposition Code.

OUTPATIENT (PART A INTERMEDIARY) QUERY REPLY CODE TYPE 4 ASSOCIATED DISPOSITION CODES and POSSIBLE TRAILER CODES

No Disposition and Trailer Codes are possible.

EXHIBIT 6 (Cont.)
TYPE 5

HOSPICE (PART A INTERMEDIARY QUERY REPLY CODE TYPE 5 ASSOCIATED DISPOSITION CODES and POSSIBLE TRAILER CODES*

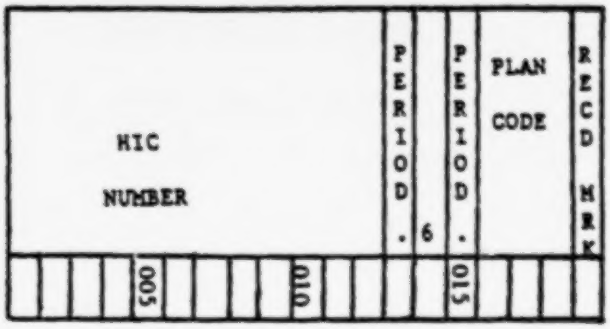
Disposition Code	Possible Trailer Codes*							
	B	C	K	O	P	T	U	Z
10	X	X	X		X	X	X	X̲
11	X	X	X		X	X	X	X̲
38	X̲	X	X	X̲			X̲	
42	X	X	X					
43	X	X	X		X	X	X̲	
44	X	X	X			X̲		
48	X	X	X					
52								

*Trailer Codes underlined will always be shown for the corresponding Disposition Code.

EXHIBIT 7

RECORD FORMATS FOR THE CODE 6 BILL HISTORY QUERY

A. The BCA record format.


HIC
NUMBER
PERIOD
.
6
PERIOD
.
PLAN
CODE
RECD MRK
005
010
015

B. The ARS record format.

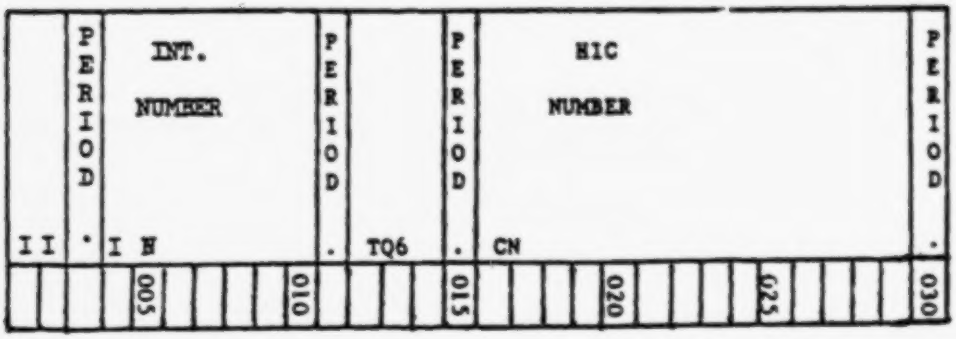

II
PERIOD
.
INT.
NUMBER
I N
PERIOD
.
TQ6
PERIOD
.
HIC
NUMBER
CN
PERIOD
.
005
010
015
020
025
030

EXHIBIT 8

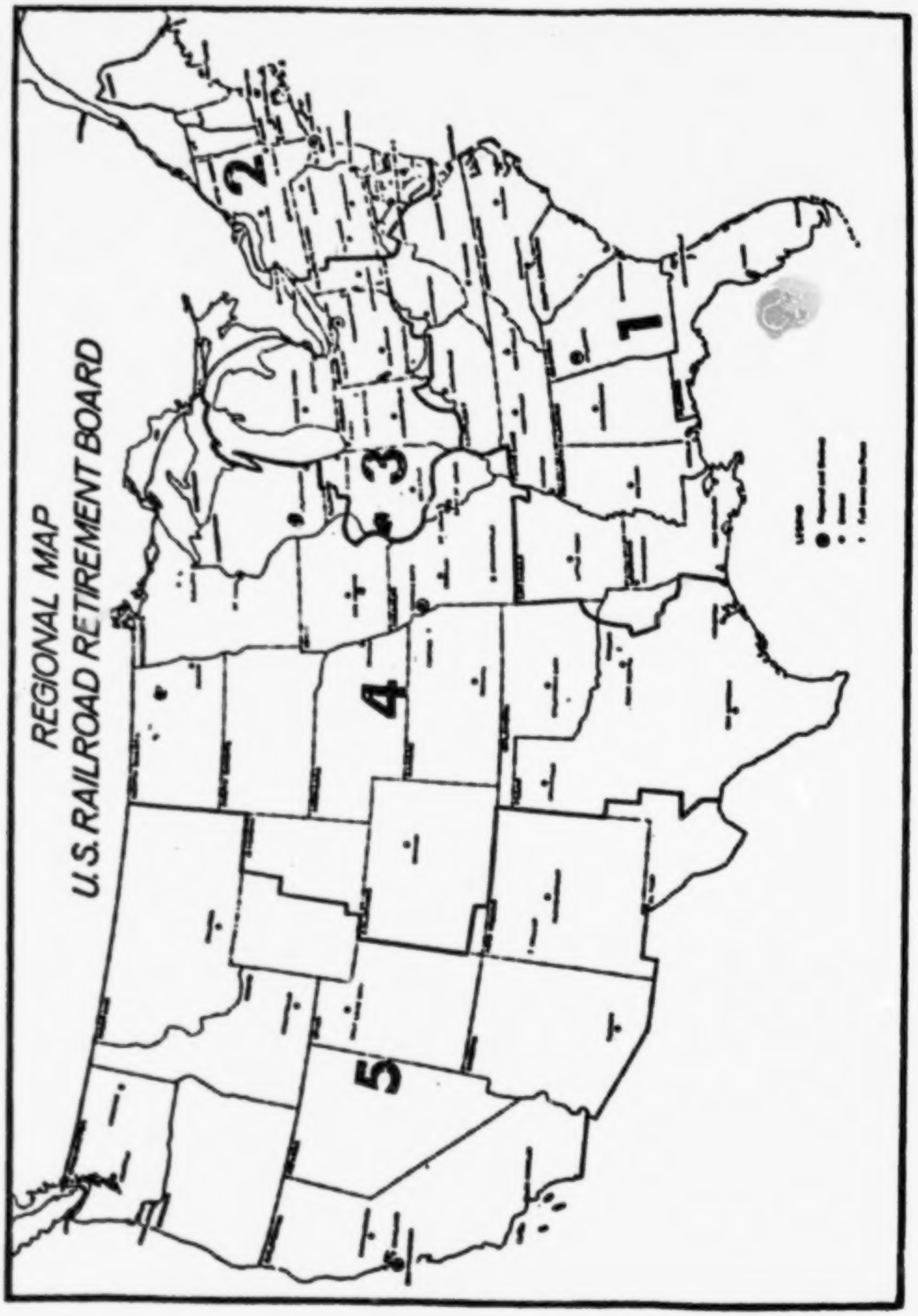

REGIONAL MAP
U.S. RAILROAD RETIREMENT BOARD
1
2
3
4
5

EXHIBIT 9

OFFICES of the U.S. RAILROAD RETIREMENT BOARD

Headquarters Office
844 RUSH STREET, CHICAGO, ILLINOIS 60611

Washington Liaison Office
PENNSYLVANIA BUILDING, ROOM 444
425 13th St., N.W., WASHINGTON, D.C. 20004

WHERE FULL–TIME SERVICE IS PROVIDED

STATE	ZIP CODE	CITY	STREET and NUMBER	REPRESENTATIVE	STATE	ZIP CODE	CITY	STREET and NUMBER	REPRESENTATIVE
Ala	35203**	Birmingham	2121 Bldg., Rm 1300, 2121-8th Avenue North	Vacant	Mo	65806	Springfield	Landmark Bldg., Rm 371, 309 North Jefferson Street	James L. Donahoe
Ala	36602	Mobile	Federal Office Bldg., Rm 1030 B, 109 St. Joseph Street	Billy F. Ingram	Mont	59103	Billings	Federal Bldg., Rm 1441, 316 North 26th St., P.O. Box 1351	Wallace J. LeClaire
Ariz	85701	Tucson	301 W. Congress, Rm 4-M	Richard A. McHenry	Nebr	68102	Omaha	New Federal Bldg., Rm 1010, 215 N. 17th St	Merle R. Shreffler
Ark	72203	Little Rock	Federal Office Bldg., Rm 1517, P.O. Box 3688	Ernest M. Hayes	N J	07102	Newark	New Federal Bldg., Rm 707, 970 Broad St	Robert J. Dade
Calif	90012**	Los Angeles	U.S. Courthouse Bldg., Rm 1006, 312 N. Spring St	Vacant	N Mex	87110	Albuquerque	1900-A Carlisle Boulevard N.E., P.O. Box 30203	Paul L. Johnson
Calif	94612†	Oakland	Federal Bldg., 1515 Clay Street	Lorraine H. Rollins	N Mex	87301†	Gallup	Fed. Bldg., Hill Ave. and Third St., Rm 130, P.O. Box 910	Tom Teachan
Calif	95825	Sacramento	Federal Bldg., Rm E-1821, 2800 Cottage Way	Jack J. Waltnetz	N Y	12207	Albany	Leo W. O'Brien Fed. Bldg., Rm 116, Clinton Ave. and N. Pearl Sts	William J. Curry
Calif	94102•	San Francisco	Federal Bldg., Rm 10043, 450 Golden Gate Ave., Box 36043	Robert L. Livingston	N Y	14202	Buffalo	Federal Bldg., Rm 1106, 111 West Huron Street	George A. Horvath
Calif	94102	San Francisco	Federal Bldg., 450 Golden Gate Ave., Box 36045	Leon Leavell	N Y	14901	Elmira	U.S. Post Office Bldg., Rm 327	Dorothy E. Kardile
Colo	80202	Denver	183 Custom House, 20th & Stout Sts	Russell L. Gibbons	N Y	10007	New York	Federal Bldg., Rm 3415, 26 Federal Plaza	William R. Spence
D C	20036	Washington	1725 L. Street N.W.	Henry F. Furlong	N Y	10007	New York	Federal Bldg., Rm 3404, 26 Federal Plaza	Hyman D. Owen
Fla	32202	Jacksonville	400 West Bay St., Rm 244, Box 35026	James H. Morgan	N Y	13202	Syracuse	Hunter Plaza, Seventh Floor, S. Salina & E. Fayette Sts	William B. Kuhlbusch
Fla	33131	Miami	168 S.E. First Street, Room 809	Glen B. Hall	N C	28205	Charlotte	Mart Office Bldg., Rm 88-503, 800 Briar Creek Rd. (at Independence)	Lee Moore
Fla	33602†	**Tampa	Barnett Bank Office Building, Rm 910, 1000 North Ashley Dr	Vacant	N C	27611	Raleigh	Federal Bldg., P.O.Cthse., Rm 446, 310 New Bern Ave	Ingram D. Bradham
Ga	30308•	**Atlanta	730 Peachtree St., N.E. Room 900	Edmund J. Sitaro	N Dak	58102	Fargo	U.S. P.O. Bldg., Rm 219, 657 Second Ave., North, P.O. Box 383	Jean R. Hesson
Ga	30308	Atlanta	730 Peachtree St., N.E. Room 900	James M. Wright, Jr.	Ohio	45202	Cincinnati	Federal Bldg., Rm 1030, 550 Main St	Thomas J. Schlinkert
Ga	31405	Savannah	719 East 65th Street	Albert Smith	Ohio	44199	Cleveland	Anthony J. Celebrezze Federal Bldg., Rm 401, 1240 E. 9th St	Frank M. Kosmerl
Idaho	83201	Pocatello	106 Fed. Bldg. & Cthse., 150 S. Arthur Ave., P.O. Box 1632	Richard McGrew	Ohio	44199•	**Cleveland	Anthony J. Celebrezze Federal Bldg., Rm 493, 1240 E. 9th St	Gene O. Wilson
Ill	60604 **	Chicago	Federal Building, 31st Floor, 230 South Dearborn	Vacant	Ohio	43215	Columbus	Federal Bldg., U.S. Cthse., Rm 210, 85 Marconi Blvd	Robert J. Lewis
Ill	62525	Decatur	132 South Water Street, Suite 517, P.O. Box 1291	Edward Kru	Ohio	43604	Toledo	Federal Bldg., Rm 321, 234 Summit St	Edwin Howell
Ill	62201	East St. Louis	Federal Building, 650 Missouri Ave., P.O. Box 207	Edward L. Filkins	Ohio	44503	Youngstown	Dollar Bank Bldg., Rm 601, Central Square	Marilynn L. Toner
Ind	46801†	Fort Wayne	Strauss Bldg., Rm 308, 809 S. Calhoun St., P.O. Box 363	Francis J. Moran, Sr.	Okla	73102	Oklahoma City	U.S.P.O. Bldg., Rm 146, 3rd & N. Robinson Sts	David L. Tobey
Ind	46402	Gary	475 Broadway, Room 504	Clara M. Lewis	Oreg	97205	Portland	U.S. Cthse., Rm 104, 620 S.W. Main St	Hardy O. Sibman
Ind	46204	Indianapolis	Federal Building, Rm 105, 575 North Pennsylvania St	Joseph T. Ruscka	Pa	16603	Altoona	615 Howard Ave., Room 10, P.O. Box 910	Charles A. McLaughlin
Iowa	50309	Des Moines	Federal Bldg., Rm 709, 210 Walnut Street	Elbert Cranford	Pa	17108	Harrisburg	Federal Bldg., Rm 500, 228 Walnut St., Box B-	James P. Begley
Kansas	66603†	Topeka	505 West Sixth Street	Vacant	Pa	19106	Philadelphia	Wm. J. Green Jr. Federal Bldg., Rm 7224, 600 Arch Street	Daniel E. O'Brien
Kansas	67202	Wichita	Petroleum Bldg., Rm 525, 221 S. Broadway	Stephen K. Rose	Pa	15222	Pittsburgh	Park Bldg., Rm 311, 355 Fifth Avenue	Frank G. Ocel
Ky	40202	Louisville	Federal Bldg., Rm 1774, 600 Federal Place	M. Warren Jeffries	Pa	18503	Scranton	U.S. P.O. & Cthse., Washington Ave. & Linden St., Rm 301	Joseph R. Heffron
La	70113	New Orleans	Tidewater Marine Bldg., Suite 422, 1706 Tulane Ave	E. L. Zimmerman, Jr.	Tenn	37901	Knoxville	Rm 239, 301 W. Cumberland Ave., P.O. Box 507	R. Bruce Cannon
La	71101	Shreveport	Federal Bldg., U.S. Cthse., 500 Fannin St., Rm 3B06	Vernon M. Holland	Tenn	38103	Memphis	Clifford Davis Federal Bldg., Rm 802, 167 N. Main Street	Frederick O. Bolton
Maine	04101†	Portland	Federal Bldg., Rm 2016, 151 Forest Ave	Louis P. [illegible]	Tenn	37203	Nashville	Federal Office Bldg., Rm 111, 701 Broadway	Marvin C. Hall
Md	21201	Baltimore	Geo. H. Fallon Federal Ofc. Bldg., Rm 112, 31 Hopkins Plaza	Peter J. Malon	Tex	79101	Amarillo	Herring Plaza, Rm 1107, P.O. Box H-4394	Maude H. McCleary
Mass	02109	Boston	John W. McCormack P.O. & Cthse., Rm 1002, P.O. Square	James A. Verpiarro	Tex	75202**	Dallas	1100 Commerce St., Rm 3 D 14	Barbara M. Jordan
Mass	01103	Springfield	Post Office Bldg., Rm 471	Angelo J. Razza	Tex	79954	El Paso	303 North Oregon, P.O. Box 5311	Edward L. Dreskwa
Mich	48226	Detroit	Book Bldg., Rm 1811, 1249 Washington Blvd	Howard A. Goth	Tex	76102	Ft. Worth	819 Taylor Street, Rm 10 A 36	John Price, Jr.
Mich	49502	Grand Rapids	Federal Bldg., Rm 776, 110 Michigan Street Northwest	John F. Conway	Tex	77208	Houston	Federal Office Bldg., Rm 2615, 515 Rusk St., P.O. Box 61166	Gerald R. Thurman
Minn	55802	Duluth	Federal Bldg., Rm 135, 515 West First Street	Verlaine C. Lebone	Tex	78206	San Antonio	Federal Building, Room B-404, 727 East Durango	Leon Chiles
Minn	55104	St. Paul	1821 University Avenue, Room 193	Stanley A. Domeracki	Utah	84111	Salt Lake City	Federal Bldg., Annex, Rm 108, 135 S. State St	David D. Daly
Miss	39205	Jackson	301 Bldg., 301 N. Lamar St., Rm 407, P.O. Box 2408	Daniel P. Wagner	Va	23502	Norfolk	Stanwick Bldg., Rm 147, 3661 Virginia Beach Blvd., East	Donald G. Sufferman
					Va	23240	Richmond	Federal Office Bldg., Rm 1207, 400 N. Eighth St., P.O. Box 10006	Patrick W. Graves
Mo	64106•	Kansas City	Federal Bldg., Rm 257, 601 East 12th St	John F. Maxwell	Va	24011	Roanoke	101 South Jefferson St., Rm 302	Hugh L. Tankersley
Mo	64106	Kansas City	Federal Bldg., Rm 258, 601 East 12th St	Donald J. Wilson	Wash	98174	Seattle	Federal Building, Room 942, 915 Second Avenue	Virgil Seaton
Mo	65301	Sedalia	Federal Bldg., Rm 109, 310 S. Lamine Ave	Richard F. Jones	Wash	99201	Spokane	U.S. Courthouse, Room 492, West 920 Riverside Avenue	Gene P. Severson
Mo	63101	St. Louis	[illegible] N. 12th Blvd., Rm [illegible]	John M. Carpenter	W Va	25722	Huntington	Federal Bldg., Room 1106, 502 8th St., P.O. Box 2153	Robert L. Hexum
					Wis	53213	Milwaukee	Continental Plaza Bldg., Suite 1040, 735 West Wisconsin Ave	Nicholas J. Gomes

For information offices part time service is maintained, write the nearest Board office, giving your name address telephone number and social security account number

• Regional Office   *Change of Address   **Change of Representative   †Full-time Duty Point

T-83

8-1-78

EXHIBIT 10

WORKERS' COMPENSATION DIRECTORY

ALABAMA
Chief
Workers' Compensation Division
Dept. of Industrial Relations
Industrial Relations Building
Montgomery, Alabama 36130

ALASKA
Director
Workers' Compensation Division
Department of Labor
P. O. Box 1149
Juneau, Alaska 99811

AMERICAN SAMOA
Chariman
Workers' Compensation Commission
Office of the Governor
American Samoa Government
Pago Pago, American Samoa 96799

ARIZONA
Chairman
Industrial Commission
1601 West Jefferson
P. O. Box 19070
Phoenix, Arizona 85005

ARKANSAS
Chairman
Workmen's Compensation Commission
Justice Building
State Capitol Grounds
Little Rock, Arkansas 72201

CALIFORNIA
Administrative Director
Division of Industrial Accidents
P. O. Box 603, Room 2178
San Francisco, CA 94101

COLORADO
Director
Dept. of Labor & Employment
1313 Sherman Street, Room 323
Denver, Colorado 80203

CONNECTICUT
Chairman
Workers' Compensation Commission
295 Treadwell Street
Hamden, Connecticut 06514

DELAWARE
Chairman
Industrial Accident Board
State Office Building, 6th Floor
820 N. French Street
Wilmington, Delaware 19801

DISTRICT OF COLUMBIA
Deputy Commissioner
Office of Workers' Compensation Programs
District 40
P. O. Box 19421
Washington, D.C. 20036

FLORIDA
Director
Division of Workers' Compensation
Department of Labor and Employment
Ashley Building
Tallahassee, Florida 32301

GEORGIA
Chairman
Board of Workers' Compensation
1800 Peachtree Street, N.W.
Suite 400
Atlanta, Georgia 30309

GUAM
Director of Labor and Personnel
Government of Guam
P. O. Box 367
Agana, Guam 96910

HAWAII
Director
Disability Compensation Division
Dept. of Labor and Industrial Relations
825 Mililani Street
Honolulu, Hawaii 96813

EXHIBIT 10 - Continued

IDAHO
Chairman
Industrial Commission
317 Main Street
Boise, Idaho 83704

ILLINOIS
Chairman
Industrial Commission
160 North LaSalle Street
Chicago, Illinois 60601

INDIANA
Chairman
Industrial Board
601 State Office Building
100 N. Senate Avenue
Indianapolis, Indiana 46204

IOWA
Industrial Commissioner's Office
State Capitol Complex
610 Des Moines Street
Des Moines, Iowa 50319

KANSAS
Director
Division of Workers' Compensation
Department of Human Resources
6th Floor
535 Kansas Avenue
Topeka, Kansas 66603

KENTUCKY
Chairman
Workmen's Compensation Board
127 Building
U.S. 127 South
Frankfort, Kentucky 42301

LOUISIANA
Commissioner
Department of Labor
1045 State Land & Natural Resources Bldg.
Box 44094
Baton Rouge, Louisiana 70804

MAINE
Chairman
Workers' Compensation Commission
State Office Building
Augusta, Maine 04333

MARYLAND
Chairman
Workmen's Compensation Commission
108 East Lexington Street
Baltimore, Maryland 21202

MASSACHUSETTS
Chairman
Industrial Accidents Board
Leverett Saltonstall Office Building
100 Cambridge Street
Boston, Massachusetts 02202

MICHIGAN
Director
Bureau of Workers' Disability Compensation
Department of Labor
309 N. Washington Square
Lansing, Michigan 48909

MINNESOTA
Commissioner
Workers' Compensation Division
Department of Labor and Industry
444 Lafayette Road
St. Paul, Minnesota 55101

MISSISSIPPI
Chairman
Workmen's Compensation Commission
1404 Walter Sillers State Office Bldg.
P. O. Box 987
Jackson, Mississippi 39205

MISSOURI
Director
Division of Workmen's Compensation
Department of Labor & Industrial
  Relations
P. O. Box 58
Jefferson City, Missouri 65101

MONTANA
Administrator
Division of Workers' Compensation
815 Front Street
Helena, Montana 59601

NEBRASKA
Presiding Judge
Workmen's Compensation Court
State House, 12th Floor
Lincoln, Nebraska 68509

EXHIBIT 10 - Continued

NEVADA
Chairman
Industrial Commission
515 E. Musser Street
Carson City, Nevada 89714

NEW HAMPSHIRE
Commissioner
Department of Labor
19 Pillsbury Street
Concord, New Hampshire 03301

NEW JERSEY
Director
Division of Workers' Compensation
Department of Labor and Industry
P.O. Box W
Trenton, New Jersey 08625

NEW MEXICO
Labor Commissioner
Labor and Industrial Commission
509 Camino De Los Marquez
Suite 2
Santa Fe, New Mexico 87501

NEW YORK
Chairman
Workers' Compensation Board
Two World Trade Center
New York, New York 10047

NORTH CAROLINA
Chairman
Industrial Commission
Dobbs Building
430 North Salisbury Street
Raleigh, North Carolina 27611

NORTH DAKOTA
Chairman
Workmen's Compensation Bureau
Russel Building
Highway 83 North
Bismarck, North Dakota 58505

OHIO
Administrator
Bureau of Workers' Compensation
246 North High Street
Columbus, Ohio 43215

OKLAHOMA
Presiding Judge
Oklahoma Workers' Compensation Court
Jim Thorpe Building
2101 North Lincoln
Oklahoma City, Oklahoma 73105

Oregon
Director
Workers' Compensation Department
Labor and Industries Building
Salem, Oregon 97310

PENNSYLVANIA
Director
Bureau of Workers' Compensation
Department of Labor and Industry
3607 Derry Street
Harrisburg, Pennsylvania 17111

PUERTO RICO
Chairman
Industrial Commissioner's Office
G.P.O. Box 4466
San Juan, Puerto Rico 00936

RHODE ISLAND
Chairman
Workers' Compensation Commission
25 Canal Street
Providence, Rhode Island 02903

SOUTH CAROLINA
Chairman
Industrial Commission
Middleburg Office Park
1800 St. Julian Place
Columbia, South Carolina 29204

SOUTH DAKOTA
Director
Division of Labor and Management
Department of Labor
Joe Foss Building
Pierre, South Dakota 57501

TENNESSEE
Director
Workmen's Compensation Division
Department of Labor
501 Union Building
Nashville, Tennessee 37219

EXHIBIT 10 - Continued

TEXAS
Chairman
Industrial Accident Board
Box 12757, Capitol Station
Austin, Texas 78711

UTAH
Chairman
Industrial Commission
350 E. 500 South
Salt Lake City, Utah 84111

VERMONT
Commissioner
Department of Labor and Industry
Montpelier, Vermont 05602

VIRGIN ISLANDS
Commissioner of Labor's Office
Government of the Virgin Islands
St. Thomas, Virgin Islands 00801

VIRGINIA
Chairman
Industrial Commission
Blanton Building
P.O. Box 1794
Richmond, Virginia 23214

WASHINGTON
Director
Department of Labor and Industries
General Administration Building
AX-31
Olympia, Washington 98504

WEST VIRGINIA
Commissioner
Workmen's Compensation Commissioner's Office
P.O. Box 3151
Charleston, West Virginia 25332

WISCONSIN
Administrator
Workers' Compensation Division
Department of Industry, Labor and Human Relations
P.O. Box 7901
Room 152
201 East Washington Avenue
Madison, Wisconsin 53702

WYOMING
Director
Workers' Compensation Division
State Treasurers' Office
2305 Carey Avenue
Cheyenne, Wyoming 82002

EXHIBIT 11

Code 36 Automatic Notice Record Description

Field Description	Dec. Size	LOC ARS	LOC BCA	Remarks
Type Reply	1	1	1	7
Field Separator	1	2	2	.
Intermediary Number	5/3	3-7	3-5	
Field Separator	1	8	6	.
Claim Number	12	9-20	7-18	
Field Separator	1	21	19	.
Disposition Code	2	22-23	20-21	
Field Separator	1	24	22	.
Surname	6	25-30	23-28	
Blank	1	31	29	
Initials	2	32-33	30-31	
Field Separator	1	34	32	.
Type Code	1	35	33	See § 3535.1, Part B 'Y' trailer for possible codes and their explaination.
Field Separator	1	36	34	.
Effective Date	6	37-42	35-40	MMDDYY. See §3535.1, Part B 'Y' trailer for an explaination of this date.
Field Separator	1	43	41	.
Blank	6	44-49	42-47	
Field Separator	1	50	—	.
Record Mark	1	—	48	≠
ARS End of Record Indicator	7	51-57	—	$\Delta\Delta\bar{0}\bar{0}\bar{0}\bar{0}\bar{0}$ (Carriage return and line feed characters)

Exhibit 12

TYPE 7 (HOSPICE) QUERY FORMAT
BCA FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Health Insurance Claim Number	1-12	Beneficiary HICN, left justified.
2. Field Separator	13	Constant '.'.
3. Name		
a. Surname	14-24	Beneficiary surname.
b. Separator	25	Constant ','.
c. Initials	26-27	First initial must be present, middle initial may be blank.
4. Field Separator	28	Constant'.'.
5. Query Code	29	Constant '7'.
6. Field Separator	30	Constant '.'.
7. Intermediary Number	31-33	Number of intermediary submitting the query.
8. Field Separator	34	Constant '.'.
9. Hospice Number	35-40	Provider number of the Hospice.
10. Field Separator	41	Constant '.'.
11. Start Date	42-46	YMMDD. The beginning date of a period of Hospice election or the beginning date of an intermediary/Hospice change within an existing period of Hospice election.
12. Field Separator	47	Constant '.'.
13. Date of Birth	48-53	YYMMDD. Beneficiary date of birth.
14. Field Separator	54	Constant'.'.
15. Termination Date	55-59	YMMDD. Termination date of an existing period of Hospice election. This field will be blank when no termination date is involved. NOTE: It is not necessary to terminate a period of election unless the beneficiary chooses to do so before the expiration of the appropriate 90 or 30 day period. Also, it is not necessary to terminate when the only action being conveyed is a change of intermediary/Hospice within an existing period of election.
16. Field Separator	60	Constant '.'.
17. Hospice Code	61	A one position code indicating the reason for this query. Allowable codes are: 1 - indicates this query is starting a new period of Hospice election.

Exhibit 12 (Cont.)

TYPE 7 (HOSPICE) QUERY FORMAT
BCA FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
		2 - indicates this query is terminating an existing period of Hospice election. This code is used only for early termination of an existing period of Hospice when chosen by the beneficiary. See NOTE under termination above. The appropriate start date must be included in the query when this code is used. 3 - indicates a change of intermediary/Hospice during an existing period of Hospice election. No termination date is necessary. NOTE: The beneficiary is allowed to change to a different Hospice once during each period of election. It is the responsibility of the new servicing intermediary to record the change of Hospice. 4 - indicates this query is attempting to void (cancel) an existing period of Hospice election. An appropriate use would be where the intermediary erroneously sent a code 1 query for the wrong beneficiary. The start date originally used must be included in the query. Additionally, if the period were terminated, either early via a code 2 query or because the appropriate 90 or 30 day period had elapsed, then the query must also include the applicable termination date.
18. Record Mark	62	≠ (0-2-8 card punch code). Indicates end of record.

Exhibit 12 (Cont.)

TYPE 7 (HOSPICE) QUERY FORMAT
ARS FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Start of Query	1-2	Constant 'II'.
2. Field Separator	3	Constant '.'.
3. Query Code		
a. Field Indicator	4-5	Constant 'TQ'.
b. Query Code	6	Constant '7'.
4. Field Separator	7	Constant '.'.
5. Intermediary Number		
a. Field Indicator	8-9	Constant 'IN'.
b. Intermediary Number	10-14	Number of intermediary submitting query.
6. Field Separator	15	Constant '.'.
7. Beneficiary Name		
a. Field Indicator	16-17	Constant 'BN'.
b. Surname	18-28	Field can contain up to 11 positions or as few as 2 positions. Field is flexible, that is, positions not used can be eliminated.
c. Separator	29	Constant ','.
d. Initials	30-31	First followed by middle initial. Middle initial may be blank.
8. Field Separator	32	Constant '.'.
9. Health Insurance Claim Number		
a. Field Indicator	33-34	Constant 'CN'.
b. HICN	35-46	Field can contain up to 12 positions or as few as 7 positions. Field is flexible, that is, positions not used can be eliminated.
10. Field Separator	47	Constant '.'.
11. Date of Birth		
a. Field Indicator	48-49	Constant 'DB'.
b. Date of Birth	50-55	MMDDYY.
12. Field Separator	56	Constant '.'.
13. Provider Number		
a. Field Indicator	57-58	Constant 'PN'.
b. Provider Number	59-64	Provider number of the Hospice involved.
14. Field Separator	65	Constant '.'.
15. Start Date		
a. Field Indicator	66-67	Constant 'DA'.
b. Start Date	68-73	MMDDYY. The beginning date of a period of Hospice election or the beginning date of an intermediary/Hospice change within an existing period of Hospice election.

Exhibit 12 (Cont.)

TYPE 7 (HOSPICE) QUERY FORMAT
ARS FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
16. Field Separator	74	Constant '.'.
17. Hospice Code		
a. Field Indicator	75-76	Constant 'HC'.
b. Hospice Code	77	A one position code indicating the reason for this query. Allowable codes are: 1 - indicates this query is starting a new period of Hospice election. 2 - indicates this query is terminating an existing period of Hospice election. This code is used only for early termination of an existing period of Hospice when chosen by the beneficiary. See NOTE under termination below. The appropriate start date must be included in the query when this code is used. 3 - indicates a change of intermediary/Hospice during an existing period of Hospice election. No termination date is necessary. NOTE: The beneficiary is allowed to change to a different Hospice once during each period of election. It is the responsibility of the new servicing intermediary to record the change of Hospice. 4 - indicates this query is attempting to void (cancel) an existing period of Hospice election. An appropriate use would be where the intermediary erroneously sent a code 1 query for the wrong beneficiary. The start date originally used must be included in the query. Additionally, if the period were terminated, either early via a code 2 query or because the appropriate 90 or 30 day period had elapsed, then the query must also include the applicable termination date.
18. Field Separator	78	Constant '.'.

Exhibit 12 (Cont.)

TYPE 7 (HOSPICE) QUERY FORMAT
ARS FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
19. Termination Date		
a. Field Indicator	79-80	Constant 'DE'.
b. Termination Date	81-86	MMDDYY. (This field, including the 'DE' and the preceding field separator, are not necessary if no termination date is being conveyed.) Termination date of an existing period of Hospice election. This field will be blank when no termination date is involved. NOTE: It is not necessary to terminate a period of election unless the beneficiary chooses to do so before the expiration of the appropriate 90 or 30 day period. Also, it is not necessary to terminate when the only action being conveyed is a change of intermediary/Hospice within an existing period of election.
20. Field Separator	87	Constant '.'.
21. ARS End of Record Indicator	88-94	$\Delta\Delta\overline{00000}$.

Exhibit 13

TYPE 4 EDIT REJECT FORMAT
BCA FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Reply Indicator	1	Constant '4'.
2. Field Separator	2	Constant '.'.
3. Plan Code	3-5	Intermediary number from query.
4. Field Separator	6	Constant '.'.
5. Health Insurance Claim Number	7-18	HICN from query.
6. Field Separator	19	Constant '.'.
7. Beneficiary Name		Name submitted on query.
a. Surname	20-30	
b. Separator	31	Constant ','.
c. Initials	32-33	First followed by middle initial.
8. Field Separator	34	Constant '.'.
9. Query Code	35	Constant '7'.
10. Field Separator	36	Constant '.'.
11. Provider Number	37-42	Hospice number from query.
12. Field Separator	43	Constant '.'.
13. Admission Date	44-48	MMDDY. Start date submitted on query. If date submitted was not numeric this field will be zeros.
14. Field Separator	49	Constant '.'.
15. Date of Birth	50-55	MMDDYY. Date submitted on query. If date submitted was not numeric this field will be zeros.
16. Field Separator	56	Constant '.'.
17. Error Codes	57-60	Field will contain up to four one position codes indicating the erroneous data. Possible codes and their meaning are: 1 - HICN 2 - Name 4 - Provider (Hospice) number 5 - Admission (Start) date 6 - Termination date 7 - Change code
18. Field Separator	61	Constant '.'.
19. Termination Date	62-66	MMDDY. Termination date submitted on query. If date submitted was not numeric this field will be zeros.
20. Field Separator	67	Constant '.'.
21. Change Code	68	Code submitted on query.
22. End of Record	69	≠ (0-2-8 card punch code) Record Mark.

Exhibit 13 (Cont.)

TYPE 3 ACKNOWLEDGEMENT FORMAT
BCA FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Reply Indicator	1	Constant '3'.
2. Field Separator	2	Constant '.'.
3. Plan Code	3-5	Intermediary number from query.
4. Field Separator	6	Constant '.'.
5. Health Insurance Claim Number	7-18	HICN from query.
6. Field Separator	19	Constant '.'.
7. Disposition code	20-21	See § 3513.1.
8. Field Separator	22	Constant '.'.
9. Beneficiary Name		Name submitted on query.
a. Surname	23-33	
b. Separator	34	Constant ','.
c. Initials	35-36	First followed by middle initial.
10. Field Separator	37	Constant '.'.
11. Query Code	38	Constant '7'.
12. Field Separator	39	Constant '.'.
13. Provider Number	40-45	Hospice number from query.
14. Field Separator	46	Constant '.'.
15. Admission Date	47-51	MMDDY. Start date submitted on query.
16. End of Record	52-54	≠≠≠ (0-2-8 card punch code) Record Marks.

Exhibit 13 (Cont.)

TYPE 5 DEFINITIVE FORMAT
BCA FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Reply Indicator	1	Constant '5'.
2. Field Separator	2	Constant '.'.
3. Plan Code	3-5	Intermediary number from query.
4. Field Separator	6	Constant '.'.
5. Health Insurance Claim Number	7-18	HICN from query.
6. Field Separator	19	Constant '.'.
7. Disposition code	20-21	See § 3513.1.
8. Field Separator	22	Constant '.'.
9. Beneficiary Name		Name submitted on query.
a. Surname	23-33	
b. Separator	34	Constant ','.
c. Initials	35-36	First followed by middle initial.
10. Field Separator	37	Constant '.'.
11. Query Code	38	Constant '7'.
12. Field Separator	39	Constant '.'.
13. Provider Number	40-45	Hospice number from query.
14. Field Separator	46	Constant '.'.
15. Admission Date	47-51	MMDDY. Start date submitted on query.
16. Field Separator	52	Constant '.'.
17. Date of Birth	53-58	MMDDYY. Date submitted on query.
18. Field Separator	59	Constant '.'.
19. Termination Date	60-64	MMDDY. Termination date submitted on query. Field will be blank if no termination was submitted on query.
20. Field Separator	65	Constant '.'.
21. Change Code	66	Code submitted on query.
22. Field Separator	67	Constant '.'.
23. Current Part A Entitlement Date	68-71	MMYY. The beneficiary's current Part A entitlement date as reflected on HCFA's record. If no entitlement exists, field will be blank. For code 38 replies field will always be blank regardless of entitlement status.
24. End of Record/ New Line Indicator	72	Record mark (≠ 0-2-8 card punch code) or '*'.

Exhibit 13 (Cont.)

TYPE 4 EDIT REJECT FORMAT
ARS FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Reply Indicator	1	Constant '4'.
2. Field Separator	2	Constant '.'.
3. Intermediary Number	3-7	Intermediary number from query.
4. Field Separator	8	Constant '.'.
5. Health Insurance Claim Number	9-20	HICN from query.
6. Field Separator	21	Constant '.'.
7. Beneficiary Name		Name submitted on query.
a. Surname	22-32	
b. Separator	33	Constant ','.
c. Initials	34-35	First followed by middle initial.
8. Field Separator	36	Constant '.'.
9. Query Code	37	Constant '7'.
10. Field Separator	38	Constant '.'.
11. Provider Number	39-44	Hospice number from query.
12. Field Separator	45	Constant '.'.
13. Admission Date	46-51	MMDDYY. Start date submitted on query. If date submitted was not numeric this field will be zeros.
14. Field Separator	52	Constant '.'.
15. Date of Birth	53-58	MMDDYY. Date submitted on query. If date submitted was not numeric this field will be zeros.
16. Field Separator	59	Constant '.'.
17. Termination Date	60-65	MMDDYY. Termination date submitted on query. If date submitted was not numeric this field will be zeros.
18. Field Separator	66	Constant '.'.
19. Change Code	67	Code submitted on query.
20. Field Separator	68	Constant '.'.
21. End of Record	69-75	ΔΔ00000. ARS end of record indicator.

NOTE: The Field Separator following the data fields listed below will contain an '*' instead of a '.' if the field is in error:

If this field is in error	This field will contain an asterick
3	4
5	6
7	8
11	12
13	14
15	16
17	18
19	20

Exhibit 13 (Cont.)

TYPE 3 ACKNOWLEDGEMENT FORMAT
ARS FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Reply Indicator	1	Constant '3'.
2. Field Separator	2	Constant '.'.
3. Intermediary Number	3-7	Intermediary number from query.
4. Field Separator	8	Constant '.'.
5. Health Insurance Claim Number	9-20	HICN from query.
6. Field Separator	21	Constant '.'.
7. Disposition code	22-23	See § 3513.1.
8. Field Separator	24	Constant '.'.
9. Beneficiary Name		Name submitted on query.
a. Surname	25-35	
b. Separator	36	Constant ','.
c. Initials	37-38	First followed by middle initial.
10. Field Separator	39	Constant '.'.
11. Query Code	40	Constant '7'.
12. Field Separator	41	Constant '.'.
13. Provider Number	42-47	Hospice number from query.
14. Field Separator	48	Constant '.'.
15. Admission Date	49-54	MMDDYY. Start date submitted on query.
16. Field Separator	55	Constant '.'.
17. End of Record	56-62	$\Delta\Delta\bar{0}\bar{0}\bar{0}\bar{0}\bar{0}$. ARS end of record indicator.

Exhibit 13 (Cont.)

TYPE 5 DEFINITIVE FORMAT
ARS FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Reply Indicator	1	Constant '5'.
2. Field Separator	2	Constant '.'.
3. Intermediary Number	3-7	Intermediary number from query.
4. Field Separator	8	Constant '.'.
5. Health Insurance Claim Number	9-20	HICN from query.
6. Field Separator	21	Constant '.'.
7. Disposition code	22-23	See § 3513.1.
8. Field Separator	24	Constant '.'.
9. Beneficiary Name		Name submitted on query.
a. Surname	25-35	
b. Separator	36	Constant ','.
c. Initials	37-38	First followed by middle initial.
10. Field Separator	39	Constant '.'.
11. Query Code	40	Constant '7'.
12. Field Separator	41	Constant '.'.
13. Provider Number	42-47	Hospice number from query.
14. Field Separator	48	Constant '.'.
15. Admission Date	49-54	MMDDYY. Start date submitted on query.
16. Field Separator	55	Constant '.'.
17. Date of Birth	56-61	MMDDYY. Date submitted on query.
18. Field Separator	62	Constant '.'.
19. Termination Date	63-68	MMDDYY. Termination date submitted on query. Field will be blank if no termination was submitted on query.
20. Field Separator	69	Constant '.'.
21. Change Code	70	Code submitted on query.
22. Field Separator	71	Constant '.'.
23. New Line Indicator	72-74	ΔΔŏ. ARS new line indicator.
24. Current Part A Entitlement Date	75-78	MMYY. The beneficiary's current Part A entitlement date as reflected on HCFA's record. If no entitlement exists, field will be blank. For code 38 replies field will always be blank regardless of entitlement status.
25. Field Separator	79	Constant '.'.
26. First Trailer Code	80	Alphabetic code of first trailer attached to this record.
OR		
26. End of Record	80-86	Δ4ŏŏōōō. ARS end of record indicator.

Exhibit 14

CODE Z HOSPICE TRAILER FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Trailer Indicator	1	Constant 'Z'.
2. Field Separator	2	Constant '.'.
3. Hospice Period	3	1, 2 or 3. Will indicate if this is the beneficiary's 1st, 2nd or 3rd period of Hospice.
4. Field Separator	4	Constant '.'.
5. Start Date	5-10	MMDDYY. The beginning date of this Hospice period.
6. Field Separator	11	Constant '.'.
7. First Hospice Provider	12-17	Provider number of the first (or only, if the Second Hospice Provider field is blank) Hospice involved in this period.
8. Field Separator	18	Constant '.'.
9. First Intermediary	19-23	Number of the first (or only, if the Second Intermediary field is blank) intermediary involved in this period. This is the servicing intermediary for the Hospice shown in field 7.
10. Field Separator	24	Constant '.'.
11. Second Hospice Start Date	25-30	MMDDYY. If this date is present then there has been a change of intermediary/Hospice and this is the date the Second Hospice provider was involved with this period.
12. Field Separator	31	Constant '.'.
13. Second Hospice Provider	32-37	Provider number of the second Hospice provider involved in this period. Field will be blank if their is no second Hospice involvement.
14. Field Separator	38	Constant '.'.
15. Second Intermediary	39-43	Number of the second intermediary involved in this period. This is the servicing intermediary for the Hospice shown in field 13. Field will be blank if there is no second intermediary/Hospice involvement.
16. Field Separator	44	Constant '.'.

Exhibit 14 (Cont.)

TYPE Z HOSPICE TRAILER FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
17. Termination Date	45-50	MMDDYY. This field will be blank if the Hospice period is still in progress. If present, this date represents 1) the normal ending date of this period, or 2) the date the beneficiary terminated the period.
BCA FORMAT		
18. End of Record	(51)	≠ (0-2-8 card punch code). Record mark.
ARS FORMAT		
18. Field Separator	51	Constant '.'.
19. End of Record	(52-58)	$\Delta\Delta\bar{0}\bar{0}\bar{0}\bar{0}\bar{0}$. ARS end of record indicator.

Exhibit 15

CODE O BENEFICIARY DATE OF BIRTH AND SEX TRAILER FORMAT

FIELD DESCRIPTION	POSITION	REMARKS
1. Trailer Indicator	1	Constant 'O'.
2. Field Separator	2	Constant '.'.
3. Date of Birth	3-8	MMDDYY. Beneficiary date of birth as recorded on the HCFA master record.
4. Field Separator	9	Constant '.'.
5. Century Indicator	10	Indicates the century of birth. Allowable codes are: 8 - 1800's (19th century) 9 - 1900's (20th century)
6. Field Separator	11	Constant '.'.
7. Sex	12	Beneficiary sex as recorded on the HCFA master record. Allowable codes are: 1 - Male 2 - Female
BCA FORMAT		
8. Trailer Separator	(13)	Constant '.'.
OR		
New Line Indicator	(13)	Constant '*'.
OR		
End of Record	(13)	≠ (0-2-8 card punch code). Record mark.
ARS FORMAT		
8. Trailer Separator	13	Constant '.'.
9. Next Trailer Code	(14)	Alphabetic code of next trailer
OR		
New Line Indicator	(14-16)	$\Delta\Delta\bar{0}$. ARS new line indicator.
OR		
End of Record	(14-20)	$\Delta\Delta\bar{0}\bar{0}\bar{0}\bar{0}\bar{0}$. ARS end of record indicator.

Exhibit 16

CODE Y OTHER PROGRAM INVOLVEMENT TRAILER FORMAT

	FIELD DESCRIPTION	POSITION	REMARKS
1.	Trailer Indicator	1	Constant 'Y'.
2.	Field Separator	2	Constant '.'.
3.	Other Program Code	3	One position code indicating the reason for the trailer. See §§ 3512.9 and 3535.1 for a list and explanation of the codes.
4.	Field Separator	4	Constant '.'.
5.	Effective Date	5-10	MMDDYY. The effective date of the applicable other program involvement. See §§ 3512.9 and 3535.1 for an explanation of this field.
6.	Unused	11-35	Field is blank. To be used for future expansion.
	BCA FORMAT		
7.	Trailer Separator	(36)	Constant '.'.
	OR		
	New Line Indicator	(36)	Constant '*'.
	OR		
	End of Record	(36)	≠ (0-2-8 card punch code). Record mark.
	ARS FORMAT		
7.	Trailer Separator	36	Constant '.'.
8.	Next Trailer Code	(37)	Alphabetic code of next trailer
	OR		
	New Line Indicator	(37-39)	$\Delta\Delta\bar{0}$. ARS new line indicator.
	OR		
	End of Record	(37-43)	$\Delta\Delta\bar{0}\bar{0}\bar{0}\bar{0}\bar{0}$. ARS end of record indicator.

EXHIBIT 17

INTERMEDIARIES SERVICING HOSPICES

Contractor Number	Organization
00010	Blue Cross and Blue Shield of Alabama
00020	Arkansas Blue Cross and Blue Shield, Inc.
00040	Blue Cross of Southern California
00050	Blue Cross/Blue Shield of Colorado
00060	Blue Cross and Blue Shield of Connecticut, Inc.
00070	Blue Cross of Delaware
00080	Group Hospitalization, Inc. (Washington, D.C.)
00090	Blue Cross and Blue Shield of Florida
00101	Blue Cross of Georgia/Columbus, Inc.
00110	Blue Cross of Idaho Health Services
00121	Health Care Service Corporation (Chicago, Ill.)
00130	Mutual Hospital Insurance, Inc. (Indianapolis, Ind.)
00140	Blue Cross of Iowa, Inc.
00141	Blue Cross of Western Iowa and South Dakota
00150	Blue Cross of Kansas, Inc.
00160	Blue Cross and Blue Shield of Kentucky, Inc.
00170	Blue Cross of Louisiana
00180	Associated Hospital Service of Maine
00190	Blue Cross of Maryland, Inc.
00210	Blue Cross and Blue Shield of Michigan
00220	Blue Cross of Minnesota
00230	Blue Cross and Blue Shield of Mississippi, Inc.
00241	Blue Cross Hospital Service, Inc, of Missouri (St. Louis)
00250	Blue Cross of Montana
00270	New Hampshire - Vermont Health Service, Inc.
00290	New Mexico Blue Cross and Blue Shield, Inc.
00308	Blue Cross and Blue Shield of Greater New York
00310	Blue Cross and Blue Shield of North Carolina
00320	Blue Cross of North Dakota
00332	Hospital Care Corporation (Cincinnati, Ohio)
00340	Blue Cross and Blue Shield of Oklahoma
00350	Blue Cross of Oregon
00362	Blue Cross of Greater Philadelphia
00370	Hospital Service Corporation of Rhode Island
00380	Blue Cross and Blue Shield of South Carolina
00390	Blue Cross and Blue Shield of Tennessee (Chattanooga)
00400	Group Hospital Service, Inc. (Dallas, Tex.)
00410	Blue Cross of Utah
00424	Blue Cross of Southwestern Virginia (Roanoke, Va.)

EXHIBIT 17 (Cont.)

INTERMEDIARIES SERVICING HOSPICES

Contractor Number	Organization
00430	Blue Cross of Washington and Alaska
00441	Blue Cross Hospital Services, Inc. (Charleston, WVA.)
00450	Blue Cross/Blue Shield United of Wisconsin
00460	Blue Cross of Wyoming
17120	Hawaii Medical Service Association
51290	Aetna Life and Casualty (Reno, Nevada)
52280	Mutual of Omaha Insurance Company (Omaha, Neb.)
53310	The Prudential Insurance Company (Milleville, NJ.)

Health Maintenance Organizations, Admissions, and Query Procedures

3555. ADMISSION AND QUERY PROCEDURES FOR SERVICES TO HMO MEMBERS

3555.1 Inpatient Services to HMO Members.--

A. Admission Procedures--General.--The provider furnishing the inpatient services, (including one owned and operated by an HMO), sends you a bill for all admissions, including those for HMO members. Review the bills for completeness and query HCFA.

B. HCFA Action on Queries.--HCFA determines the status of the HMO member and the payment option that the particular HMO elected. HCFA sends you a utilization reply including the appropriate ID trailer. (See §3512.8 for description.)

C. Intermediary Actions on Query Replies.--

1. R Trailer Code "1".--The beneficiary is unrestricted in an HMO which elected to have you process all bills. Process the claim as usual (§§3600ff.) and send a notice of payment or nonpayment (photocopy of the bill or other medium) to the HMO. Send the bill data to HCFA in UNIBILL.

2. R Trailer Code "2".--The beneficiary is unrestricted in an HMO which elected to process only bills for directly provided services and for providers with whom it has effective arrangements. Check the directory (see §3558) to determine if services are directly provided or from a provider with whom the HMO has an effective arrangement.

a. Directly Provided or Effective Arrangements.--Return the bill and instruct the provider to bill the HMO.

b. All Other Services.--Process the bill as described in 1 above.

3. R Trailer Code "A".--The beneficiary is restricted to an HMO which elected to have you process all bills. Check the directory (see §3558) to determine if services are in-plan.

a. Services are In-Plan.--Process the claim as usual (§§3600ff.) and send a notice of payment or nonpayment (photocopy of the bill or other medium) to the HMO. Send the bill data to HCFA in UNIBILL.

b. Services Are Out-Of-Plan.--Determine if the beneficiary lives in the HMO's service area. (See §3558.) If the beneficiary does not, process the claim as in a. above.

If the beneficiary lives in the HMO's service area, determine if the services were emergency or were provided outside the HMO's service area but were urgently needed. Notify the provider to send emergency documentation within three days. (See Nonparticipating Domestic Hospital Supplement, D-§3605.1.)

If the services were either emergency or urgently needed, but provided outside the HMO's service area, process the claim. Send the UNIBILL to HCFA and a copy to the HMO.

If the services were not emergency or urgently needed but provided inside the HMO's service area, deny the claim. Send the nonpayment bill to HCFA in UNIBILL and the denial notice to the HMO, the beneficiary, and the provider. Forward a copy of the bill to the HMO.

NOTE: Claims which involve emergency services can be paid whether the services were received inside or outside the HMO's service area.

4. R Trailer Code "B".—The beneficiary is restricted to an HMO which elected to process bills only for directly provided services. Check the directory (see §3558) to determine if services are in-plan or directly provided.

a. Services Directly Provided.—The HMO has elected to process all bills. Return the bill to the provider and instruct the provider to bill the HMO.

b. Services are In-Plan.—Follow 3a above.

c. Services are Out-of-Plan.—Notify the provider to send emergency documentation (see Nonparticipating Domestic Hospital Supplement, D§3605.1) within 3 days unless the beneficiary does not live in the HMO's service area. Process the claim as described in 3b above.

5. R Trailer Code "C".—The beneficiary is restricted to an HMO which elected to process all bills for restricted members. Check the directory (see §3558) to determine if services are in-plan.

a. Services are In-Plan.—Return the bill and instruct the provider to bill the HMO.

b. Services are Out-of-Plan.—Notify the provider to send emergency documentation to the HMO within 3 days unless the beneficiary does not live in the HMOs service area. (See Nonparticipating Domestic Hospital Supplement, D§3605.1.) Instruct the provider to bill the HMO. The HMO follows the procedures in 3b. above.

3555.2 Outpatient and Part B Inpatient Services to HMO Members.—

A. Billing and Reporting Procedures.—The provider (including one owned and operated by an HMO), furnishing the outpatient services, prepares a bill.

1. If the provider knows that the bill will be paid and processed by you, it sends it to you indicating condition code 04 to show HMO status. Upon receipt of the bill, query HCFA, and pay or deny the bill.

2. If the provider knows that the bill will be paid and processed by the HMO, it sends the bill directly to it. Do not query unless blood deductible pints are involved. The query is accepted by HCFA even when option code C is shown with the R trailer. After the HMO makes its coverage determination on a claim involving blood charges, it sends a copy of the billing to you in a specially marked envelope annotated "HMO blood claim for query." Upon receipt of the query response from HCFA, attach it to the photocopy of the bill and return it to the HMO unless an option code of 1 or A (intermediary jurisdiction) is involved. If option code 1 or A, request the HMO to send the original bill to you for processing.

3. If the provider does not know whether you or the HMO has jurisdiction, it sends the bill to you. Check the directory (see §3558) to determine if the HMO or you have jurisdiction. If the directory does not list the HMO, send a status query to verify the HMO allegation on the bill and to determine jurisdiction. If the HMO has jurisdiction send the bill to the HMO; and notify the provider, otherwise, process the bill as in 1 above.

4. If you receive a bill without an indication of HMO enrollment and subsequently discover that the beneficiary is a member of an HMO which has jurisdiction of bill payment, delete the query and send the bill to the HMO. Notify the provider.

B. HCFA Action on Queries.—HCFA determines the status of the HMO member and the payment option that the particular HMO elected. The appropriate ID trailer is included (see §3512.8 for a description of the trailers.)

C. Definitions of HMO Trailers Received.—

1. R Trailer Code "1".—The beneficiary is unrestricted in an HMO which elected to have you process all bills. Process the claim and send an informational copy of the bill to the HMO.

2. R Trailer Code "2".—The beneficiary is unrestricted in an HMO which elected to process bills for directly provided services or effective arrangement providers.

a. Services are Directly Provided or Effective Arrangements.—The provider sends the bill to the HMO. The HMO processes the bill.

b. All Other Services.—Process the claim as described in §3640 and send an informational copy of the bill to the HMO.

3. R Trailer Code "A".—The beneficiary is restricted to an HMO which elected to have you process all bills. Check the directory (§3558) to determine if services are in-plan.

a. Services Are In-Plan.--Process the bill and send an informational copy of the HCFA-1450 to the HMO.

b. Services Are Out-Of-Plan.--Determine if the beneficiary lives in the HMO's service area (see §3558). If the beneficiary does not, process the claim and send an informational copy of the bill to the HMO. If the beneficiary lives in the HMO's service area, determine if the services were emergency or were urgently needed if provided outside the HMO's service area.

If the services were neither emergency nor urgently needed, nor urgently needed, but provided inside the HMO's service area, deny the claim, submit a delete query, and notify the beneficiary, the provider, and HMO.

4. R Trailer Code "B".--The beneficiary is restricted to an HMO which elected to process bills for only directly provided services.

a. Services Directly Provided.--The HMO elected to process all bills. The provider sends the bill to the HMO.

b. Services are In-Plan.--Process the bill and send an informational copy to the HMO.

c. Services Are Out-Of-Plan.--Determine if the beneficiary lives in the HMO's service area. (See §3558.) If the beneficiary does not, process the claim and send an informational copy of the bill to the HMO. If the beneficiary lives in the HMO's service area, determine if the services were emergency or were urgently needed if provided outside the HMO's service area.

If the services were either emergency, or urgently needed and provided outside the HMO's service area, process the claim and send an informational copy of the bill to the HMO.

If the services were neither emergency nor urgently needed, but provided inside the HMO's service area, deny the claim, submit a delete query, and notify the beneficiary, provider, and HMO.

5. R Trailer Code "C".--The beneficiary is restricted to an HMO which elected to process all bills for restricted members. The provider sends the bill to the HMO. The HMO processes the bill and submits to HCFA.

NOTE: Regardless of the option, process all bills for dialysis and related services provided through an approved dialysis facility.

For option 2, process all bills for outpatient psychiatric services or services by an independent physical therapist.

3555.3 Home Health Services to HMO Members.--

A. Part A Home Health Services.--For intermediary and HMO processed bills, follow the procedures in §3555.1. All HMO trailer codes applicable to inpatient bills also apply to home health under Part A. Process bills in accordance with §3650.

B. Part B Home Health Services.--

1. Start of Care Procedures.--(See §§3540ff.) If the provider knows that the bill will be paid and processed by you, it sends you the bill in an envelope containing only HMO bill(s). The envelope is marked to that effect. Process and query HCFA. (See §3545.) If the query reply shows that the HMO has jurisdiction for bill payment, send the bill to the HMO.

a. If the provider knows that the bill will be paid and processed by the HMO, it sends it to the HMO. The HMO may request you to status query. If after checking its enrollment records, the HMO determines that it does not have jurisdiction, it sends you the bill.

b. If the provider does not know whether you or the HMO has jurisdiction, it sends the bill to you. Check the directory (§3558) to determine if the HMO or you have jurisdiction. If the directory does not list the HMO, status query to verify the HMO's existence and determine jurisdiction. If the HMO has jurisdiction, send the bill to the HMO for processing; and notify the provider, otherwise, process the bill as in 1a above.

c. If you receive the bill without an indication of HMO enrollment and find that the beneficiary is a member of an HMO, which has jurisdiction of bill payment, send the bill to the HMO. Notify the provider.

2. Billing Procedures.--

a. If you pay the bill, process in accordance with §3650. Send the HMO an informational copy of all bills.

b. HMO paid bills are processed in accordance with §3650. The HMO keeps a record of Part B visits for its members. After processing, the HMO sends the bill to you for submission to HCFA.

3560. INTERMEDIARY SYSTEMS TESTING PROJECT (ISTP).

The Intermediary Systems Testing Project (ISTP) has been designed to identify errors in your claims processing system which require corrective action. It tests your ability to process and pay bills correctly while making correct entitlement, eligibility, medical review, and utilization determinations. Test materials are updated annually to reflect changes in deductible and coinsurance and to test new program initiatives. You are assigned test account numbers containing area code 697 and a unique two-digit group code.

You will be assigned an RO test coordinator who will have overall responsibility for proper administration of the ISTP. This individual insures that all testing is performed as scheduled and, during the testing, performs the following functions:

o Briefs your personnel on the purpose and general requirements of the test and discusses procedures for processing the test claims.

o Provides you with test materials.

o Serves as the source of data for claim investigation, i.e., provides data that would normally be required from providers, beneficiaries, the servicing SSO, another intermediary, or HCFA's central records. This data is provided in response to your specific requests.

o Evaluates and scores the output you generate.

o Analyzes, with you, the "Final Report of Test Results."

o Follows up to insure that required corrections are made timely.

Perform the test in a normal production environment. Use claims in the test package marked "PREPROCESSED" in the remarks area to set up test conditions. They contain no errors, based on information available at the time they are received. Process them prior to the rest of the test claims. Process the test using normal procedures. If additional data is required to resolve eligibility or entitlement questions, request this information from the test coordinator via telephone.

Send a copy of each corrected claim to the RO. Claim payments will be mailed to you since your address is used for the provider address. Void the checks and send a copy with the provider listings for the claims to the RO. Mail any correspondence to the beneficiary to the address on the bill in the normal manner. Where possible, intercept and void checks generated to test beneficiaries prior to their being mailed. Submit a copy of the voided check and related correspondence to the RO. The RO voids and returns any checks that you did not intercept.

Send the processed claims to HCFA along with regular bills on the paid claims tape. When they enter the HCFA System, a printout of the updated history will be prepared for inclusion in the evaluation of the test. Rejected claims will not be returned. They will appear on the Batch Clearance Tape with the error code blanked out to eliminate the possibility of a corrected claim being resubmitted. Suppress test data before going to any data files, e.g., MSP Data Exchange or PS&R Report. The error listings and bill history printouts for rejected test claims will be used by HCFA in the test evaluation. At the completion of the test, HCFA, using the checks, EOMBs, Medicare Benefit Notices, paid claim listings, and corrected claim copies prepared by you, and using the query/reply reports, bill history printouts, and error listings prepared by the Health Insurance System, prepares a "Final Report of Test Results." The report indicates error conditions requiring corrective action. It also indicates as errors any claims that were either not completed or not received by the established cutoff date. Copies of the report will be sent to you and to Central Office.

Based on the report, prepare and forward a response to the RO within 30 days. Indicate the necessary corrective actions you and the regional office deem necessary to insure the errors are corrected and your proposed completion dates. Report the completion dates of your corrective actions to the RO.

3561. CONSISTENCY EDIT TESTING

The consistency edit test material includes:

- Approximately 200 test claims.

- A consistency edit reject listing (Error Code Matrix) that shows the HCFA error code expected for each test claim and a brief narrative of the error condition. The error code expected on each claim is also shown in the "Remarks" block on the bill.

- Information needed to set up a file of test providers. These are the same as those used for ISTP testing. Use only the data that is applicable to your provider file. Additionally, use your two-digit State code with the test provider numbers shown.

Data Preparation

- Convert test claim data to machine readable form.

NOTE: If data entry device restrictions prevent entering invalid characters or other informational fields from test claims, document and notify the RO in your report of test results.

Test Conduct

- Perform the test without RO administration.

- Process the test file in the regular production system.

- Within a week of processing the test file through your consistency edit programs, provide written notification to the RO indicating when the test was run (start/completion dates), identification (HICN) of claims that rejected, your error code and reasons why they rejected, identification of claims that did not reject (Name, HICN). Investigate those which did not reject to determine and schedule any necessary corrective actions.

- Do not attempt to correct claims after editing runs are completed.

- Purge or invalidate all test claims.

- The RO follows up to assure that the indicated corrective actions are satisfactorily completed. Following completion of the corrective actions, retest the claims that failed to reject and notify the RO of the results.

3563. RETESTING.

Run ISTP annually. Also run it upon implementation of any major systems change.

Retest the consistency test whenever directed to do so by your RO.

ADMISSION AND QUERY PROCEDURES

ADDENDUM A--ADVANCED RECORD SYSTEM

Section

The SSA Advanced Record System.......................... 1
Part A Query--Completing Form SSA-1577a.......... 2
Part A Replies from SSA.................................. 3
Type 1 Reply... 4
Type 1 - Code 45 Reply................................. 5
Reply to HHA Notice..................................... 6
Trailer Codes... 7
Acknowledgement Reply................................. 8
Edit Rejection Reply.................................... 9
The Part B Query... 10
Completing the Form 1577.............................. 11
Part B Replies... 12
Reply Codes... 13
Disposition Code.. 14
Trailer Codes... 15
Format of Part B Replies............................... 16
Reply Code 3 With Disposition Code "00" 17
Reply Code 4 Format..................................... 18
Reply Code 6.. 19

Part A Replies from SSA

Exhibit 1--Part A--Notice of Admission Coding Sheet
Exhibit 2--Part B--Inquiry Coding Sheet

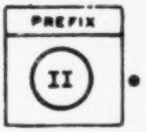
ADDENDUM A--ADVANCED RECORD SYSTEM

1. THE GSA ADVANCED RECORD SYSTEM.--The teletype system operated by the General Services Administration is called The Advanced Record System. Part A intermediaries who have been furnished Government-owned teletype equipment use this system to query the SSA records in Baltimore. Part A intermediaries using the Blue Cross Association teletype system should refer to "Telecommunications System Principles of Operation Tributary Station."

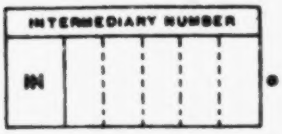
The ARS data transmission system uses a floating format for transmission of queries to SSA and a fixed format for transmitting replies to the intermediary. To facilitate floating format transmission, Part A intermediaries using the ARS are furnished Form SSA-1577a (Part A Notice of Admission Coding Sheet) and Form SSA-1577 (Part B Inquiry Coding Sheet).

The following sections deal with completing the forms SSA-1577 and SSA-1577a. For details of transmission and keying for queries to SSA, see the SSA "Telecommunication Operating Procedures Manual."

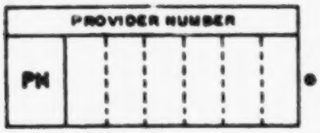
2. PART A QUERY--COMPLETING FORM SSA-1577a.--Following is a description of each item on the form SSA-1577a and how it is completed.



This code identifies the request as a data message initiated by an intermediary and transmitted to SSA via the ARS telecommunications system. This code serves as a case separator for the computer. It is the most important code on the request. If incorrectly keyed or omitted, the request itself will be lost.



The "IN" code must precede the intermediary number. It identifies the intermediary who will process the Part A claim for this admission. It is recorded as part of an "open item"-and in the event SSA or another intermediary needs information concerning an open item, it tells whom they must contact for this information. If this number is incorrect or not furnished, the notice of admission cannot be processed.



The "PN" code must precede the six-position number which identifies the provider who will submit a bill for payment. The notice cannot be processed without this number. It also facilitates investigation of open items by SSA or an intermediary. If the number is incorrect, payment of the bill may be delayed until the number is corrected on the "open item."

TYPE QUERY	
TQ	

The TQ code tells the SSA EDP system what action to take as a result of the query. TQ code 1 is used normally. This code indicates that a Notice of Admission or Start of Care has been received by the intermediary and is being reported to the SSA utilization record. A list of Part A query codes is shown in section 3507.3.

CLAIM NUMBER HOLDER		INITIALS
CH		

The name of the individual being admitted is entered immediately following the "CH" code. Up to 11 positions of the last name of the individual are entered. If the last name is longer than 11 positions, enter only the first 11 positions. Enter a comma immediately following the last letter of the name or in the 12th position if the name exceeds 11 positions. Immediately following the comma key one or two initials. The proper entry for "William B. Jones" would be: "CHJONES,WB." The proper entry for a name with one initial only would be: "CHJONES,W.", etc. Do not space within the last name field. Example: "Von Charles" would be keyed thus: "CHVONCHARLES,--.". Similarly, do not use hyphens or other punctuation within the last name field. Example: O'Rourke is keyed "OROURKE,--.". If known, space after surname and show: Jr., Sr., III, etc; do not use any punctuation.

CLAIM NUMBER	
CN	

The CN code indicates that the alpha-numeric information which follows is the claims number. This field is variable in length. For example, an entry for a person who has an HI card issued by the Railroad Retirement Board could look like this: "CNA991273." An entry for a person who has an HI card issued by SSA could look like this: "CN123456789F2." The field can contain up to 12 characters and may contain as few as 7 characters.

DATE OF BIRTH			
	MO.	DAY	YEAR
DB			

The DB code is shown followed by the date as a 6-digit number: 2 digits for month, 2 digits for day, and 2 digits for year. September 4, 1900 is shown 090400. The date must be transmitted to SSA in that numerical order. If the date of birth is unknown, make no entry. If only the year of birth is known, enter 00 for the month or day if either of these is not known. (Omitted in ECF admissions.)

Date of Admission			
	Mo.	Day	Year
DA			

Enter the date of admission or date of start of care as a six-position numeric immediately following the code DA. For home health start of care notices, show the date of start of care. The first month of the year is "01," the last month 12. The first two positions following "DA" indicate the month of admission. The next two positions indicate the day of admission. The third day of the month is shown as "03." The last two positions indicate the year of admission. The proper entry for an admission date of April 7, 1979, would be: "DA040779." If the date of admission is not correct, the bill cannot be processed. Beginning July 1, 1981 the home health visits (A/B) as given in the type 1 and 2 replies, is fixed at full value (i.e., 100).

3. PART A REPLIES FROM HCFA.--HCFA will transmit a reply message in response to each Part A notice of admission even though it is unable to process the notice. Replies will be furnished the day following the receipt of the admission notice by HCFA. These replies will be sent via teletype. They will be separated by 5 linefeeds on your hard copy. Decimal points will be used to separate the individual items of reply data.

The replies will be transmitted in fixed format; that is, certain positions in the reply will be assigned to certain types of data. An asterisk will appear in place of a decimal when a reply transmits an edited request to you for retransmission. The last field in a line will be terminated by a decimal point. It may be terminated by an asterisk if the field contained an edit error.

A reply may contain more than one line of information. If this is the case, a "trailer code" will identify the kinds of information in the second line.

4. Type 1 reply.—The example below is a typical reply to a hospital notice of admission. The list of data beneath it explains what each item of data means.

1.01212.021102011D.01.081581.60.30.190.100.100.20400.2.3.____.0766.
0766.78.

Reply Code
Intermediary #
HI Claim #
Disposition Code
Date of Admission
Hospital Days (full coverage)
Hospital Days (co-pay)
Psychiatric Days
SNF Days
HHA Visits Part A
In-Patient Hospital Deductible
Part B Deductible
Blood Deductible
Last Discharge Date
Part A Effective Date
Part B Effective Date
Year Benefit Period Began

5. TYPE 1 OR 2 - CODE 38 REPLY.—See § 3512.7 for an explanation of the 38 disposition code. An example of the code 38 reply to an admission or start of care notice follows:

1 or 2.01212.021102011D .38.0101.120177.SMITH JB.1.091177.123456.

Reply Code
Intermediary #
HI Claim #
Disposition Code
Date of Birth (MMYY)
Date of Death (MMDDYY)
Surname (6 positions)
Initials
Sex Code (1-M, 2-F)
Date of Admission
Provider #

5.1 TYPE 1 or 2 - CODE 50 SERIES REPLY.—The following example is a definitive reply to a query where HCFA cannot match the name and claim number submitted with any name and claim number on the master record. After the reply code and intermediary number, HCFA shows the claim number, disposition code 50, 51, 52, 54, 55, 56, or 57 and the date of admission.

1. 12345. 470389297 A . 50. 110883. 00. 00. 000. 000. 000. 0000. 0. 0

Reply Code (1)
Intermediary Number (12345)
HI Claim Number (470389297 A)
Disposition Code (50)
Date of Admission (110883)

7. TRAILER FORMATS.-The second line of a reply to an admission query may contain one or more of the following trailers: (See S3512.8 for explanations of trailers).

TRAILER CODE B - Name Correction Information

Here is a typical second line of a Reply to a Hospital Admission query where name correction information is furnished:

0766. 85. B. MAHONEY. TA.

Part B Effective Date (0766)
Year Benefit Period Began (85)
Trailer Code (B)
Last Name on HCFA Record (MAHONEY)
Initials on HCFA Record (TA)
The surname field is 11 positions

TRAILER CODE C - HI Claim Number Correction Information

Here is a typical second line of a reply to a hospital admission query where HICN correction information is furnished.

0766.84.C.484100337D.

Part B Effective Date (0766)
Year Benefit Period Began (84)
Trailer Code (C)
HICN on HCFA's record (484100337D)

TRAILER CODE G

Here is a typical last line of a Reply to a Hospital Admission Notice where the beneficiary has used one or more of his 60 lifetime reserve days. The G trailer always begins a new line and is always the last line of the reply.

EXAMPLE:
0766.68.
G.55.

Part B Effective Date
Year Benefit Period Began
Trailer Code

Number of Reserve Days Remaining

TRAILER CODE K

Here is a typical second line of a reply to a hospital admission notice where a cross-referred HI claim number is furnished:

0766.68.K.484100344B.

TRAILER CODE L

Here is a typical second line of a duplicate reply to a hospital admission notice where the disposition code of the original reply is furnished:

0766.68.L.25

If there are other trailers, the L trailer will be the last trailer furnished.

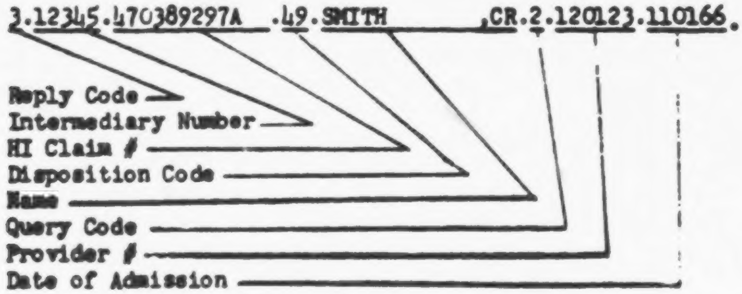
8. ACKNOWLEDGMENT REPLY.--Whenever SSA cannot process a case within the EDP system immediately, it will nevertheless acknowledge receipt of the Admission Notice. This acknowledgment looks like this:

3.01212.51320441A .00.GOODFELLOW ,M .1.21996.090366.

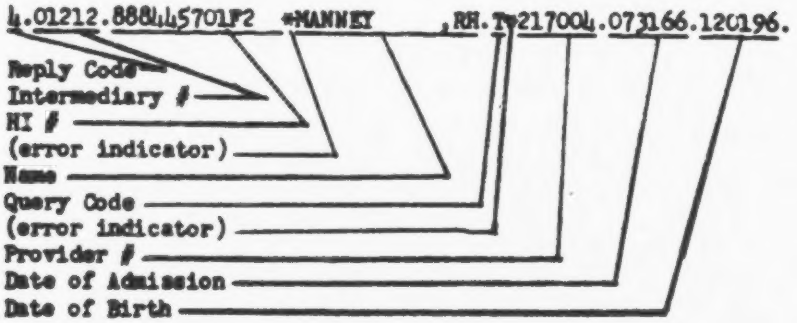
Reply Code
Intermediary #
HI Claim #
Disposition Code
Name
Query Code
Provider #
Date of Admission

The reason for sending this reply is merely to acknowledge receipt of the notice so it will not be retransmitted. A type "1" or "2" reply will be furnished by HCFA as quickly as possible. Do not retransmit the original query once a reply is received. However, if a 1 or 2 reply is not received within 30 days, requery.

When HCFA processes a deletion item (query code 2), the intermediary receives an acknowledgment reply containing disposition code 00, 03, or 49. (For an explanation of the codes, see § 3512.7.)


3.12345.470389297A .49.SMITH ,CR.2.120123.110166.
Reply Code
Intermediary Number
HI Claim #
Disposition Code
Name
Query Code
Provider #
Date of Admission

9. EDIT REJECTION REPLY.--If it is impossible for HCFA to process a query, the query will be returned as received with your block codes replaced by decimals or an asterisk. The asterisk indicates an error in the data preceding the asterisk. This reply code is "4." Shown below is a typical rejection reply. Requery HCFA when this type of reply is received after correcting the errors indicated on the reply


4.01212.888445701F2 *MANNEY ,RH.T*217004.073166.120196.
Reply Code
Intermediary #
HI #
(error indicator)
Name
Query Code
(error indicator)
Provider #
Date of Admission
Date of Birth

NOTE: The HI number is not possible. The query code furnished is not possible.

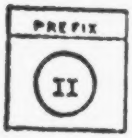
10. THE PART B QUERY.--HCFA maintains individual records of utilization and eligibility for each individual now entitled (or previously entitled) to Part B insurance. When the intermediary receives the first Part B claim in a calendar year, the HCFA record must be queried to see if the individual is eligible, has met his deductible, and to determine if any limitation on payment exists. The intermediary must continue to query HCFA each time a claim for payment is received until HCFA has furnished a "deductible met" reply. An intermediary with a fully automated claims processing system must maintain its files in such a way that it can determine that the deductible has been met previously in the year. Once the intermediary is informed that the deductible is met, subsequent claims may be paid without querying HCFA. HCFA will automatically notify the intermediary of any pertinent changes in an individual's status once it has sent a "deductible met" reply to the intermediary.

A Part B query is sent to HCFA when:

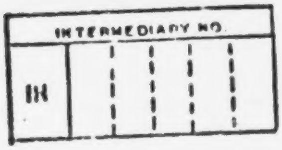
(a) A claim for payment is pending and HCFA has not previously notified the intermediary that the deductible is met for that year. (However, another query must be made later if the situation in item (b) applies.)

(b) A claim for payment is pending where expenses were incurred in the last 3 months of the year, unless the intermediary's records show that the deductible was met in the first 9 months of the year.

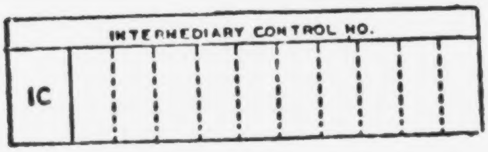
11. COMPLETING A PART B INQUIRY CODING SHEET (EXHIBIT 2).



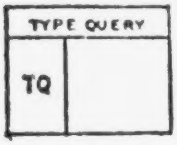
The II code tells the computer that this is the beginning of a new Part B inquiry. This two-position alphabetical code serves as a request separator. Proper keying of this code is extremely important. If it is not keyed properly at the beginning of each request, the request cannot be processed.



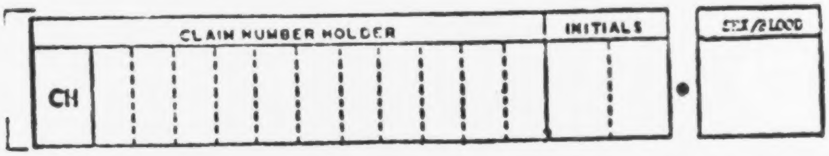
The IN code indicates that the five-position numeric information following is the intermediary identification number. This must be entered on each request so HCFA will know where to send the reply. Errors in keying this information will result in the request not being processed or in routing the reply to the wrong intermediary.



The IC code indicates that the alpha, numeric, or alpha-numeric data following is an intermediary control number. This number is used by HCFA and the intermediary to prevent processing the same query twice. It is displayed on the reply to facilitate processing by the intermediary. The control may be 1 - 10 positions in length.

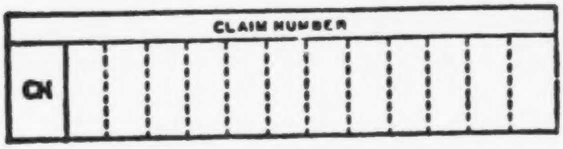


The TQ code tells the HCFA EDP system what type of action to take as a result of the query. TQ code "I" is normally used to report incurred expenses for Part B. This code indicates that the intermediary has a pending claim, is furnishing an amount of incurred expenses to the system, and wants to know the status of the individual's record.

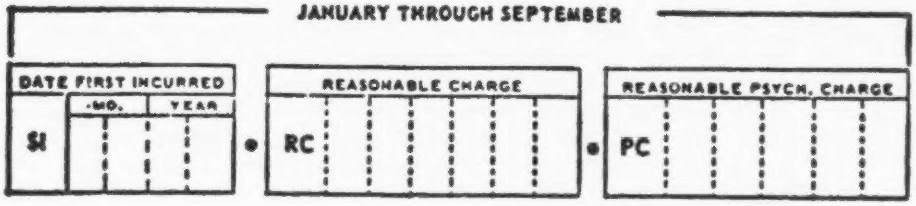


The CH code indicates that the alphabetic characters following represent the name information for the individual. This field is variable in length. Up to 11 letters of the last name may be furnished. If the last name is longer than 11 letters, do not enter more than 11 letters. Up to two initials may be entered. If the individual has only one initial, enter it followed by a decimal. A comma is keyed immediately following the last character of the last name and immediately preceding the initial or initials. The proper entry for William B. Jones would be: "CHJONES, WB." The proper entry for a name with one initial only would be: "CHJONES, W.". Do not space within the last name field. Example: "Von Charles" would be keyed: "CHVONCHARLES,--". Similarly, do not use hyphens or other punctuation within the last name field. EXAMPLE: O'Rourke is keyed "CHOROURKE,--". If known, space after surname and show: Jr., Sr., III, etc; do not use any punctuation.

Immediately after the decimal following the initial or initials, key a one-position numeric sex/blood code. Select the proper code from the chart given in § 3527.


CLAIM NUMBER
CN

The CN code indicates that the alpha-numeric information which follows is the claim number. This field is variable in length. For example, an entry for a person who has an HI card issued by the Railroad Retirement Board would look like this: "CNA991273." An entry for a person who has an HI card issued by HCFA could look like this: "CN123456789F2." The field can be up to 12 characters long and may contain as few as 7 characters. (See § 3504 for possible HI claim numbers.)


JANUARY THROUGH SEPTEMBER
DATE FIRST INCURRED
MO.
YEAR
SI
REASONABLE CHARGE
RC
REASONABLE PSYCH. CHARGE
PC

The three data blocks shown above are used to report claims data for a pending bill or to correct information previously submitted depending on the type of query being sent. Incurred expenses during the period January-September are reported using the three blocks above. Any information about the last three months of a calendar year are furnished using other codes. Each data block is completed as follows:

Date First Incurred (CD) (4 positions)
Enter the month and year during which services were first incurred in the first 9-month period of a calendar year. If the total includes services in two or more months, show the earliest month within the 9-month period. Enter 4 numeric characters immediately following the SI code to show month and year in that order.

Reasonable Charge (CC) (6 positions)
Enter the reasonable charge for regular medical services. The field is variable and may be 6 positions long. If charges exceed $9999.99, enter this amount. Example: Enter a charge of $96 as "RC9600," a charge of $9.68 as "RC968," and a charge of $100 as "RC10000." Minimum field length is 2 positions (01 cent).

Reasonable Psych. Charge (CP) - (5 positions)
Entries are the same as for the RC block except only outpatient psychiatric expenses are entered. Do not report amounts in excess of the limits shown in §3535.1, trailer code D.

Report psychiatric expenses incurred as an inpatient under the RC code. Report HHA services as regular medical expenses, not as psychiatric expenses even though they may be of that nature.

Split queries for psychiatric expense that exceed $999.99 in a single claim in order to meet the 5-position (dollars and cents) limit in the query record. When you split a query, assign a different control number to each.

OCTOBER THROUGH DECEMBER

Date First Incurred
Reasonable Charge
Reasonable Psych. Charge

Use the three data blocks to report claims data for a pending bill or to correct information previously submitted depending on the type of query being sent. Report incurred expenses during the period October-December using these blocks. Report information about the first 9 months under the other codes as instructed. Each data block is discussed below:

Date First Incurred (CD) (4 positions)

Enter the month and year in which services were first incurred immediately following a CD code. Enter 4 numeric characters.

Reasonable Charge (CC) - (6 positions)

Enter the reasonable charge for regular medical services. This field varies in length from 2 to 6 positions. If charges exceed $9999.99 enter this amount. Always enter 2 positions for "cents."
Example: Report $137.00 as: "CC13700."

Reasonable Psych. Charge (CP) - (6 positions after 1988)

Entries in this block are similar to the CC block. However, report only outpatient psychiatric expenses. Do not report amounts in excess of the limits shown in §3535.1, trailer code D. (The maximum field length will be increased to 6 positions in 1989.) Report psychiatric expenses incurred as an inpatient using the CC code. Part B HHA expenses are considered to be regular medical expenses.

10. PART B REPLIES.-- HCFA transmits a reply, transmitted typically within 24 hours of receipt of the query, even though it is unable to furnish detailed information. This reply is typically transmitted within 24 hours of receipt of the query. You will not receive a reply if the intermediary number you furnished is incorrect. Each reply is separated by 5 line-feeds on your teletype hard-copy.

Part B replies are a combination of "fixed" and "floating" formats. The first replies are in "fixed" format. That is, certain information is always shown in the same place. The remainder may be "floating". That is, information may not always appear in the same position. Whether or not a reply is in "fixed" or "floating" format is indicated by the reply and/or the disposition codes shown.

13. REPLY CODES.--A Part B reply will contain a 3, 4, 6, or 7 in the first position of the reply. This number is called a reply code. Reply code 3 identifies the reply as a message acknowledging receipt of a query but does not furnish deductible information. Reply code 4 identifies the reply as a message indicating that the query to which the reply pertains failed the initial SSA edit operation and could not be processed by SSA. Reply code 6 identifies a reply to a Part B query where SSA is furnishing information to the intermediary. Reply code 7 identifies an automatic notification of termination, reinstatement, adjustment, or cross referred HI claim number. The reply code and disposition code identify the format of the reply.

14. DISPOSITION CODE.--The disposition code is a 2-position numeric code appearing in positions 22 and 23 of a Part B reply which contains a type code 3, 6, or 7. Replies with a type code 4 do not contain a disposition code. The disposition code is a coded remark which either constitutes the reply or explains or amplifies upon other information contained in the reply. The disposition code and the reply code identify the format of the reply. (See § 3535 for explanation of the meaning of the various disposition codes.)

(See §3535.1 for trailer codes.)

16. FORMAT OF PART B REPLIES.-- The reply code in the first position of the Part B reply and the disposition code in positions 22-23 dictate the format of the reply. The first 21 positions of the reply are always the same format and show the reply code, the intermediary number, and the HI claim number.

The formats of the various replies are shown in the following sections.

17. REPLY CODE 3 WITH DISPOSITION CODE "00".-- All replies with reply code "3" in the first position of the reply are "fixed" format replies. An example of a code 3 message is shown below with each item of data identified:

```
3.01212.387129686B    .00.MEYER       ,AW.I.1.0766.034265.
A.1234567899.
```

Reply Code (3)
Intermediary Number (01212)
HI Claim Number (387129686B)
Disposition Code (00)
Surname (MEYER)
Initials (AW)
Query Code (I)
Sex (1)
Month Expenses Incurred (0766)
Reasonable Charge Medical (034265)
Reasonable Charge OPT/Psych (blanks)

Line #2

Trailer Code (A)
Intermediary Control Number (1234567899)

18. REPLY CODE 4 FORMAT.-- All replies with reply code "4" in the first position of the reply are "fixed" format replies. An example of a reply code 4 message is shown below with each item of data identified:

```
4.01212.396031217D .LANGE     ,RT.I.1.0866.        *10000.
A.1296066109.
```

Line #1

Reply Code (4)
Intermediary Number (01212)
HI Claim Number (396031217D)
Surname (LANGE)
Initials (RT)
Query Code (I)
Sex (1)
Month Expenses Incurred (0866)
Reasonable Charge Medical (Blank)
Reasonable Charge OPT/Psych (10000)

Line #2

Trailer Code (A)
Intermediary Control Number (1296066109)

Significance of the Asterisk (*).-- The asterisk in a reply code 4 message indicates that the data immediately preceding it failed the edit. In the example above note an asterisk appears in place of the decimal which would normally indicate the end of the reasonable charge medical field. The presence of an alphabetical character in this field in a query would cause a reply code 4 reply as illustrated.

19. TYPE 6 REPLIES.-- An example of a regular type 6 reply is shown below. This is followed by an explanation of this example plus an explanation of the special format for a code 38 type 6 reply.

6.01212.049077395A .01.0866.0866.0.6000.A.1234567891.
C.049707395A.
G.CONSUELLA G DAVIS &, PIERINA F ARSENA, GDNS OF
MARIA C BASILE, 59 WRIGHT ST, NEW BERLIN N Y.

Explanation

Line 1

6.01212.049077395A .01.0866.0866.0.6000.A.1234567891.

Reply Code (6)
Intermediary Number (01212)
HI Claim Number (049077395A)
Disposition Code (01)
Part B Effective Date (0866)
Part A Effective Date (0866)
Blood Deductible (0)
Part B Deductible (6000)
Trailer Code (A)
Intermediary Control Number (1234567891)

NOTE: Part B Effective Date, Part A Effective Date, Blood Deductible, and Part B Deductible are blank for disposition Code 40,42,43,47, and 49 type 6 replies. Blood deductible and Part B deductible fields are blank for disposition code 44 type 6 replies.

Line 2

C.049707395A.

Trailer Code (C)
HI Claim Number Correction (049707395A)

Line 3

G.CONSUELLA G DAVIS &, PIERINA F ARSENA, GDNS OF.
MARIA C. BASILE, 59 WRIGHT ST, NEW BERLINE, N Y.

Representative Payee Information

TYPE 6-Code 38 Reply.--

6.01212.021102011D .38.1212.121277.SMITH JB.1.A.1234567891.

Reply Code (6)
Intermediary Number (01212)
HI Claim Number (021102011D)
Disposition Code (38)
Date of Birth (MMYY) (1212)
Date of Death (MMDDYY) (121277)
Surname (SMITH)
Initials (JB)
Sex Code (1-M, 2-F) (1)
Trailer Code (A)
Intermediary Control Number (1234567891)

16. TYPE CODE 7.-- Positions 1-58 appear for all disposition codes. In disposition codes 70, 71, and 72, the contents of fields 42-45 vary according to the disposition code as indicated below. Positions 47 through 58 are always blank except for 52 and 58 which have periods.

Disposition Codes 70, 71, and 72

```
7.01212.422223223A  .70.MALONE JB.071069.0769
```

Position	
1	Type of Reply Code (7)
2	.
3-7	Number of Intermediary to Who Automatic Notice Is Being Sent
8	.
9-20	HICN
21	.
22-23	Disposition Code
24	.
25-30	Surname
31	Blank
32-33	First and Middle Initials
34	.
35-40	Processing Date
41	.
42-45	Effective Date:

Disposition Code 70 (Termination), represents the last month and year for which the beneficiary is entitled. If termination is caused by a determination of erroneous entitlement this field contains xxxx.

Disposition Code 71 (Reinstatement), represents the effective month and year that benefits were reinstated.

Disposition Code 72 (Adjustment), contains the calendar year, e.g., 1988, for which the cash or blood deductible has been adjusted from a "met" to a "not met" condition or the amounts previously applied to the maximum for psychiatric care have been adjusted below the applicable amount shown in §3535.1, trailer D.

When HCFA receives a date of death, or an adjustment to a date of death, this field contains the year of death. When HCFA removes a date of death, this field contains zeros. When HCFA receives notification of a period of Hospice care, this field contains the year of such Hospice care.

Disposition Code 77 (Cross-Referred HICN)

```
7.01212.422223223B  .77.MALONE RB.041470.422287536A   . .
```

Position	
1	Type of Reply Code (7)
2	.
3-7	Intermediary Number
8	.
9-20	HICN from which entitlement is being transferred.
21	.
22-23	Disposition Code
24	.
25-30	Surname
31	Blank
32-33	First and Middle Initials
34	.
35-40	Processing Date
41	.
42-53	New HICN
54	.

PART A REPLIES FROM SSA

The example below is a typical SSA message electrically transmitted in response to Hospital Notices of Admission.

The first three lines and the last two lines of the message; that is, the pre-answer-back, pre-message header, message header, end of message and post-answer-back, are fully explained in the Telecommunications Operating Procedures Manual.

```
[57136 EVEII.

152335 [13013 MSCEV123456.

PAAU JAZ RUEVECC0017 1080000-UUUU--RUEVEII.

4.12345.888445701F2 *MANNEY      ,RH.T*217004.073166.120196.



3.12345.5132044411A    .00.GOODFELLOW ,M .1.210996.090366.



1.12345.396320606    .21.102866.60.30.190.100.100.4000.2.3.     .0766.
0766.C.396320606A    .D.02241.240001.080366.



1.12345.058097757A  .02.071566.59.30.190.100.100.2000.2.3.070566.0766.
0766.B. MAHONEY   ,TA.



2.12345.212016317B   .21.121466.100.100.2.2       .0766.0766.
B.ELWOOD     ,R .D.02241.240001.110266.

NNNN.

[57136 EVEII.
```

EXHIBIT 1

PART A - NOTICE OF ADMISSION CODING SHEET

PREFIX	INTERMEDIARY NUMBER	PROVIDER NUMBER	TYPE QUERY
II	IN	PN	TQ

CLAIM NUMBER HOLDER	INITIALS	CLAIM NUMBER
CN		CN

DATE OF ADMISSION				DATE OF BIRTH			
	MO.	DAY	YEAR		MO.	DAY	YEAR
DA				DB			

FORM SSA-1577a (6-66)

PART B – INQUIRY CODING SHEET

PREFIX	INTERMEDIARY NO.	INTERMEDIARY CONTROL NO.	TYPE QUERY
II	IM	IC	TQ

CLAIM NUMBER HOLDER	INITIALS	SEX/BLOOD	CLAIM NUMBER
CH			CN

JANUARY THROUGH SEPTEMBER

DATE FIRST INCURRED			REASONABLE CHARGE	REASONABLE PSYCH. CHARGE
	MO.	YEAR		
SI			RC	PC

OCTOBER THROUGH DECEMBER

DATE FIRST INCURRED			REASONABLE CHARGE	REASONABLE PSYCH. CHARGE
	MO.	YEAR		
CD			CC	CP

CHAPTER VII
BILL REVIEW

	Section	Page
General Requirements	3600	6-11
Control and Processing Timeliness	3600.1	6-11
Time Limitation for Filing Provider Claims	3600.2	6-14.1
Reviewing Bills for Services After Suspension, Termination, Expiration, or Cancellation of Provider Agreement, or After a SNF is Denied Payment for New Admissions	3600.3	6-15
Change of Intermediary	3600.4	6-16
Multiple Provider Numbers or Changes in Provider Number	3600.5	6-16
Reduction in Reimbursement Due to P.L. 99-177, P.L. 100-119, and P.L. 100-203	3600.6	6-16.1
Billing Forms and Formats	3602	6-16.2
Electronic Media Claims (EMC)	3602.1	6-16.2
Requirements for Submission of EMC Data	3602.2	6-17
File Specifications, Records Specifications, and Data Element Definitions for EMC Bills	3602.3	6-18
National EMC Formats	3602.4	6-18
Paper Bills	3602.5	6-19
Frequency of Billing	3603	6-19
Review of Form HCFA-1450	3604	6-25
Exhibits	3604.1	6-54
Form HCFA-1450 Consistency Edits	3606	6-65
Hospital Inpatient Bills General	3610	6-85
Charges to Beneficiaries by PPS Hospitals	3610.1	6-90
Payment for Ancillary Services	3610.2	6-95
Outpatient Services Treated as Inpatient Services	3610.3	6-95
Admission Prior to and Discharge After PPS Implementation Date	3610.4	6-95
Transfers Between Hospitals	3610.5	6-96
Split Bills	3610.6	6-97
Outliers	3610.7	6-97
Adjustment Bills	3610.8	6-100
Waiver of Liability	3610.9	6-100
Effects of Guarantee of Payment	3610.10	6-100.1
Remittance Advice to the Hospital	3610.11	6-100.1
Noncovered Admission Followed by Covered Level of Care	3610.12	6-100.1
Billing for Alcohol and Drug Related Services	3610.13	6-101
Repeat Admissions and Leave of Absence	3610.14	6-104
Additional Payment Amounts for Hospitals With Disproportionate Share of Low Income Patients	3610.15	6-105
Rural Referral Centers (RRCs)	3610.16	6-108
Kidney Transplantation - General	3612	6-131
The Standard Kidney Acquisition Charge	3612.1	6-131
Billing for Kidney Transplant and Acquisition Services	3612.2	6-132
Charges for Kidney Acquisition Services	3612.3	6-132
Notifying Carriers	3612.4	6-132
Heart Transplants	3613	6-133
Notifying Carriers	3613.1	6-136
Payment of Nonphysician Services Hospitals Obtain for Hospital Inpatients	3618	6-137

CHAPTER VII
BILL REVIEW

Section Page

Determining Covered/Noncovered Days and Charges.............. 3620 6-139
Spell of Illness.. 3622 6-145
Processing No-Payment Bills................................... 3624 6-149
Hospital Outpatient and Other Part B Bills.................... 3626 6-153
    Inpatient Part B Services................................. 3626.1 6-153
    Outpatient Services....................................... 3626.2 6-153
    Calculating the Part B Payment............................ 3626.3 6-154
    Reporting Outpatient Surgery and Other Services........ 3626.4 6-155
HCFA Common Procedure Coding System (HCPCS).................. 3627 6-156.1
    Use and Maintenance of CPT-4 in HCPCS..................... 3627.1 6-156.2
    Addition, Deletion and Change of Local Codes............ 3627.2 6-156.3
    Use and Acceptance of HCPCS Codes......................... 3627.3 6-156.3
    HCPCS Manuals... 3627.4 6-156.4
    Fee Schedule and Diagnostic Lab and DME................. 3627.5 6-156.4
    Public Relations.. 3627.6 6-156.4
    HCPCS Training.. 3627.7 6-156.4
Clinical Diagnostic Laboratory Services Other Than to Inpatients.. 3628 6-157
Billing of Durable Medical Equipment (DME) and Orthotic/Prostheic Devices.................................. 3629 6-167
Skilled Nursing Facilities.................................... 3630 6-175
    Processing Beneficiary Demand Bills for Noncovered Admissions... 3630.1 6-175
    Processing Beneficiary Demand Bills for Continued Stay Denials... 3630.2 6-175
    Processing Beneficiary Compliants and Inquiries Regarding Demand Bills................................ 3630.3 6-176
    Review of SNF Denial Notices for Demand Bill Request.. 3630.4 6-176
Swing-Bed Services.. 3634 6-179
Billing by Home Health Agencies............................... 3638 6-181
    When Bills are Submitted.................................. 3638.1 6-181
    Billing for Nonvisit Charges.............................. 3638.2 6-181
    Payment System for HHA Claims............................. 3638.3 6-182
    DME Furnished as a Home Health Benefit.................... 3638.4 6-182
    More Than One Agency Furnished Home Health Services.... 3638.5 6-183
    Home Health Services are Suspended or Terminated Then Reinstated.. 3638.6 6-183
    Preparation of a Billing Form in No-Payment Situations.. 3638.7 6-183
    Intermediary Denies HHA Bill But Plan of Treatment Still in Effect... 3638.8 6-184
    Billing for Part B Medical and Other Health Services... 3638.9 6-185
Rural Health Clinics.. 3642 6-197
    Coordination Between RHC Intermediaries and Carriers... 3642.1 6-197
Dialysis for ESRD - General................................... 3644 6-205
    Special Considerations When Processing ESRD Bills Under Method I.. 3644.1 6-267
    Review of ESRD Bills Under Method I....................... 3644.2 6-271
    Special Considerations When Processing ESRD Bills Under Method II... 3644.3 6-279

CHAPTER VII
BILL REVIEW

Physician Services

	Section	Page
Review of Hospice Bills	3648	6-289
Billing for Covered Medicare Services Unrelated to Hospice Care	3648.1	6-295
Billing for Covered Medicare Services After Hospice Benefits are Exhausted	3648.2	6-295
Comprehensive Outpatient Rehabilitation Facilities (CORFS)	3650	6-299
Coordination With Health Maintenance Organizations	3654	6-305
Provider Billing for Services Provided to HMO Beneficiaries	3654.1	6-305
Patient is a Member of HMO for Only Part of Billing Period	3654.2	6-305
Computer Programs Supplied by HCFA	3656	6-307
Medicare Code Editor	3656.1	6-307
DRG Grouper Program	3656.2	6-313
PPS Pricer Program	3656.3	6-314
Ambulatory Surgical Center (ASC) Pricer Program	3656.4	6-324
Outpatient Code Editor	3656.5	6-324.6
Special Billing Situations	3660	6-325
Ambulance Services	3660.1	6-325
Hepatitis B Vaccine	3660.2	6-329
Rental or Purchase of DME	3660.3	6-330
All-Inclusive Rate Providers	3660.4	6-334
Hospitals That Do Not Charge	3660.5	6-339
Billing for Enteral and Parenteral Nutritional Therapy	3660.6	6-341
Pneumococcal Pneumonia Vaccinations	3660.7	6-341
Immunosuppressive Drugs Furnished to Transplant Patients	3660.8	6-342
Adjustment Bills	3664	6-344.1
Tolerance Guides for Submitting Adjustment Bills	3664.1	6-344.3
Physician Services	3668	6-345
Billing for Physicians Services	3668.1	6-345
Combined Billing by All-Inclusive Rate and Teaching Hospitals	3668.2	6-345
Residents and Interns Not Under Approved Teaching Programs	3669	6-351
Detection of Duplicate Claims	3670	6-352
Coordination with Carriers	3672	6-357
Part A Denials	3672.1	6-359
Nonphysician Services Furnished to Hospital Inpatients are Billed to Carriers	3672.2	6-359
Corrective Action When Nonphysician Services are Furnished to Hospital Inpatients	3672.3	6-360
Recovery of Overpayment when Nonphysician Services are Furnished to Hospital Inpatient Paid by Carrier	3672.4	6-360
Format and Content of A/B Data Match Record Furnished by Carrier	3672.5	6-362

Section Page

Coordination with the PRO.................................... 3674 6-367
  Waiver of Liability Provision............................... 3674.1 6-367
  Responsibility of Hospitals, PROs, and Intermediaries for Medical Review.................................... 3674.2 6-367
  Responsibilities for Issuing Denial Notices and Making Limitations of Liability Determinations................. 3674.3 6-368
  PRO Prepayment Review System (PRS)......................... 3674.4 6-368
  PRO Reporting on Medical Review............................ 3674.5 6-373
  Edits for PRO Report on Medical Review..................... 3674.6 6-379

Billing in Situations Where Medicare is Secondary Payer

Cost Reimbursement Providers

Enforcement of Provider Billing Timeliness and Accuracy Standard to Continue PIP.................................. 3676 6-391
Establishing Pacemaker Register Records - Pacemaker Related ICD-9-CM Procedure Codes.......................... 3678 6-397
Billing Procedures Where Services are Reimbursable Under Workers' Compensation.............................. 3679 6-415
Billing Procedures Where Services are Reimbursable Under Automobile Medical or No-Fault Insurance, or Any Liability Insurance... 3680 6-431
Billing Procedures Where Medicare Benefits are Secondary to Employer Group Health Plans When Individuals are Entitled to Benefits Solely on the Basis of ESRD........ 3681 6-449
Billing Procedures for Cost Reimbursement Providers Where Medicare Benefits are Secondary to Group Health Plans for Employed Beneficiaries/Spouses and the Disabled... 3682 6-473
How to Determine Current Medicare Interim Reimbursement Amount 3683 6-495
Benefits Exhausted Situations When Medicare is Secondary Payer.. 3684 6-496
Billing Procedures for Hospitals on Prospective Payment When Medicare is Secondary Payer............... 3685 6-501
Development of Claims Where There May be Other Payer Involvement.. 3686 6-510
Development of ESRD Claims Where Basis for Medicare Entitlement Changes.................................... 3687 6-510
Deductible and/or Coinsurance Rates Applicable on Medicare Secondary Claims When an Inpatient Stay Spans Two Calendar Years.. 3688 6-511
Coordination of Other Insurance Coverage With Carriers.... 3689 6-512
Review Protocol for Medicare Secondary Payer.............. 3693 6-575
    Frequency of Reviews and Selection Criteria......... 3693.1 6-575
    Methodology for Review of Admissions and Bill Processing Procedures............................ 3693.2 6-575
    Methodology for Review of Hospital Billing Data..... 3693.3 6-578
    Assessment of Hospital Review....................... 3693.4 6-580
    Exhibits.. 3693.5 6-581

CHAPTER VII
BILL REVIEW

Request for Information from the Public

	Section	Page
Request for Information Required in the Development of Medicare Secondary Payer Claims	3694	6-591

MSP Outpatient Claims Involving Lab Charges

	Section	Page
Calculation of Deductible and Coinsurance for MSP Outpatient Claims Involving Lab Charges Paid by Fee Schedule	3695	6-601

MSP Data Exchange

	Section	Page
Medicare Secondary Payer Data Exchange	3696	6-609
MSP Data Exchange Tape Format	3696.1	6-610
MSP Data Exchange Tape Record Layout	3696.2	6-612
Computer Programs Supplied by HCFA to Support MSP	3697	6-635
Review of Primary Claims (MSPPRIM)	3697.1	6-636
Review of Secondary Claims (MSPSEC)	3697.2	6-637
Payment Calculation for MSP Claims (MSPPAY)	3697.3	6-641
Services Rendered in Nonparticipating Providers	3698	3-300
Establishing an Emergency	3698.1	3-301
Qualifications of an Emergency Services Hospital	3698.2	3-301
Claims from Hospital-Leased Laboratories Not Meeting Conditions of Participation	3698.3	3-302
Coverage Requirements for Emergency Hospital Service Furnished in Canada or Mexico	3698.4	3-302
Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence	3698.5	3-303
Coverage of Physician and Ambulance Services Furnished Outside U.S	3698.6	3-304
Claims for Services Furnished in Canada and Mexico to Qualified Railroad Retirement Beneficiary	3698.7	3-305
Nonemergency Part B Medical and Other Health Services	3698.8	3-306
Canadian or Mexican Christian Science Services Claims	3698.9	3-306.1
Elections to Bill for Services Rendered in Nonparticipating Hospitals	3698.10	3-306.1
Submitting Claims	3698.11	3-307
Processing Claims	3698.12	3-308
Accessibility Criteria	3698.13	3-309
Medical Necessity	3698.14	3-311
Documenting Medical Necessity	3698.15	3-313
Time Limitation on Claims	3698.16	3-313
Appeals	3698.17	3-314

CHAPTER VII
BILL REVIEW

Section Page

Reimbursement for Services Received in Nonparticipating Hospitals.. 3699 3-316
  Reimbursement for Services of Nonparticipating Domestic Hospitals.................................. 3699.1 3-316
  Reimbursement for Services of Canadian/Mexican Hospitals 3699.2 3-318
  Designated Inermediaries............................... 3699.3 3-321
  Designated Carriers.................................... 3699.4 3-323
  HCFA 1771.. 3699.5 3-325
  HCFA 2628.. 3699.6 3-327
  Exhibits... 3-329

Addenda

Addendum A - Provider Electronic Billing File and Record Formats.. A-1
Addendum B - Alphabetic Listing of Data Elements........... B-1
Addendum C - Coding Structures............................. C-1
Addendum D - Plan of Treatment - Data Definitions and Codes.. D-1
Addendum E - MCE Edit Tables............................... E-1
Addendum F - ASC Edit Tables............................... F-1
Addendum G - ASC MSA Wage Index and Constituent Counties.... G-1
Addendum H - DME, Prosthetics and Orthotics HCPCS Codes and Definitions... H-1

3600. GENERAL REQUIREMENTS

3600.1 Claims Processing Timeliness.--

A. General.--Establish a control record and timely processing of claims as described below.

1. Claims Processing Timeliness Requirements.--Pay or deny "clean" claims within the applicable number of days from the date of their receipt as follows:

Time Period for Claims Received	Applicable Number of Days
02-01-86 thru 09-30-87	30
10-01-87 thru 09-30-88	26
10-01-88 thru 09-30-89	25
10-01-89 and later	24

NOTE: For interest payments and PIP requirements the time period began April 1, 1987.

See subsection A.3. for the definition of a clean claim. All claims (e.g., paid claims, partial and complete denials, no payment claims), including PIP and EMCs are subject to the above requirements.

Start your count on the day after the receipt date except where you receive and deny the claim on the same day. (In such cases you have 1 day's processing time.) End your count on the scheduled payment date. For example, for claims received October 1, 1987 through September 30, 1988, if this span is 26 days or less, you met the requirement.

2. Payment Floor Standards.--Do not pay, issue, mail, or otherwise reimburse for any claim you receive within the waiting period indicated below. The length of the waiting period is determined by the date the claim is received. Start your count on the day after the day of receipt. For example, a claim received July 1, 1988 can be paid on or after July 12, 1988.

Claims Receipt Date	Waiting Period (Calendar Days)
07-01-88 thru 09-30-88	10
10-01-88 thru 09-30-89	14

Do not hold claims upon receipt. Process them immediately and, when necessary, delay payment to meet these requirements. Regardless of when the check is dated, show as the scheduled payment date the actual date the check is mailed.

Continue to apply existing rules governing PIP to all PIP claims (e.g., should cover a period beginning 3 weeks after discharge). The rules have not changed with the introduction of the payment floor standards as they apply only to payment for individual claims. You may, however, release notification of the disposition of claims to PIP hospitals at any point in time convienent with your operations as long as you meet the claims processing timeliness requirements.

best copy available

NOTE: No payment claims are not subject to the payment floor standards.

3. Definition of "Clean Claim".--A "clean" claim is one on which:

- You do not investigate or develop external to your operation on a prepayment basis; and

- You receive a definitive query response within 7 days of your original query. A definitive query response is one which provides all the eligibility data you need to process the claim.

Examples are claims which:

- Pass all edits and are processed electronically;

- Are investigated within your claims, medical review, or reimbursement office *without* the need to contact the provider, beneficiary, or SSA;

- Are subject to medical review but complete medical evidence is attached or forwarded simultaneously with EMC records in accordance with your instructions to the provider. If medical evidence must be requested, see first example under subsection 4 below; or

- Are developed on a postpayment basis.

A claim handled manually, solely because of the design of your particular system, is a clean claim.

4. Other Claims.--Claims which do not meet the definition of "clean" claims are considered "other" claims. These include those which require investigation or development external to your operation on a prepayment basis. In addition, if you do not receive a definitive query response within 7 days of your original query, the claim is considered an "other" claim regardless of whether you develop externally. Examples are claims on which you:

- Request additional information from the provider or other external source. This includes routine data omitted from the bill, medical information, or information to resolve discrepancies;

- Request information or assistance from another contractor, e.g., development data obtained through the carrier-intermediary data exchange;

- Develop MSP information;

- Request information necessary for a coverage determination;

- Perform sequential processing when the earlier claim is in development;

- Requery because an original query has not been answered within 7 days (See §§3501 and 3507.3); or

- Do not receive a definitive query response within 7 days of your original query date. Receipt of an acknowledgement within 7 days such as 00 or 09 does not constitute a definitive reply.

NOTE: For Common Working File dependent intermediaries, a claim is considered "other" if after the second time the claim is recycled you continue to receive a 50, 53, 54, 60 or 61 response.

Enter condition code 64 in positions 352-365 of the UNIBILL record to indicate that the claim is not a "clean" claim and therefore, not subject to the mandated claims processing timeliness standard.

5. Interest Payment on Clean Non-PIP Claims, Not Paid Timely.—Effective April 1, 1987, you must pay interest on clean non-PIP claims if payment is not made within the applicable number of calendar days after the date of receipt as described in subsection A.1. For example, a claim received on October 1, 1987 must have been paid before the end of business on October 27, 1987. Interest is not required on:

- Claims requiring external investigation or development;
- Claims on which no payment is due;
- Full denials; or
- Claims for which the provider is receiving PIP.

However, PIP on inpatient bills does not preclude interest payments on outpatient bills.

Pay interest on a per bill basis at the time of your payment. Interest is a Federal expense and is not assessed against you.

6. Continuation of PIP.—Continue PIP upon request to subsection (d) hospitals as defined in subsection B.1. (including units excluded from PPS) that received PIP on June 30, 1987, until you meet the requirement to pay 95 percent of all clean claims (for which PIP payment is not made) in the applicable number of days for 3 consecutive months. (See subsection A.1. for the applicable number of days.)

Regardless of your claims processing timeliness performance on clean, non-PIP bills, PIP continues, upon request, for:

o DSHs that have at least a 5.1 percent disproportionate share adjustment (as discussed below); or

o Rural hospitals with 100 or fewer beds.

The request to continue PIP by such hospitals is a one time opportunity and must have been made no later than July 1, 1987. It is limited to hospitals that:

o Received PIP on June 30, 1987; and

o Continued to meet requirements specified in regulations that were applicable on October 1, 1986. (Qualified DSHs and rural hospitals with 100 or fewer beds may receive PIP payments indefinitely provided that they continue to meet standards established by the Secretary that were applicable on October 1, 1986.)

Section 1815(e)(1)(B)(i) of the Act (as added by §9311(a)(1) of OBRA), requires the amount of a hospital's disproportionate share adjustment percentage for purposes of this PIP provision be based upon the data base used by HCFA to standardize the FY 1987 PPS rates. The disproportionate share adjustment was calculated by HCFA from the hospital's percentage of low income patients based on the FY 1985 SSI/Medicare data and the Medicaid percentage from the FY 1984 cost report data. HCFA furnished you a list of DSH payment percentages to use to determine whether a hospital meets the DSH requirement to retain PIP. Except as follows, use the listing to determine whether a hospital meets the 5.1 percent criterion. A hospital meets the criterion where it included adequate Medicaid days in its 1984 cost report but HCFA failed to properly include them in its data base when computing the 1984 Medicaid percentage. It also can meet the criterion where it had adequate Medicaid days in its 1984 cost reporting year even though it did not include them in its cost report.

In the latter situation, a hospital must submit to you previously unsubmitted Medicaid data applicable to the 1984 cost report year (cost reports beginning October 1, 1983 through September 30, 1984). Verify the accuracy of this subsequently submitted Medicaid data and take appropriate steps, including audit where necessary, to assure the data's validity.

A hospital's request and the data must be received by you no later than 3 years from the date of the Notice of Program Reimbursement for the 1984 cost report. Remove from PIP after June 30, 1987 any hospital not qualifying based on the HCFA listing, or improper exclusion from the data base. Any hospital removed from PIP that has notified you of its intention to submit additional Medicaid data, or which has submitted the data with its request, will remain off PIP pending your evaluation of the data.

Consult your RO for specific timeframes involved and subsequent actions required where you permit PIP for a hospital not on the listing.

For rural hospitals to continue PIP, they must be located in a rural area (as defined for PPS) and have 100 or fewer beds on July 1, 1987. A rural hospital is a hospital outside any Metropolitan Statistical Area (MSA). Use the guidelines for determining MSAs for PPS hospitals to determine whether a hospital is rural.

In determining the bed count, a bed means a general routine or intensive care type adult or pediatric bed maintained in a patient care area for inpatient lodging. Do not count beds assigned to newborns, to custodial or domiciliary care, to units excluded from PPS, to hospital based SNFs, to areas maintained and utilized for only a portion of a patient's stay, or primarily for special procedures (e.g., labor rooms, birthing rooms, postanesthesia and postoperative recovery rooms, outpatient areas or emergency rooms, or ancillary departments).

Where hospitals have significant cash flow problems as a result of removal from PIP, accelerated payments are payable in accordance with Provider Reimbursement Manual §2412.

If the provider has previously elected PIP and continues to qualify, continue PIP for:

- Inpatient services from hospitals other than subsection (d) hospitals;

- Hospitals which receive payment under a State hospital reimbursement system under §§1814(b)(3) or 1886(c) of the Act, if payment on a PIP basis is approved by HCFA as an integral part of such reimbursement system. (PIP is an integral part of the New Jersey system but is not of the Maryland system);

- SNF services; or

- Home health services.

In addition, upon request you can implement PIP effective July 1, 1987 or later for hospices meeting the requirements to qualify for PIP.

7. Receipt Date.—The receipt date is the date you receive the claim subject to the qualifications in subsection C on whether a claim is sufficiently complete to be considered received. Using this date permits use of UNIBILL to monitor your performance. Enter this date in positions 1955-1960 of the UNIBILL record.

8. Scheduled Payment Date.—The scheduled payment date is the date the check you issued is mailed, deposited by you in the provider's account, or transferred electronically. For PIP claims and no payment bills, the scheduled payment date is the date for payment bills in the same adjudication batch. For adjustments (action code 3 in position 2 of the record) the scheduled payment date is the date you forward the UNIBILL record to HCFA. Enter this date in positions 1967-1972 of the UNIBILL record. Determine the date based upon your scheduled remittance and mailing operations before you prepare the UNIBILL record.

B. Systems Requirements.—

1. Determine Whether You May Remove Hospitals From PIP Based on Your Processing Timeliness.—In determining whether your processing timeliness is adequate to remove hospitals from PIP, consider all clean, non-PIP bills. Select cases based upon:

Pay interest at the rate used for §3902(a) of title 31, U.S. Code (relating to interest penalties for failure to make prompt payments). The interest rate is determined by the rate applicable on your scheduled payment date.

This rate is determined by the Treasury Department on a 6 month basis. The rate is 9 3/4 percent from January 1, 1989 through June 30, 1989. The prior rate was 9 1/4 percent effective through December 30, 1988. Changes to the rate will be issued to you. Calculate the interest using the following formula:

- o Reimbursement amount x rate x days divided by 365 = interest payment.

The interest period begins on the day after payment is due and ends on the scheduled payment date.

EXAMPLE: Date received - January 1, 1989
Payment due - on January 26, 1989
Payment made - February 09, 1989
Interest begins - on January 27, 1989
Interest ends - February 09, 1989
Days for which interest due - 14 days
Amount of reimbursement = $100
Annual interest rate = 9.75%

The formula is applied as follows:

$100 x .0975 x 14 divided by 365 = $.373 or $.37 when rounded to the nearest penny.

Use the UNIBILL reimbursement amount (locations 1707-1715) as the amount of principal. This is the payment after all deductions for deductible, coinsurance, and MSP. Round to the nearest penny. Report as value code 70 in UNIBILL the amount of interest you pay.

4. Reinstatement of PIP.—If you fail to pay 95 percent of all "clean" claims (for which PIP payments are not made) in the applicable number of days (as described in subsection A.1.) for each of 3 consecutive months, implement PIP for subsection (d) hospitals that qualify for PIP and request it. (See subsection B3 for instructions for selecting claims for this calculation.)

- Initial bill;
- Scheduled payment date during the month;
- Reimbursement amount greater than zero; and
- Neither condition code 62 nor 64 applies.

If for April, May, and June you pay 95 percent of these bills in 30 days after the day of receipt, discontinue PIP for subsection (d) hospitals, beginning July 1, 1987 for bills with discharge dates of July 1, 1987 and later, for hospitals that do not meet the exceptions in subsection A5.

Subsection (d) hospitals are hospitals in the 50 States, D.C. and Puerto Rico other than:

- Psychiatric hospitals;
- Rehabilitation hospitals;
- Whose inpatients are predominantly under 18 years old; and
- Whose average inpatient length of stay exceeds 25 days.

Hospitals in Maryland and New Jersey are included, but PIP is continued to New Jersey hospitals.

Treat excluded units of subsection (d) hospitals in the same manner as the hospital.

If you did not pay 95 percent of your clean bills in 30 days for April, May, or June 1987, notify your hospitals sufficiently early in order to permit them to timely submit their request to continue PIP and to assure that their PIP payments continue uninterrupted.

Discontinue PIP beginning with the first month after you have met the claims processing timeliness standard described in subsection A.5. for 3 consecutive months.

2. Determine Which DSHs and Small Rural Hospitals Will Continue on PIP.—Determine which hospitals will meet the DSH and rural hospital requirements to retain PIP (see subsection A.5. for requirements). Notify these hospitals sufficiently early in order to permit them to timely submit their request for continuation and to assure that their PIP payments continue uninterrupted.

3. Determine and Pay Interest.—Beginning with claims received April 1, 1987 you must pay interest on clean, non-PIP claims for which you do not make payment within the applicable number of calendar days (as described in subsection A.1.) beginning on the day after the receipt date. Select claims for interest based upon:

- Received April 1, 1987 or later;
- Processing time exceeds applicable number of days in Subsection A1. (Julian scheduled payment date minus Julian receipt date equals more than applicable number of days in A1.)
- Neither condition code 62 nor 64 applies; and
- Reimbursement amount is greater than zero.

5. Report Interest Payment on Remittance Records.—When interest payments are applicable, i.e., days after April 1, 1987, indicate for the individual claims on your remittance record the amount of interest.

6. Payment Made to Beneficiary.—If payment is made directly to the beneficiary on a clean claim for which you did not make payment within the applicable number of days (as described in subsection A.1.) apply interest. Add the following messages on any EOMB that you prepare. "Your payment includes interest since we were unable to process your claim timely."

7. Prepared Bills for DME.—Where you prepare bills for payment for purchased DME because the $50 tolerance is exceeded (see §3600.3) establish any date consistent with your system processing requirements as the receipt date for the second and succeeding bills. Use the date as close to your payment as possible.

8. Claims Paid Upon Appeal.—Interest payments are not payable on clean claims initially processed to denial and on which payment is made subsequent to the initial decision as a result of an appeal request. This applies to appeals where more than the applicable number of days (as described in subsection A.1.) had elapsed before an initial denial, but the claim was later paid upon appeal. Even though, in this situation, your mechanism for processing may be an initial debit action, no interest is due. Where an appeal of a previously paid claim results in increased payment follow 9 below.

9. Handling Interest on Postpayment Denials and Other Adjustments.—If a paid claim is later denied in full, recover any interest paid as well as the incorrect payment. Do not pay interest on the related no payment bill. If the claim is partially denied, interest is payable on the reduced amount. Recalculate the interest due based upon the new reimbursement amount. Use the rate of interest and elapsed days applicable to the original claim. This can be accomplished by applying a ratio of the new reimbursement amount (from your debit action) to the reimbursement amount on the initial claim (from your credit action). Multiply the result by the interest amount paid on the initial claim. The result is the interest amount payable on your debit action. Report this amount in value code 70 of UNIBILL. Use the following formula:

$$\text{Interest} = \frac{\text{debit action reimbursement amount}}{\text{credit action reimbursement amount}} \times \text{original interest paid}$$

This formula applies to the following actions where interest was initially paid:

- o DRG changes (higher or lower payment);
- o Postpayment partial denials;
- o Postpayment increase in payments (regardless of source of action); and
- o RTIs.

Use of the formula is preferable to expanding your system to handle multiple scheduled payment dates and calculation procedures.

10. Preparation of IRS Form 1099 INT.--IRS requires that interest paid in the course of a "trade or business" be reported if it totals $600 or more for any person. Interest payments you make fall within the "trade or business" definition. Therefore, prepare and file with the IRS, Form 1099 INT when interest payments for a calendar year to a beneficiary or provider total at least $600. Use the beneficiary's individual Social Security Number (SSN) to report interest. Individual SSNs are identified by the suffix A or M, J, T, or TA. Other suffixes mean benefits are based upon a spouse's, parent's or child's (F1 thru 8) SSN. If the spouse's, parent's or child's SSN is involved, determine the individual's SSN to report interest. The active HICN plus the preceding SSN are cross-referenced on the BEST file. (See §3506.) If the SSN is not known, all zeros appear in the cross-referenced field. If the individual's SSN is not present, contact your parallel SSO for the information. The cross-reference is not shown on the CAST file.

C. Control and Counting.--Consider claims as received for processing time purposes from the date of their receipt. Improperly completed claims that you return are considered received from processing time purposes when received again, properly completed. See §3894 for counting of claims on the workload report.

1. Provider Billing Via Terminal or Equivalent.--If the provider bills via remote terminal with on-site (in the provider) editing or if you otherwise can communicate edit results to it electronically, establish a control record when the bill passes your consistency edits. Count it as received for UNIBILL date received, for administration of timely billing under PIP, and for your timely processing on the day you receive it properly completed. Normally, this is the same day the bill passes your edits, unless you delay entry into your system of a properly completed bill.

2. Manual Hardcopy Bills, Magnetic Tapes.--Establish a control record when you enter the initial claim into your system. Count the bill for administering timely billing for PIP, and timely bill processing by you, only if it passes your edits. The date received for UNIBILL and PIP is the date you received it properly completed even if entered into your system on a later date.

3. Bill Returned To Provider.--If you return the bill, retain a claim record to minimize data entry cost when returned. Assign a receipt date for UNIBILL and PIP monitoring only when it is properly completed and passes your edits.

Forward PRO prepayment review claims that you receive and identify in batch processing as needing PRO prepayment review either to the PRO directly or to the hospital to forward to the PRO. These are incomplete bills needing additional development. count them received when they are returned.

If you forward cases directly to the PRO, you may want to develop a list or memorandum for providers advising them that the claims were forwarded to the PRO for review. This eliminates subsequent provider status inquiries.

4. Bills Requiring Medical Information.—When you request medical information, retain the bill as a pending record until you either pay or deny it. Returning cases for review by the PRO is not a request for medical information. Claims that fail your initial edits because required medical reports or other required attachments are not included are not requests for medical evidence.

5. Deleting Control.—Retain your control record unless deleted as described in 1, 2, 3, or 4 above until final resolution. For inpatient records which affect utilization, this is when the claim passes your final edits immediately prior to sending to HCFA via UNIBILL. For other records (outpatient, HHA, SNF, etc.) it is when the claim passes your final edits immediately prior to sending to HCFA via UNIBILL or a denial letter is generated.

D. Adjustment Bills.—An adjustment bill is a correction to a claim previously processed. Establish a control record for it.

Count hospital, MSP or manual PRO adjustments as pending when received. PRO electronic adjustments are received and pending only when they pass your edits. (See §3674.6.)

Assign the date received in your mailroom as the receipt date for hospital and MSP adjustments. On PRO adjustments, assign the later of the date you receive the request (passed your edits) or the date the batch clearance record was received from HCFA for the claim to be adjusted.

Count adjustment bills as processed when no further action by you is required. The final action taken on the adjustment bill depends upon the situation. If an adjustment bill involves only money adjustments (no utilization changes) and will not be submitted to HCFA, count it as "processed" after review and adjustment in payment. If an adjustment bill involves utilization changes and the original bill was accepted by HCFA, consider it processed when submitted via UNIBILL.

3600.2 Time Limitations for Filing Provider Claims.—

A. Time Limitation for Medical Information Requests.—When you request medical information for initial claims review, send one request to the provider. Indicate in the request that the information must be received within 30 days of the date of the request and that if the information is not received within 30 days the claim will be denied for "failure to submit medical evidence." If the medical information is subsequently received, reopen the claim and pay or deny as appropriate. Generate appropriate notices to the beneficiary and provider. File and process these bills to update utilization using an "R" code to identify "refused payment."

B. Time Limitation for Provider Claims.—Provider cost claims must be filed on, or before, December 31 of the calendar year following the year in which the services were furnished. (See §§3307ff. for details of the rules and exceptions. See §3816E for the effect on adjustment bills.)

Deny bills not received timely. However, such bills should be filed and processed because of the spell-of-illness implications. In provider fault situations, record the days, visits, cash and blood deductibles.

When a bill is received from a provider paid on a cost basis where only part of the services were rendered within the prescribed time limitations, obtain a breakdown of charges before and after the time limit. This enables you to determine how much of the bill to deny. For example, you received a bill on February 3, 1987, for provider services furnished September 16, 1985 through October 30, 1985; because the time for filing expired December 31, 1986, treat services furnished before October 1 as noncovered. Accordingly, obtain a breakdown of the charges for the covered and noncovered periods to properly complete UNIBILL.

3600.3 Reviewing Bills for Services After Suspension, Termination, Expiration, or Cancellation of Provider Agreement, or After a SNF is Denied Payment for New Admissions.—See §3008.4 for provisions for payment following a termination, expiration, or cancellation of a provider agreement. Effective August 1986, a SNF may be denied payment for new admissions as an option to termination of its provider agreement for noncompliance with one or more conditions of participation. The SNF may only be reimbursed for covered services furnished on or after the effective date of denial of payments if such services were furnished to beneficiaries who were admitted to the SNF before the effective date payments were denied.

EXAMPLE: Effective date of denial of payment - 9-30-86
Beneficiary admitted before 9-30-86 - pay for covered Part A or B services
Beneficiary admitted on or after 9-30-86 - deny payment under Part A or B

NOTE: An inpatient who goes on leave from the SNF before or after the effective date of denial of payments for new admissions is not considered a new admission when returning from leave.

You are notified of SNF payment denials through the HCFA-2007. Install appropriate edits or other safeguards to prevent incorrect payments to the provider.

Obtain a list of Medicare inpatients when a SNF or hospital agreement is terminated, or after a SNF is denied payment for new admissions to assure that nonpayment spell of illness bills are filed. (See §3604, Item 24.)

Following termination, expiration, or cancellation of its agreement, a hospital or SNF is considered to be a "nonparticipating provider." An inpatient of such an institution who has Part B coverage, but for whom Part A benefits have been exhausted or otherwise not available, is entitled to reimbursement only for services that are covered in a nonparticipating institution. A patient admitted to the SNF on or after the effective date of denial of payment who has Part B coverage is entitled to reimbursement for services covered in a nonparticipating institution. Such services furnished on or after the effective date of termination, or in the case of expiration or cancellation of an SNF agreement, on or after the day following the close of such agreement, are billed on Form HCFA-1500, Health Insurance Claim Form and sent to the carrier.

A terminated hospital may be certified to provide emergency services. If it meets the criteria, it is assigned an emergency provider number (E suffix). This procedure is not automatic, and hospitals terminated for Life Safety Code violations may not be able to qualify. If a terminated hospital qualifies, billings are handled by the designated emergency intermediary.

In a no-payment situation, where the entire billing period represents charges for which no Part A payment can be made, it is not necessary to submit two bills. Submit only a final no-payment bill, with a discharge date, under the former provider number.

Services furnished during the "no-payment" period may subsequently be determined to be covered. Where such covered services were furnished before the date of change in provider number, the provider submits one corrected bill covering the entire period showing the former provider number. Where the services were furnished after the date of change in provider number or both before and after the date of change, the provider submits a corrected discharge bill.

3600.4 Change of Intermediary.—The RO sends the official notice to you of changes in your list of providers. (See Part 2, §2810.) The following special procedures apply:

A. Outgoing Intermediary is Still Connected with Medicare Program.—Non-PPS providers and excluded units submit interim bills to the outgoing intermediary for services and supplies furnished prior to the date of change. Bills for services and supplies furnished beginning with the effective date of change are submitted to the new intermediary. Each intermediary updates HCFA utilization records based upon the bill it processes.

When an intermediary change occurs, HCFA does not require a new admission query. The established admission remains on HCFA's records until a final bill is accepted.

PPS hospitals do not submit separate bills. The incoming intermediary is billed for the entire stay upon the beneficiary's discharge.

B. Outgoing Intermediary is Not Connected with Medicare.—Where the prior intermediary is no longer connected with the Medicare program, it may be necessary for the new intermediary to handle bills which it normally would not process. Where the outgoing intermediary is terminating participation, the RO makes the necessary arrangements to effect a smooth transition.

3600.5 Multiple Provider Numbers or Changes in Provider Number.—Where a multiple facility provider is assigned separate provider numbers for each facility or where it is assigned a different number, special billing procedures are necessary. The provider uses the new number for all bills, beginning with the date the new number takes effect.

It submits a bill with the old provider number for the period before the change and another with the new provider number for the period after the change. The date of discharge on the first bill and the date of admission on the second bill are the same, i.e. the effective date of the new provider number. All subsequent billings are submitted under the new provider number.

3600.6 Reduction in Reimbursement Due to P.L. 99-177, P.L. 100-119, and P.L. 100-203.—

A. General.—P.L. 99-177 requires reduction in all Medicare program payments when the total Federal budget deficit exceeds set limits. P.L. 100-203 sets the reduction at 2.324 percent for services rendered November 21, 1987 through December 31, 1987 for Part A home health, hospice, and SNF services. The 2.324 percent reduction continues for services rendered through March 31, 1988 for inpatient hospital services and all services reimbursed under Part B.

Reduce all Medicare program payments after applying any deductible, coinsurance, and any applicable MSP adjustments. Make the reduction for each claim or interim payment (including PIP).

B. Definitions.—

Date of Service: For PPS hospital services, the date of discharge is the date of service. Reduce payment if the discharge date is November 21, 1987 or later, but before April 1, 1988.

For non-PPS inpatient services (excluded hospital units, non-PPS hospitals, SNFs and inpatient Part B services) apply the reduction if the through date on the bill is on or after November 21, 1987 through March 31, 1988. Do not search for earlier bills to apply the reduction.

For all other services (including outpatient hospital, SNF, HHA, CORF, hospice, renal dialysis facility, RHC), apply the reduction to all bills received with through dates on or after November 21, 1987 through March 31, 1988. The provider is responsible for billing earlier services separately to avoid the reduction. Do not incur expense to develop split bills where the bill may contain some earlier services, except for services the facility must bill on a monthly basis (ESRD, HHAs, and repetitive therapies). You may accept adjustment bills or adjust the bills only for these types of services. Do not accept adjustment bills to correct earlier bills spanning November 21, 1987 for other types of services.

Affected Providers: All Medicare providers, both PPS and non-PPS, including those in areas with special reimbursement rules (Maryland, New Jersey, and the Finger Lakes region of New York) are affected.

Reduction Amount: The reduction amount for Medicare program payment is 2.324 beginning November 21, 1987. Although the reduction provided in the law is limited to 2 percent for FY 1988, 2.324 percent must be withheld for discharges and services on or after November 21, 1987 through December 31, 1987 for Part A home health, hospice, and SNF services and November 21, 1987 through March 31, 1988 for inpatient hospital services and all services reimbursed under Part B (hospital outpatient department, Part B home health, clinical diagnostic laboratory fee schedule, ESRD, CORF, etc.). Apply the ESRD network reduction before sequestration. Calculate interest payment on claims either before or after the 2.324 percent reduction, whichever is more efficient for your system.

For FYs after 1988, you will be informed via a Program Memorandum of the specific percentage by which to reduce bills. Inform your providers of the reduction amount. Hold any bills with a discharge date on or after October 1 until you receive the reduction amount.

C. Changes Required in Bill Payment Procedures.—Your program for calculating payment must change the sum remaining after deductible, coinsurance, and MSP to reduce the payment by the appropriate percentage. Do this in all calculation modules, rounding to the nearest cent. Base calculations upon a percentage reduction of payment, not on interim rates or DRG amount.

Adjust final PPS (DRG) payments and interim payments (cost based interim payments), PIP payments, and PPS pass-through payments.

Adjust payment amount not payment rates. Apply the reduction to the amount that would have been paid before P.L. 99-177, i.e., after reduction for deductible, coinsurance, and MSP. This provides a slightly higher payment to the provider than applying the percentage reduction before deductible, coinsurance, and MSP.

When payment is for laboratory services, make the percentage reduction after you decide whether the charge or fee schedule is lower.

Make your changes in the most feasible manner to permit further changes if necessary. Effective each October 1, it may be necessary to change the reduction amount, based upon the discharge date or date of services.

D. Reporting.—Report the payment amount, after making the percentage reduction, to your PS&R and in UNIBILL. This applies to both reimbursement amount (UNIBILL inpatient and outpatient positions 1707-1715) and inpatient pass-thru per diem (positions 1846-1851).

3602. BILLING FORMS AND FORMATS

3602.1 Electronic Media Claims (EMC).—Develop automated system capabilities to receive EMC data from providers or their billing services in lieu of hardcopy data. You must have the ability to receive EMC via telecommunications unless you can demonstrate to your RO that is not cost effective. You may also develop the capability to receive EMC submitted via other electronic media where it is cost effective.

Review the provider's capability to submit EMC if fewer than 95 percent of its bills pass your automated consistency edits. Use edit specifications in §3606.

A. Assessment of Provider EMC Capacity.—To maximize provider participation, peridically reassess using hardcopy EMC capacity of providers. To the extent that it would be cost-effective, encourage provider EMC. Urge providers and billing services to convert to EMC.

B. Ro EMC Approval of Intermediary System.--The procedures you plan to use to support EMC are subject to RO approval. Upon request, your RO will advise you of the informatin it requires.

3602.2 Requirements for Submission of EMC Data.--Receive and process claims reported by providers electronically if the claims adhere to the file and record formats and utilize the data set in §3602.3.

A. Requirements.--

1. Control.--Account for all EMC received. Minimally, identify and report to the provider the claims received in each group/batch of claims it submitted. Include the number of EMC received in the workload report. (See §3894.) Once EMC submissions have passed the consistency edits, your system must have the capability to suspend and control claims in which errors are found and reassociate corrective data with the suspended claims. Additionally, to determine providers', accuracy levels maintain data on the number in which errors are found.

2. Retention.--Retain the bill records submitted exactly as submitted. The media of rention is left to your discretion, so long as individual claims are readily accessible. (For example, bills submitted on magnetic tape may be retained on microfilm or microfiche, rather than on the original reel of magnetic tape.) Retain data for the same period that hardcopy claims are stored prior to microfilming, destruction, or Federal storage. Store any paper forms, including error correction documents, that are subsidiary to the EMC data to insure their retrieval, if necessary.

3. Claims Review.--Exercise the same vigilance and utilize the same criteria in performing medical necessity and coverage reviews as for hardcopy claims. The method of performing this review, whether automated, clerical, or a combination, is left to your discretion (unless specified otherwise in this manual) so long as it complies with the requirements. An example of an acceptable approach is utilization of an approved automated means of performing review on both hardcopy and EMC, e.g., automated screens.

4. Return of Beneficiary Data.--Beneficiary eligibility and utilization data can be returned to a provider or to its billing service.

5. Assignment of Benefits.--If a complementary claim is involved, the provider must indicate on the specific claim record whether payment of complementary benefits has been assigned to it by the beneficiary.

6. Technical Assistance.--If it is cost effective, provide technical assistance to providers that wish to bill electronically.

B. Provider Requirements.--

1. Provider Representative Certification.—The initial group of claims submitted to you must be accompanied by a covering letter, signed by the provider's representative. (For hospitals and SNFs the appropriate representative is the administrator.) The letter must include the following statements: "In submitting machine readable claims, I understand that I am certifying that the required patient signatures, or, where applicable, appropriate signatures on behalf of the patient, and required physician certifications and recertifications (PRO certifications where applicable) are on file and that anyone who misrepresents or falsifies essential Medicare claims information, may, upon conviction, be subject to fine and imprisonment under Federal law." The statement should be resubmitted annually, or upon a change in provider representative if that occurs first.

2. Claims Submission.—Claims may be submitted individually or in periodic groups/batches at intervals mutually established between you and the provider. Where limitations on frequency of billing are applicable (e.g., monthly billing for ESRD, HHA, or the therapies) providers must comply with established rules.

3. Control.—Provider systems must have the capability to resubmit lost or garbled claims data or unreadable tapes, cassettes, floppy disks, or whatever other medium is used, and be able to reassociate data found to be in error with the original claim for correction and resubmission.

4. Retention.—Providers must retain all applicable source data in accordance with existing requirements and make it available for periodic verification.

3602.3 File Specifications, Records Specifications, and Data Element Definitions for EMC Bills.--In addition to accommodating the requirements for Medicare claims, specifications are designed to meet the needs of other private and government programs.

Provision has been made for users to expand the file and record format to accommodate needs of a specific locality or type of coverage. If an entire physical segment is desired within a subset, record types n5 through n9, where no represents 1 through 9, are available. Within the nationally defined physical segments, where space permits, a portion is set aside for local use. The File and Record Formats are described in Addendum A. The data elements are listed alphabetically and defined in Addendum B. Coding structures for data represented by codes are defined in Addendum C. Addendm D contains the home health plan of treatment data definitions and codes. Addendum E contains MCED edits. Addendum F contains OCE edits.

3602.4 National EMC Formats.—The maintenance of the file and record formats is the responsibility of a committee chaired by HCFA's Director of the Division of Provider Procedures known as the Provider Electronic Billing Technical Advisory Groups—PEBTAG. Other groups represented are the American Hospital Association, the Health Insurance Association of America, the Blue Cross Association, the Medicaid Systems Technical Advisory Group, and CHAMPUS. The PEBTAG meets on a regular basis at a time and place designated by the chairman.

3602.5 Paper Bills.—HCFA Form 1450 was developed by representatives of the hospital and health insurance industries to be used when EMC billing is not feasible. Instructions for review of the form are contained in §3604.

3603. FREQUENCY OF BILLING

Inform providers about the frequency with which you can accept billing records and the frequency with which they may bill on individual cases.

In your requirements, consider your billing systems operations and bill review procedures, the provider's systems operations and Medicare program and administrative requirements. The following requirements apply.

Inpatient services in SNFs and non-PPS hospitals (i.e., excluded units or hospitals) may be billed upon discharge or after 30 days (and if necessary, as often as every 30 days thereafter). You may permit more frequent billing if the cost is not excessive (e.g., if the provider bills electronically). Each bill must include all applicable diagnoses and procedures. However, it must not include charges billed on an earlier bill. The from date must be the day after the thru date on the earlier bill. Interim billing is not necessary for providers that receive PIP payments. Therefore, do not permit interim billing for them.

Repetitive Part B services to a single individual must be billed monthly (or at the conclusion of treatment). This avoids processing costs in holding such bills for monthly review and reduces bill processing costs for relatively small claims. Services are:

Service	Revenue Code
- DME Rental	290-299
- Therapeutic Radiology	330-339
- Therapeutic Nuclear Medicine	342
- Respiratory Therapy	410-419
- Physical Therapy	420-429
- Occupational Therapy	430-439
- Speech Pathology	440-449
- Home Health Visits	570-599
- Kidney Dialysis Treatments	820-859
- Cardiac Rehabilitation Services	482, 943
- Psychological Services	(910-919 in a psychiatric facility)

Other one time Part B services may be billed upon completion of the service. Bills for outpatient surgery must contain all services provided on the day of surgery on a single bill. (Outpatient services furnished on a day other than the day of surgery must not be included on the outpatient surgical bill.)

See §3628 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

Where there is an inpatient stay, or outpatient surgery, during a period of repetitive outpatient services, one outpatient bill is required for services prior to the day of surgery or admission and another for those following discharge (or the day of outpatient surgery). This is in addition to the bill for the inpatient stay or outpatient surgery.

Periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques you may use are:

- o Sample review of bills to determine if most are for a monthly period (by using from and thru dates or number of services). This may be done manually or electronically. You may rely on informal communications from your medical review staff.

- o Modification of your duplicate screens to detect bills that meet duplicate criteria except for billing period, but which fall in the same 30 day period.

Where providers bill improperly, attempt an educational contact. If this fails, return bills with an explanation and request proper billing.

Be alert to situations where the treatment plan is completed or discontinued because the beneficiary dies or moves.

HCFA-1450

3604. REVIEW OF FORM HCFA-1450 FOR INPATIENT AND OUTPATIENT BILLS

This form, also known as the UB-82, serves the needs of many payers. Some data elements may not be needed by a particular payer. All items on the HCFA-1450 are described, but detailed information is given only for items required for Medicare claims. Items listed as "Not Required" need not be reviewed although providers may complete them when billing multiple payers. All intermediary processed Medicare claims are billed on the HCFA-1450 or related electronic data records.

If the provider omits required data, obtain it from the provider or other sources and maintain it on your history record. It is not necessary to search paper files to annotate missing data unless you do not have an electronic history record. You need not obtain data not needed to process the bill.

Data elements in the HCFA uniform electronic billing specifications are consistent with the HCFA-1450 data set to the extent that one processing system can handle both. Definitions are identical. In some situations the electronic record contains more characters than the corresponding item on the form because of contraints on the form size not applicable to the electronic record. Also, for a few data elements not used by Medicare, conversion may be needed from an alpha code to a numeric, but these do not affect Medicare processing. The revenue coding system for both the HCFA-1450 and the electronic specifications are identical.

Admitting Diagnosis
For inpatient hospital claims subject to PRO review (see §3770.1), the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization. This definition is not the same as that for SNF admissions. Providers report admitting diagnoses in a 5 position ICD-9-CM code in block E.

Item 1. (Untitled) - Provider Name, Address, and Telephone Number
Required. The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit ZIP codes are acceptable. Use the information to reconcile provider number discrepancies.

Item 2. (Untitled)
Not Required. This is one of the four fields which have not been assigned for national use. Use of the field, if any, is assigned by the SUBC and is uniform within a State.

Item 3. Patient Control Number
Not Required. Some providers use an identifying number to facilitate retrieval of case records and posting payment. Where you have made arrangements to use this number in your communications to the provider, the provider shows it here.

Item 4. Type of Bill

Required. This three-digit numeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

1st Digit - Type of Facility

1 - Hospital
2 - Skilled Nursing
3 - Home Health
4 - Christian Science (Hospital)
5 - Christian Science (Extended Care)
7 - Clinic (Requires special information in second digit, below)
8 - Special Facility or hospital ASC surgery (Requires special information in second digit, below)

2nd Digit - Classification (Except Clinics and Special Facilities)

1 - Inpatient (Part A)
2 - Inpatient (Part B) (Includes HHA visits under a Part B plan of treatment.)
3 - Outpatient (Includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment.)
4 - Other (Part B) (Includes HHA medical and other health services not under a plan of treatment and hospital and SNF diagnostic clinical laboratory services to "nonpatients."
8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).

2nd Digit - Classification (Clinics Only)

1 - Rural Health
2 - Free Standing Renal Dialysis Center
4 - Comprehensive Outpatient Rehabilitation Facility (CORF) or Other Rehabilitation Facility.

2nd Digit - Classification (Special Facilities Only)

1 - Hospice (Nonhospital Based)
2 - Hospice (Hospital Based)
3 - Hospital Outpatient (ASC Procedure)

3rd Digit - Frequency	Definition
A - Admission Notice	This code is used when the hospice is submitting the HCFA-1450 as an admission notice.
0 - Nonpayment/zero claims	This code is used when the provider does not anticipate payment from the payer for the bill, but is informing the payer about a period of nonreimbursable confinement or

termination of care. The "Through" date of this bill (Item 22) is the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are unneeded and may be returned to the provider.

1 - Admit Through Discharge Claim	This code is used for a bill encompassing an entire inpatient confinement or course of outpatient treatment for which the provider expects reimbursement from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2 - Interim - First Claim	This code is used for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement or course of treatment.
3 - Interim - Continuing Claim	This code is used when a bill for which utilization is chargeable for the same confinement or couse of treatment had already been submitted and further bills are expected to be submitted later.
4 - Interim - Last Claim	This code is used for a bill for which utilization is chargeable and which is the last of a series for this confinement or course of treatment. The "Through" date of this bill (item 22) is the discharge date for this confinement or course of treatment.
5 - Late Charge Only	This code is used only for outpatient claims. Late charge bills are not accepted for Medicare inpatient claims.
6 - Adjustment of Prior Claim	This code is used by the provider to show an increase and/or decrease in charges. The provider may use this code only with your permission. If you grant such permission, you must create a code 7 and code for UNIBILL.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is also submitted by the provider showing corrected information.

P	- PRO Adjustment Claim	Use this code to identify a debit adjustment initiated as a result of PRO review.
I	- MISC Adjustment Claim (Other Than PRO or Provider)	Use this code to identify a debit adjustment initiated by HCFA or you.

Item 5. Blue Cross/Blue Shield Provider Number

Not Required.

Item 6. Federal Tax Number

Not Required.

Item 7. Medicare Provider Number

Required. This is the six-digit number assigned by Medicare.

Item 8. Medicaid Provider Number

Not required.

Item 9. (Untitled)

See item 2, above.

Item 10. Patient's Name

Required. The patient's name is shown with the surname first, first name, and middle initial, if any.

Item 11. Patient's Address

Required. This item shows the patient's full mailing address including street number and name, post office box number or RFD, city, State and ZIP code. A valid ZIP code is required for PRO purposes on inpatient bills.

Item 12. Patient's Birthdate

Required. The month, day, and year of birth is shown numerically as MM-DD-YY. If the date of birth was not obtained after reasonable efforts by the provider, the field will be blank. For hospitals reimbursed under PPS the date of birth in the query response is used for assigning a DRG.

Item 13. Patient Sex

Required. A "M" for male or a "F" for female must be present. This item is used in conjunction with items 78-86 (diagnoses and surgical procedures) to identify inconsistencies.

Item 14. Patient's Marital Status

Not Required.

Item 15. Admission Date

Required. The month, day, and year of admission for inpatient care is shown numerically as MM-DD-YY. When using the HCFA-1450 as a hospice admission notice, the facility shows the date the beneficiary elected hospice care.

Item 16. Admission Hour
Not Required.

Item 17. Type of Admission
Required on inpatient bills only. This is the code indicating priority of this admission.

Code Structure:

1	Emergency	The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
3	Elective	The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4	Newborn	A baby born within this facility. Use of this code necessitates the use of special Source of Admission codes - see Item 18.
9	Information Not Available	The hospital cannot classify the type of admission. This code is used only on rare occasions.

Item 18. Source of Admission
Required on inpatient bills only. This is the code indicating the source of this admission.

NOTE: Newborn coding structure must be used when the Type of Admission Code in Item 17 is code 4.

Code Structure:

1	Physician Referral	The patient was admitted upon the recommendation of a personal physician.
2	Clinic Referral	The patient was admitted upon the recommendation of this facility's clinic physician.
3	HMO Referral	The patient was admitted upon the recommendation of a HMO physician.

4	Transfer from a Hospital	The patient was admitted as a transfer from an acute care facility where he or she was an inpatient.
5	Transfer from a SNF	The patient was admitted as a transfer from a SNF where he or she was an inpatient.
6	Transfer from Another Health Care Facility	The patient was admitted as a transfer from a health care facility other than an acute care facility or a SNF.
7	Emergency Room	The patient was admitted upon the recommendation of this facility's emergency room physician.
8	Court/Law Enforcement	The patient was admitted upon the direction of a court of law, or upon the request of a law enforcement agency's representative.
9	Information Not Available	The means by which the patient was admitted is not known.

Code Structure (for Newborn):

1	Normal Delivery	A baby delivered without complications.
2	Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
4	Extramural Birth	A baby born in a nonsterile environment.

Item 19. Accident Hour
Not Required.

Item 20. Discharge Hour
Not Required.

Item 21. Patient Status
Required. (For all Part A inpatient, SNF and hospice services.) This code indicates the patient's status as of the "Through" date of the billing period (item 22).

Code	Structure
01	Discharged to home or self care (routine discharge)
02	Discharged/tranferred to another short-term general hospital
03	Discharged/transferred to SNF

Code	Structure
04	Discharged/transferred to an ICF
05	Discharged/transferred to another type of institution (including distinct parts)
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice
20	Expired (or did not recover- Christian Science Patient)
30	Still patient
40	Expired at home (Hospice claims only)
41	Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)
42	Expired - place unknown (Hospice claims only)

Item 22. Statement Covers Period (From-Through)
Required. The beginning and ending dates of the period included on this bill are shown in numeric fields (MM-DD-YY). Days before the patient's entitlement are not shown. Use the "From" date to determine timely filing. (See §§3307ff.)

Item 23. Covered Days
Required. The total number of covered days during the billing period applicable to the cost report including lifetime reserve days elected for which Medicare payment is requested, is entered. This should be the total of accommodation units reported in Item 52. Covered days exclude any days classified as noncovered as defined in Item 24, leave of absence days, and the day of discharge or death.

If you made an adverse coverage decision, enter the number of covered days through the last date for which program payment can be made. If waiver of liability provisions apply, see §3441.

The provider does not deduct any days for payment made under WC, automobile medical, no-fault, liability insurance, an EGHP for an ESRD beneficiary, employed beneficiaries and spouses age 65 or over or an LGHP for disabled beneficiaries. Enter the number of days shown in this Item in the cost report covered days field 24 (positions 145-147) of the UNIBILL RECORD. However, when the other insurer has paid in full (see §§3679B, 3680B, 3681B, 3682B and 3685), enter zero days in the UNIBILL RECORD. Calculate utilization based upon the amount Medicare will pay and enter the utilization days chargeable to the beneficiary in the covered days field 22 (positions 138-140) of the UNIBILL RECORD. (See §§3679B and C, 3680B and C, 3681B and C, 3682 B and C, and 3685.)

For discussion of how to determine whether part of a day is covered, see §§3620ff.

If the provider reported an incorrect number of days, report the correct number when submitting the UNIBILL RECORD.

Item 24. Noncovered Days
Required. The total number of noncovered days during the billing period within the "From" and "Through" date that are not claimable as Medicare Patient Days on the cost report.

Item 25. Coinsurance Days
Required. The number of covered inpatient hospital days occurrring after the 60th day and before the 91st day or the number of covered inpatient SNF days occurring after the 20th day and before the 101st day of the benefit period are shown for this billing period. Verify this entry with the admission query response and use the data from the admission query response if different.

See §3106.2 for special considerations in election of lifetime reserve days. The provider enters the number of lifetime reserve days applicable. You may need to change this entry based on data developed by your claims processing system.

Item 27. (Untitled)
See Item 2, above.

Items 28, 29, 30, 31, and 32. Occurrence Codes and Dates
Required. Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown. Event codes are two numeric digits and dates are shown as six numeric digits (MM-DD-YY). When occurrence codes 01-04 and 24 are entered, they must be accompanied by the entry of the appropriate value code in Items 46-49, if there is another payer involved.

Occurrence and occurrence span codes are mutually exclusive. Occurrence codes have values from 01 through 69 and occurrence span codes have values from 70 through 99.

When Item 33 is utilized, for an occurrence span, Items 31 and 32 may be used to contain the "From" and "Through" dates of another occurrence span code. In this case, the code in Item 31 is the occurrence span code and the occurrence span "From" date is in the date field. Item 32 contains the same occurrence span code as the code in Item 31 and the occurrence span "Through" date is the date field.

Code Structure (only codes used to bill Medicare are shown)

Code	Title	Definition
01	Auto accident	Code indicating the date of an auto accident. This code is used to report an auto accident that inovolves liability insurance. (See §§3419ff.)
02	Auto Accident/No Fault Insurance Involved	Code indicating the date of an accident where State has applicable no-fault liability laws (i.e., legal basis for settlement without admission or proof of guilt). This code us used to report the date of an auto accident that involves auto medical/no-fault insurance. (See §§3489ff.)
03	Accident/Tort Liability	Code indicating the date of an accident resulting from a third party's action that may

Code	Title	Definition
		involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Code indicating the date of accident relating to the patient's employment. (See §§3407-3416.)
05	Other Accident	Code indicates the date of an accident not described by the above codes. This code is used to report that the provider has developed for other casualty related payers and has determined there are none (additional development not needed).
11	Onset of Symptoms/Illness	Code indicates the date the patient first became aware of symptoms/illness.
18	Date of Retirement Patient/Beneficiary	Code indicates the date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Code indicates the date of retirement for the patient's spouse.
20	Guarantee of Payment Began	(Part A claims only.) Code indicates date on which the provider began claiming payment under the guarantee of payment provision. (See §3714.)
21	UR Notice Received	(Part A SNF claims only.) Code indicates date of receipt by the SNF of the URC finding that an admission or further stay was not medically necessary. (See §3421.1.)
22	Date Active Care Ended	(SNF claims only.) Code indicates date on which a covered level of care ended in a SNF. Code is not required if code "21" is used.
23	Benefits Exhausted	(Part A claims only/not reported by providers.) Code indicates the last day benefits can be paid based on your query response from HCFA. Enter this date only when benefits have been exhausted before the date of discharge or death and during the period described in Item 22.

Code	Title	Definition
24	Date Insurance Denied	Code indicates the date of receipt of a denial of coverage by a higher priority payer.
26	Date SNF Bed Available	Code indicates the date on which a SNF bed became available to a hospital inpatient who required only SNF level of care. (See §§3327C and 3421ff.)
27	Date HHA Plan Established or Last Reviewed	Code indicates the date a plan of treatment was established or last reviewed for home health care as required by §§3326 and 3328.
28	Date CORF Plan Established or Last Reviewed	Code indicates the date a plan of treatment was established or last reviewed for CORF care as required by §3350.
29	Date OPT Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for OPT as required by §3350.
30	Date Speech Pathology Plan Established or Last Reviewed	Code indicates the date a plan was established or last reviewed for outpatient speech pathology as required by §3350.
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	Code indicates the date of the notice provided to the patient by the hospital stating that he no longer requires a covered level of inpatient care.
32	Date Beneficiary Notified of Intent to Bill (procedures or treatment)	Code indicates the date of the notice provided to the patient by the hospital stating that requested care (dignostic procedures or treatments) is not considered reasonable or necessary by Medicare.
33	First Month of the 12 Month Coordination Period for ESRD Beneficiaries Covered by EGHP	Code indicates the first day of the first month of the 12 month period, defined in §3490.2D, during which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.
34	Date of Election of Extended Care Services	Code indicates the date the guest elected to receive extended care services (used by Christian Science Sanatoria only).

Code	Title	Definition
35	Date Treatment Started	Code indicates the date treatment began for any of the therapies.
36	Date of Inpatient Hospital Discharge for Transplant Procedure	Code indicates the date of discharge for the inpatient hospital stay in which the patient received a transplant procedure when the hospital is billing for immunosuppressive drugs.
42	Date of Discharge	(Hospice claims only.) Code indicates date on which the beneficiary terminated his election to receive Hospice benefits from the facility rendering the bill. (See §3648, Items 28-32, code 42.) The frequency digit (3rd digit, Item 4, Type of Bill) should be 1 or 4.
47-49	Payer Codes	Codes reserved for internal use only by third party payers. HCFA will assign as needed for your use. Providers will not report them.

Item 33. Occurrence Span Code and Dates Required. Code and associated beginning and ending date(s) defining a specific event relating to this billing period are shown. Event codes are two numeric digits and dates are shown numerically as MM-DD-YY.

Code Structure (Only codes used for Medicare bills are shown)

Code	Title	Definition
70	Qualifying Stay Dates	(Part A claims for SNF level of care only.) Code indicates the dates shown are for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed on this claim.

Code	Title	Definition
71	Hospital Prior Stay Dates	(Part A claims only.) Code indicates the from/through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	Code indicates the actual dates of the first and last visits occurring in this billing period where these dates are different from those in Item 22, Statement Covers Period.
74	Noncovered Level of Care	Code indicates the From/Through dates of a period at a noncovered level of care in an otherwise covered stay excluding any period reported with occurrence span code 76 or 77.
75	SNF Level of Care	Code indicates the From/Through dates of a period of SNF level of care during an inpatient hospital stay. The code also means that a PRO, reviewing the stay, has approved the patient's remaining in the hospital because of the nonavailability of a SNF bed. For hospitals under PPS, this code is needed only in length of stay outlier cases, (code "60" in Items 35-39). This code is applicable to swing bed cases.
76	Patient Liability	Code indicates the From/Through dates of a period of noncovered care for which the hospital is permitted to charge the beneficiary. Code should be used only where you or the PRO have approved such charges in advance and the patient has been notified in writing 3 days prior to the "From" date of this period. (See occurrence codes 31 and/or 32.)
77	Provider Liability	Code indicates the From/Through dates of a period of noncovered care for which the provider is liable.
78	SNF Prior Stay Dates	(Part A claims only.) Code indicates the From/Through dates given by the patient of any SNF or nursing home stay that ended within 60 days of this hospital or SNF admission. An inpatient stay in a facility or part of a facility that is certified solely as an ICF, or licensed by the State solely at, or below, an ICF level of care, does not continue a spell of illness and

		therefore, is not shown in Item 33. (See §3880.2 for the importance and use of such information for PRO medical review for hospital admissions. Also, see §3035.B.2 for a listing of specific provisions by State.)
79	Payer Code	Code reserved for internal use only by third party payers. HCFA will assign as needed for your use. Providers will not report it.

Item 34. (Untitled except on Patient Copy of the bill) Responsible Party Name and Address (For Hospice claims only, the name, address, and provider number of a transferring Hospice is shown by the new Hospice on its HCFA-1450 admission notice. See §3648, Item 34.) For claims which involve payers of higher priority than Medicare as defined in Item 65, the address of the other payer may be shown or in Item 94 (Remarks).

Items 35, 36, 37, 38, and 39. Condition Codes
Required. Code(s) identifying conditions related to this bill which may affect processing.

Code structure (only codes affecting Medicare payment/processing are shown).

02	Condition is Employment Related	Code indicates patient alleges that the medical condition in this episode of care is due to environment/events resulting from employment. (See §§3415.2ff. for WC and §§3415.3ff. for BL.)
04	Patient is HMO Enrollee	Code indicates patient is a member of a HMO.
07	Treatment of Nonterminal Condition for Hospice Patient	Code indicates the patient has elected hospice care but the provider is not treating the terminal condition and is therefore requesting regular Medicare reimbursement.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Code indicates the beneficiary would not provide information concerning other insurance coverage. Develop to determine the proper payer. (See §3686 for development guidelines.)
09	Neither Patient Nor Spouse is Employed	Code indicates that in response to development questions, the patient and spouse have denied any employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Code indicates that in response to development questions, the patient and spouse have indicated that they are employed but hold no group coverage from an EGHP.

Code	Title	Definition
11	Disabled Beneficiary But no LGHP	Code indicates that in response to development questions, the disabled beneficiary and/or family member has no group coverage from a LGHP.
12-16	Payer Codes	Codes reserved for internal use only by third party payers. HCFA will assign as needed for your use. Providers will not report them.
17	Patient is Over 100 Years Old	Code indicates that the patient was over 100 years old at the date of admission.
20	Beneficiary Requested Billing	Code indicates the provider realizes the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination of coverage.
21	Billing for Denial Notice	Code indicates the SNF or HHA realizes services are at a noncovered level of care or excluded, but requests a denial notice from Medicare in order to bill Medicaid or other insurances.
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) Code indicates the hospital temporarily placed the patient in a special care unit because no general care beds were available.
37	Ward Accommodation at Patient's Request	(Not used by hospitals under PPS.) Code indicates that the patient was assigned to ward accommodations at his own request. This code must be supported by a written request in the provider's files as described in §3101.F. Also, see §3101.1F.1.
38	Semi-Private Room Not Available	(Not used by hospitals under PPS.) Code indicates that the patient's assignment to a ward or private room was because there were no semi-private rooms available at admission.
39	Private Room Medically Necessary	(Not used by hospitals under PPS.) Code indicates patient's assignment to a private room was for medical reasons.
40	Same Day Transfer	Code indicates patient was transferred from one participating provider to another before midnight on the day of admission.

Code	Title	Definition
55	SNF Bed Not Available	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because his condition made it inappropriate to begin active care within that period.
57	SNF Readmission	Code indicates the patient previously received Medicare covered SNF care within 30 days of the current SNF admission.
60	Day Outlier	(Not reported by providers.) Pricer indicates this bill is a length-of-stay outlier. Indicate the outlier portion in code 17.
61	Cost Outlier	(Not reported by providers.) Pricer indicates this bill is a cost outlier. Indicate the outlier portion paid in code 17.
62	PIP Bill	(Not reported by providers.) Code indicates bill was paid under PIP. You must record this from your system.
63	PRO Denial Received Before Batch Clearance Report	(Not reported by providers.) Code indicates that the "date received" on a PRO adjustment bill is the date the HCSSACL file was received indicating acceptance of the original bill by HCFA. Use the HCSSACL receipt date if the PRO's notification is earlier than the acceptance report of the original bill.
64	Other Than Clean Claim	(Not reported by providers.) Code indicates claim is not a "clean" claim. You must record this from your system.
65	Non-PPS Bill	(Not reported by providers.) Code indicates bill is not a PPS bill. You must record this from your system for non-PPS hospital bills.
66	Provider Does Not Wish Cost Outlier Payment	A hospital being paid under PPS is not requesting additional payment for this stay as a cost outlier.
71	Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.

72	Self-Care In Unit	Code indicates the billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	Code indicates the billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.
74	Home	Code indicates the billing is for a patient who received dialysis services at home but code 75 below did not apply.
75	Home 100 Percent Reimbursement	Code indicates the billing is for a patient who received dialysis services at home using a dialysis machine that was purchase under the 100-percent program.
76	Back-up Infacility Dialysis	Code indicates the billing is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full	Code indicates the provider has accepted or is obligated/required due to a contractual arrangement or law to accept payment as payment in full. Therefore, no Medicare payment is due.
79	CORF Services Provided Off Site	Code indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.

NOTE: If the revenue charge codes indicate a ward accommodation was assigned and neither code 37 or 38 apply, and the provider is not reimbursed under PPS, the provider's reimbursement is at the ward rate. Otherwise, pay semi-private costs.

Item 40. Pints of Blood Furnished
Required. The total number of pints of whole blood or units of packed red cells furnished, whether or not replaced, is shown. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.

Item 41. Pints of Blood Replaced
Required. The total number of pints of blood which were donated on the patient's behalf is shown. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. (See §3235.4A.) Where the provider charges only for the blood procesing and administration, i.e., it does not charge a "replacement deposit fee" for unreplaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 39X revenue code series (blood administration) or under the 30X revenue code series (laboratory).

Item 42. Pints of Blood Not Replaced

Required. The difference between the number of pints of blood furnished and the number of pints replaced is shown.

Item 43. Blood Deductible Pints

Required. The number of unreplaced deductible pints of blood supplied is shown. If all deductible pints furnished have been replaced, no entry is made.

Item 44. Special Program Indicator

Required. A code indicates that the services on this bill are covered under special program provisions.

Code Structure (Only a code pertaining to Medicare is described)

06	PPV/Medicare 100 percent Payment	Code indicates this bill is for administration of pneumococcal vaccine reimbursed at 100 percent.
09	Second Opinion/Surgery	Code indicates services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.

Item 45. (Untitled)

See item 2, above.

Items 46, 47, 48, and 49. Value Codes and Amounts

Required. Code(s) and related dollar amount(s) identify data of a monetary nature that are necessary for the processing of this claim. The codes are two numeric digits, and each value allows up to eight numeric digits (000000.00). Negative amounts are never shown. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b." Items 46a through 49a are used before items 46b through 49b (i.e., the first line is used up before the second line is used).

Code	Title	Definition
05	Professional Component Included in Charges and Also Billed Separately to Carrier	Code indicates the charges shown are included in billing charges (column 53) but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the bill for physician's services is processed by the carrier. These charges are also deducted when computing interim reimbursement.

06	Medicare Part A Blood Deductible	Code indicates the amount shown is the product of the number of unreplaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each unreplaced pint furnished. If all deductible pints have been replaced, this code is not used. When the provider gives a discount for unreplaced deductible blood, charges after the discount is applied are shown.
07	Medicare Part A Cash Deductibles	Code indicates the amount shown is the Part A cash deductible where Part A blood deductible is also shown in value code 06. In all other cases, the entry in item 60 reflects the Part A cash deductible, and no entry is needed in this item.
08	Medicare Lifetime Reserve Amount for First Calendar Year in Billing Period	Code indicates the amount shown is the product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. (See §§3206 and 3211.) These are days used in the year of admission.

Code	Title	Definition
09	Medicare Coinsurance Amount for First Calendar Year in Billing Period	Code indicates the amount shown is the product of the number of coinsurance days used in the first calendar year of the billing period times the applicable coinsurance rate. These are days used in the year of admission. (See §§3206 and 3211.) This code is not used on Part B bills.
10	Medicare Lifetime Reserve Amount for Second Calendar Year in Billing Period	Code indicates the amount shown is the product of the number of lifetime reserve days used in the second calendar year of the billing period times the applicable lifetime reserve rate. The code is used only for stays spanning two calendar years when lifetime reserve days were used in the year of discharge.
11	Medicare Coinsurance Amount for Second Calendar Year in Billing Period	On Part A bills, this code indicates the amount shown is the product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. This code is used only for stays spannning two calendar years when coinsurance days were used in the year of discharge. This code is not used on Part B bills.
12	Working Aged Beneficiary/Spouse With EGHP	Code indicates the amount shown is portion of a higher priority EGHP payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because the EGHP has denied coverage. (See §3491.)
13	ESRD Beneficiary in the 12 Month Coordination Period With an EGHP	Code indicates the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment. (See §3490.)

Code	Title	Definition
14	Automobile, No-Fault or Any Liability Insurance	Code indicates the amount shown is that portion of a higher priority automobile, no-fault or liability insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. (See §§3419-3489.)
15	WC	Code indicates the amount shown is that portion of a higher priority WC payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. If six zeros (0000.00) are enterd in the amount field the provider is claiming a conditional payment because there has been a substantial delay in the other payer's payment. (See §§3407-3416.4.)
16	PHS, Other Federal Agency	Code indicates the amount shown is that porition of a higher priority PHS or other Federal Agency's payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. (See §§3153ff.)
17	Outlier Amount	(Not reported by providers.) Report the amount of outlier payment made (either cost or day) in UNIBILL with this code.
18	Disproportionate Share Amount	(Not reported by providers.) Report the disproportionate share amount applicable to the bill in UNIBILL with this code. Use the amount provided by the disproportionate share field in the Pricer report.
19	Indirect Medical Education Amount	(Not reported by providers.) Report the indirect medical education amount applicable to the bill in UNIBILL with this code. Use the amount provided by the indirect medical education field in the Pricer report.
20	Payer Code	Codes reserved for internal use only by third party payers. HCFA will assign as needed for your use. Providers will not report them.

Code	Title	Definition
31	Patient Liability Amount	Code indicates the amount shown is that which was approved by you or the PRO to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
41	BL	Code indicates the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field the provider is claiming a conditional payment because there has been a substantial delay in its payment. (See §§3415ff.)
42	VA	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill. (§§3153.1A.)
43	Disabled Beneficiary Under Age 65 With LGHP	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill.
70	Interest Amount	(For internal use by third party payers only.) Report the amount of interest applied to this claim.
71	Funding of ESRD Networks	(For internal use by third party payers only.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.
72-79	Payer Codes	Codes reserved for internal use only by third party payers. HCFA will assign as needed. Providers will not report them.

Item 50. Revenue Description
Required. A narrative description or standard abbreviation for each revenue code in column 51 is shown on the adjacent line in column 50. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown in Addendum C. "Other" code categories descriptions are locally defined and individually described on each bill.

Also, in the space to the right of the dotted line on hospital diagnostic clinical laboratory bills for outpatients or nonpatients (bill type 13X and 14X) the hospital enters the HCPCS code describing the procedure.

290s - rental/purchase of DME
304 - rental and dialysis/laboratory
330s - radiology therapeutic
367 - kidney transplant
420s - therapies
520s - type of clinic visit (RHC or other)
550s-590s - home health services
800s-850s - ESRD services

Zero level billing is encouraged for all other services; however, based upon your knowledge of a particular provider's facilities or billing practices, you may require detailed breakouts of other revenue code series. This is acceptable to the extent that it is used for bill review purposes.

See §3626.4 concerning the level of coding for outpatient surgical procedures.

Item 52. Units of Service
Required. The entries in this column quantify services by revenue category, e.g., number of days in a particular type of accommodation, pints of blood. Providers have been instructed to provide the number of covered days, visits, treatments, tests, etc. applicable for the following:

Accommodations - 120s-150s, 200s, 210s (days)
Blood - 380s (pints)
Emergency room visits - 450 (visits)
Clinic visits - 510s and 520s (visits)
Dialyses treatments - 800s (sessions or days)
Outpatient therapy visits - 410, 420, 430, 440, 480, 910, and 943 (visits)
Outpatient clinical diagnostic laboratory tests - 30s-31s (tests)
Radiology and other diagnostic services - for CPT-4 codes

Up to three numeric digits may be entered. Charges for noncovered services are shown as noncovered.

Item 53. Total Charges
Required. The total charges for the billing period are summed by revenue code (column 51) or in the case of diagnostic laboratory tests for outpatient or nonpatients by HCPCS procedure code and entered on the adjacent line in column 53. The last revenue code entered in column 51 is "001" which represents the grand total of all charges billed. Column 53 totals on the adjacent line. Each line allows up to eight numeric digits (000000.00).

HCFA policy is for providers to bill Medicare on the same basis that they bill other payers to provide consistency of bill data with the cost report, so that bill data may be used to substantiate the cost report.

Medicare and non-Medicare charges for the same department must be reported consistently on the cost report. This means that the professional component is included on, or excluded from, the cost report consistently for Medicare and non-Medicare charges.

Where billing for professional component is not consistent for all payers, for example where some payers require net billing and others require gross, the provider must adjust either net charges up to gross, or gross charges down to net for cost report preparation. In such cases adjust accordingly your provider statistical and reimbursement records that you derive from the bill.

Laboratory tests (revenue codes 300-319) are billed net for outpatient or nonpatient bills because payment is based on the lower of charges for the hospital component or the fee schedule. Determine, in consultation with the provider, whether it must bill net or gross for each revenue center other than lab. Where "gross" billing is used, adjust interim payment rates to exclude payment for hospital-based physician services.

The physician component must be billed to the carrier to obtain payment.

Items 54, 55, and 56. Unlabeled Charge Columns
Required. The SUBC decides whether to show "total covered charges" or "total noncovered charges" in one of these columns. Showing "total noncovered charges" requires fewer entries by the provider.

Each line allows up to eight numeric digits (000000.00).

Item 57A, B, C. Payer Identification
Required. If Medicare is the primary payer, "Medicare" is entered on line A. If Medicare is entered on line 57A, the provider has developed for other insurance and has determined that Medicare is the primary payer. All additional entries across line A (Items 58-64) supply information needed by the payer named in Item 57A. If Medicare is the secondary or tertiary payer, the provider will identify the primary payer on line A and enter Medicare information on line B or C, as appropriate. See §§3407-3415, §§3419, 3489, 3490, and 3491 to determine when Medicare is not the primary payer.

Item 58A, B, C. Assignment of Benefits Certification Indicator
Not Required.

NOTE: The back of the HCFA-1450 contains a certification that all necessary release statements are on file.

Item 59A, B, C. Assignment of Benefits Certification Indicator
Not Required.

Item 60 A, B, C. Deductible
Required. On inpatient hospital and SNF bills, the provider enters the sum of the Part A cash and/or blood deductibles, if any, applicable to the billing period. It also enters value codes 06 or 07 in Items 46-49, as appropriate. Although the provider reports the deductible in this item, you must report it by value code upon submittal of the UNIBILL record for inpatient claims.

Amounts collected from the patient by the provider toward Part B deductible are reported on the fourth line of Item 63.

Code	Title	Definition
31	Patient Liability Amount	Code indicates the amount shown is that which was approved by you or the PRO to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
41	BL	Code indicates the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. If six zeros (0000.00) are entered in the amount field, the provider is claiming a conditional payment because there has been a substantial delay in its payment. (See §§3415ff.)
42	VA	Code indicates the amount shown is that portion of a higher priority VA payment made on behalf of a Medicare beneficiary that the provider is applying to Medicare charges on this bill. (See §3153.1A.)
43	Disabled Beneficiary Under Age 65 With LGHP	Code indicates the amount shown is that portion of a higher priority LGHP payment made on behalf of a disabled beneficiary that the provider is applying to Medicare charges on this bill.
50	Physical Therapy Visit	Code indicates the number of physical therapy visits from onset (at the billing provider) through this billing period.

NOTE: This is not a money but a number of visits value. Entries for the number of visits are right justified from the dollars/cents delimeter as shown.

				1	3		

Accept zero or blanks in cents position. Convert blanks to zero for UNIBILL.

70	Interest Amount	(For internal use by third party payers.) Report the amount of interest applied to this claim.
71	Funding of ESRD Networks	(For internal use by third party payers only.) Report the amount the Medicare payment was reduced to help fund the ESRD networks.

Code	Title	Definition
72-79	Payer Codes	Codes reserved for internal use by third party payers. HCFA will assign as needed. Providers do not report them.

Item 50. Revenue Description
Required. A narrative description or standard abbreviation for each revenue code in column 51 is shown on the adjacent line in column 50. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown in Addendum C. "Other" code categories descriptions are locally defined and individually described on each bill.

When coding HCPCS, i.e., outpatient surgery bills, clinical diagnostic laboratory bills for outpatients or nonpatients, the hospital enters in the space to the right of the dotted line the HCPCS code describing the procedure. See §3628 for diagnostic clinical laboratory services and §3626.4 for other outpatient services and surgery.

On inpatient hospital or SNF bills, the accommodation rate may be shown in the space to the right of the dotted line.

HHAs identify the specific piece of DME or nonroutine supplies for which they are billing in this area on the line adjacent to the related revenue code. This description may be narrative or HCPCS coding if coding is acceptable to you. (Also, see Item 94, Remarks.)

Providers reporting a separate date for each date of service for outpatient claims enter the dates in this item. They have the option of using either approved format. (See §3604.1.)

Item 51. Revenue Code
Required. For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned (see Addendum C for complete list of revenue codes and definitions). The appropriate three-digit numeric revenue code is entered on the adjacent line in column 51 to explain each charge in column 53. This data takes the place of fixed line item descriptions on the billing form.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "001" is always entered last in column 51. Thus, the adjacent charge entry in column 53 is the sum of charges billed. This is also the same line on which charges, if any, in columns 54-56 are summed.

To assist in bill review, revenue codes are listed in ascending numeric sequence to the extent possible. To limit the number of line items on each bill, revenue codes are summed at the "zero" level to the extent possible.

Providers have been instructed to provide detail level coding for the following revenue code series:

If the entry contains only the Part A cash deductible, there is no value code "06" entry. (See discussion under Items 46-49.) Each line allows up to eight numeric digits (000000.00).

Item 61A, B, C. Coinsurance
Required. For inpatient or SNF claims, the hospital enters the sum of the regular and lifetime reserve coinsurance amounts, if any. It also enters value codes 08-11, in Items 46-49 as appropriate.

Amounts collected from the patient by the provider toward Part B coinsurance or coinsurance on Part A DME are reported on the fourth line of Item 63.

Each line allows up to eight numeric digits (000000.00).

Item 62A, B, C. Estimated Responsibility
Not Required.

Item 63A, B, C. Prior Payments
For all services other than inpatient hospital and SNF the sum of any amount(s) collected by the provider from the patient toward deductibles (cash and blood) and/or coinsurance are entered on the unnumbered (fourth/last) line of this column.

Part A home health DME cost sharing amounts collected from the patient are reported in this item. In apportioning payments between cash and blood deductibles, the first 3 pints of blood are treated as noncovered by Medicare. Thus, for example, if total inpatient hospital charges were $350 including $50 for a deductible pint of blood, $300 would be apportioned to the Part A deductible and $50 to blood deductible. Blood is treated the same way in both Part A and Part B.

Items 64A, B, C. Estimated Amount Due
Not Required.

Due From Patient (Unnumbered line below 57-64C)
See Items 63A, B, C, above.

Items 65A, B, C. Insured's Name
Required. On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in Items 57-63, the provider enters the patient's name as shown on his HI card or other Medicare notice. All additional entries across line A (Items 66-75) pertain to the person named in Item 65A. The instructions which follow explain when those items are completed.

If there are payers of higher priority than Medicare and the provider is requesting payment because another payer paid some of the charges and Medicare is secondarily liable for the remainder, another payer denied the claim, or the provider is requesting a conditional payment as described in §§3679K, 3680K, 3681K, or 3682K, it enters the name of the individual in whose name the insurance is carried. If that person is the patient, the provider enters "Patient." Payers of higher priority than Medicare include:

- o EGHPs for employed beneficiaries and their spouses. (See §3491.);

- EGHPs for beneficiaries entitled to benefits solely on the basis of ESRD during a period up to 12 months. (See §3490);
- LGHPs for disabled beneficiaries;
- Automobile medical, no-fault, or liability insurer. (See §§3419 and 3490); or
- WC, including BL. (See §§3407-3416.)

Item 66A, B, C. Insured's Sex
If the provider is claiming a payment under any of the circumstances described in the second paragraph of Items 65A, B, or C it enters the sex of the insured. The following codes are used:

M=Male
F=Female

Item 67A, B, C. Patient's Relationship to Insured
If the provider is claiming a payment under any of the circumstances described in the second paragraph of Items 65A, B, or C it may enter the code indicating the relationship of the patient to the identified insured, if this information is readily available.

Code	Title	Definition
01	Patient is Insured	Self-explanatory
02	Spouse	Self-explanatory
03	Natural Child/Insured has Financial Responsibility	Self-explantory
04	Natural Child/Insured does not Financial Responsibility	Self-explanatory
05	Step Child	Self-explanatory
06	Foster Child	Self-explanatory
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
11	Organ Donor	Code is used in cases where a bill is submitted for care given to an organ donor where it is paid by the receiving patient's insurance coverage.
12	Cadaver Donor	Code is used where a bill is submitted for procedures performed on a cadaver donor where they are paid by the receiving patient's insurance coverage.
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.

Item 68A, B, C. Certificate/Social Security Number/HI Claim/Identification Number
On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in items 57-63, the provider enters the patient's HICN, i.e., if Medicare is the primary payer, this information is entered in item 68A. The number is shown as it appears on the patient's HI card, Certificate of Award, Utilization Notice, EOMB, Temporary Eligibility Notice, or as reported by the SSO.

If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., EGHP coverage for the patient or the spouse or during the first year of ESRD entitlement), the involved claim number for that coverage is shown on the appropriate line.

Item 69A, B, C. Group Name
Where the provider is claiming a payment under the circumstances described in the second paragraph of Items 65A, B, or C and there is WC involvement or an EGHP, it enters the name of the group or plan through which that insurance is provided.

Item 70A, B, C. Insurance Group Number
Where the provider is claiming a payment under the circumstances described in the second paragraph of Items 65A, B, or C and there is WC involvement or an EGHP, it enters the identification number, control number, code assigned by such health insurance carrier to identify the group under which the insured individual is covered.

GUIDELINES FOR
EMPLOYMENT INFORMATION

The following items are grouped together for ease in providing instructions on their completion: 71, 72, 73, 74, 75. Space is reserved for reporting the necessary employment data for up to two individuals. The following sequence of decision making is used in completing these fields.

INDIVIDUALS CLAIMING INSURANCE

- o If any of the insureds named under A, B, or C in the insurance section of the form (Item 65) has group insurance provided by an organization other than the employer, the insured's employment information is entered and the EID (Item 71) coded A, B, or C depending upon the payer line on which the indiviudal's insurance information is recorded. (For example, Item 69 records Group Name as Wasington Area Ford Dealers, Inc. but the insured's employer is Capital Ford, Inc. Because the insurance is held with a company other than the employer, the employer information is required for the insured.)

- o If any of the individuals recorded under A, B, or C in this insurance section of the form (Item 65) has group insurance coverage provided by an employer who operates from multiple locations, employment information (and location) is entered and the EID (Item 71) coded A, B, or C depending upon the payer line on which the individual insurance information is recorded.

Item 71. Employment Information Data

Where the provider is claiming a payment under the circumstances described in the second paragraph of Items 65A, B, or C it enters the code that indicates whether employment information given on the same line in Items 72-75 applies to the insured, the patient or the patient's spouse. Either the "A, B, C" codes or "P, S, F, M" codes, below, are used in this item, depending upon which set best handles the billing situation.

Code Structure

A=Employment Information relates to primary insured
B=Employment Information relates to secondary insured
C=Employment Information relates to tertiary insured
P=Patient Employment Information
S=Spouse Employment Information
F=Father's Employment Information
M=Mother's Employment Information

Item 72. Employment Status Code

Where the provider is claiming a payment under the circumstances described in the second paragraph of Items 65A, B, or C and there is WC involvement or an EGHP, it enters the code which defines the employment status of the individual identified on the same line in Item 71, if the information is readily available.

Code	Title	Definition
1	Employed Full Time	Individual stated that he or she is employed full time.
2	Employed Part Time	Individual stated that he or she is employed part time.

Item 73. Employer Name

Where the provider is claiming a payment under the circumstances described in the second paragraph of Items 65A, B, or C and there is WC involvement or an EGHP, it enters the name of the employer that provides health care coverage for the individual identified on the same line in Item 71.

Item 74. Employee Identification Number

Where the provider is claiming a payment under the circumstances described in the second paragraph of Items 65A, B, or C and there is WC involvement or an EGHP, it enters the identification nubmer assigned by the employer to the individual identified on the same line Item 71.

Item 75. Employer Location

Where the provider is claiming a payment under the circumstances described in the second paragraph of Items 65A, B, or C and there is WC involvement or an EGHP, it enters the specific location of the employer of the individual identified on the same line in Item 71. A specific location is the city, plant, etc., in which the employer is located.

Item 76. Principal and Other Diagnoses Descriptions
Not Required.

Item 77. Principal Diagnosis Code
The diagnosis codes shown and Items 78-81 must be the full ICD-9-CM diagnosis codes. including all five digits where applicable.

HCFA only accepts ICD-9-CM diagnostic and procedural codes which use definitions contained in DHHS Publication No. (PHS) 80-1260 or HCFA approved errata and supplements to this publication. HCFA approves only changes issued by the Federal ICD-9-CM Coordination and Maintenance Committee.

Inpatient--Required. The provider reports the principal diagnosis in this item. The principal diagnosis is the condition established after study to be chiefly responsible for this admission.

Even though another diagnosis may be more severe than the principal diagnosis, the principal diagnosis, as defined above, is entered. Entering any other diagnosis may result in incorrect assignment of a DRG and an overpayment to a hospital under PPS.

If an alcohol and/or drug-related ICD-9-CM code is used as the principal diagnosis, it must be accompanied by a specific additional diagnosis code in Items 78, 79, 80, or 81 and/or a specific procedure code in Items 84, 85, or 86 to indicate whether the type of treatment provided involved rehabilitation and/or detoxification therapy. (See §3610.13.)

Outpatient--Required. ICD-9-CM diagnostic coding is required in Items 77-81 of the bill. Hospitals report the full ICD-9-CM code for the diagnosis shown to be chiefly responsible for the outpatient services in Item 77. Hospitals report the diagnosis to their highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported (786.2). If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported (466.0).

If the patient arrives at the hospital for examination or testing without a referring diagnosis and cannot provide a complaint, symptom, or diagnosis, the hospital reports an ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination and Investigation of Individuals and Populations (V70-V82). Examples include:

- Routine general medical examination (V70.0);
- General medical examination without any working diagnosis or complaint, patient not sure if the examination is a routine checkup (V70.9); and
- Examination of ears and hearing (V72.1).

Items 78-81. Other Diagnoses Codes
Inpatient--Required. The provider reports the full ICD-9-CM codes for up to four additional conditions if they co-existed at the time of admission or developed subsequently, and which had an effect upon the treatment or the length of stay.

The principal diagnosis entered in Item 77 should not under any circumstances be duplicated as an additional or secondary diagnosis. If it is duplicated, eliminate it before Grouper. Proper installation of MCE identifies situations where the principal diagnosis is duplicated.

Outpatient—Required. Hospitals report the full ICD-9-CM codes in Items 78-81 for other diagnoses that coexisted in addition to the diagnosis reported in Item 77. For instance, if the patient is referred to the hospital for evaluation of his hypertension and the medical record also documents diabetes, diabetes is reported in Item 78.

Item 82. Procedure Coding Method
Not Required.

Item 83. Principal and Other Procedures Descriptions
Not Required.

Item 84. Principal Procedure Code and Date
Inpatient Required. The provider enters the ICD-9-CM code for the inpatient principal procedure. The principal procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes, or which was necessary to take care of a complication. It is also the procedure most closely related to the principal diagnosis (Item 77). See §3626.4 for reporting outpatient procedures.

For this item, surgery includes incision, excision, amputation, introduction, repair, destructions, endoscopy, suture, and manipulation. Review this item against Items 50-53. It may alert you to noncovered services or omissions.

The procedure code shown must be the full ICD-9-CM, Volume 3, procedure code, including all four digit codes where applicable. See second paragraph under Item 77 for acceptable ICD-9-CM codes.

The date applicable to the principal procedure is shown numerically as MM-DD in the "date" portion.

Transmit to HCFA the original codes reported by the provider. If in the course of the claims development process you determine the codes are incorrect, transmit the corrected codes.

Pacemaker related ICD-9-CM procedure codes (37.70 and 37.73-37.85) require you to follow special procedures. (See §3678.)

Item 85 and 86. Other Procedure Codes and Dates
Inpatient Required. The full ICD-9-CM, Volume 3, procedure codes, including all four digit codes where applicable, must be shown for the two most significant surgical procedures other than the principal procedure (which is shown in Item 84). See Item 77 for acceptable codes. The date of each procedure is shown in the date portion of Items 85 or 86, as applicable, numerically as MM-DD.

Transmit to HCFA the original codes reported by the provider. If in the course of the claims development you determine that the reported codes are incorrect, transmit the corrected codes.

Pacemaker related ICD-9-CM procedure codes (37.70 and 37.73-37.85) require you to follow special procedures. (See §3678.)

Item 87. PRO/UR Approval Indicator
Required. The code entered indicates whether this claim has been reviewed and/or approved by the PRO. Providers will not report URC decision to you in this item.

Code Structure

Code	Title	Definition
1	Approved as Billed	Code indicates claim has been reviewed by the PRO and has been fully approved including any day or cost outlier.
2	Automatic Approval (Focused Review)	Code does not apply to Medicare claims.
3	Partial Approval	Code indicates the bill has been reviewed by the PRO and some portion (days or services) has been denied. The From/Through dates of the approved portion of the stay, excluding grace days and any period at a noncovered level of care (code "77" in Item 33), are shown in Items 88 and 89.
4	Admission Denied	Code indicates patient's need for inpatient services was reviewed and the PRO found that none of the stay was medically necessary.
5	Postpayment Review Applicable	Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
6	Preadmission/Preprocedure	Code indicates that the PRO authorized this admission/procedure but has not reviewed the services provided.

Item 88 and 89. PRO/UR Stay Dates
Required. If a code "3" is in Item 87, the "From" date of the approved billing period is shown in Item 88, and the "Through" date of that period in Item 89. The fields contain MM-DD-YY, numerically.

Item 90. Number of Grace Days
Required. If a code "3" or "4" is in Item 87, indicating that the PRO has denied all or a portion of this billing period, the number of days determined by the PRO to be covered while arrangements are made for the patient's post discharge are shown. The field contains one numeric digit.

Item 91. Treatment Authorization Code
Not required.

Item 92. Attending Physician I.D.
Require. This is the State license number of the physician who has primary responsibility for the patient's medical care and treatment, except where the SUBC has agreed on an alternate identification number. If the State license number is used, it must be prefixed by the two position post office abbreviation of the State which issued the license.

Item 93. Other Physician I.D.
Required. This is the State license number of the physician who performed the principal procedure, except where the SUBC has agreed on an alternate identification number. If the State license number is used, it must be prefixed by the two position post office abbreviation of the State which issued the license. If this physician is also the attending physician shown in Item 92, the I.D. number is also shown here. "Same" is not an acceptable entry.

Item 94. Remarks
Required. For DME billings by HHAs, the rental rate, cost and anticipated months of usage are shown so that you may determine whether to approve the rental or purchase of equipment. In addition, special annotations may be entered where Medicare is not the primary payer because WC, an automobile medical or no-fault insurer, any liabilty insurer or an EGHP/LGHP is primary to Medicare. (See §§3679, 3680, 3681, and 3682.)

This space is also available to report overflow from other items.

Provider Representative Signature and Date.—No signature is required for a general care hospital unless a certification is required. (See §3315.2.) A provider representative's signature or facsimile is required on the bill of a psychiatric or tuberculosis hospital.

INTERMEDIARY USE ONLY AREA

Hospitals report the admitting diagnosis in block E under this area. The admitting diagnosis is the condition requiring hospitalization identified by the physician at the time of the patient's admission. This definition is not the same as that for SNF admissions. Providers report admitting diagnoses in 5 position ICD-9-CM codes.

The remainder of this space is available for your internal coding for bill processing or other specific needs. The following describes information to include on the UNIBILL which is not reported to you.

Verified Noncovered Stay Days.—Report the "From" and "Through" dates of any noncovered stay which extends or begins a spell of illness in field 77 (positions 1933-1938 for the From date and positions 1939-1944 for the Through date) of the UNIBILL. (See §3305 for special rules relating to spell of illness.) If more than one stay is involved, show the admission date of the first stay and the discharge date of the last.

Prior Psychiatric Days.—When the beneficiary is a patient in a psychiatric hospital at the time of initial entitlement to Medicare, report the number of days, not necessarily consecutive, in which he was confined to a psychiatric hospital in the 150-day period immediately preceeding entitlement. Show this information in field 70 (positions 1843-1845) of the UNIBILL. (See §§3104 and 3510.3.)

Amount Reimbursed.—Report the reimbursement amount for this bill in field 53 (positions 1707-1715) of the UNIBILL for outpatient claims, or field 42 (positions 1707-1715) of the UNIBILL for outpatient and HHA claims.

Nonpayment Code.—Report the appropriate nonpayment code in the UNIBILL where no payment is being made for the entire bill except in the situations where there is another insurer primary to Medicare. (See §§3679 through 3685.) Do not enter a code where benefits are exhausted but some payment is being made based upon the bill. Report one of the following codes as appropriate in field 73 (position 1853) of the UNIBILL:

B - Benefits Exhausted, including the situation where the regular spell of illness days have been exhausted and the patient elects not to use lifetime reserve days.

R - Spell of Illness Benefits Refused, Certification Refused, Failure to Submit Evidence, Provider Responsible for Not Filing Timely, or Waiver of Liability—the provider is at fault.

E - Cases Which are Denied Because the HMO out-of-plan services were neither "emergency" nor "urgently needed."

N - All Other Reasons for Nonpayment (e.g., entire bill is for noncovered services, emergency denied).

Date Approved.—Report the date the bill passed your computer edits in field 80 (positions 1961-1966) of the UNIBILL for inpatient claims, or field 61 (positions 1961-1966 of the UNIBILL) for outpatient and HHA claims.

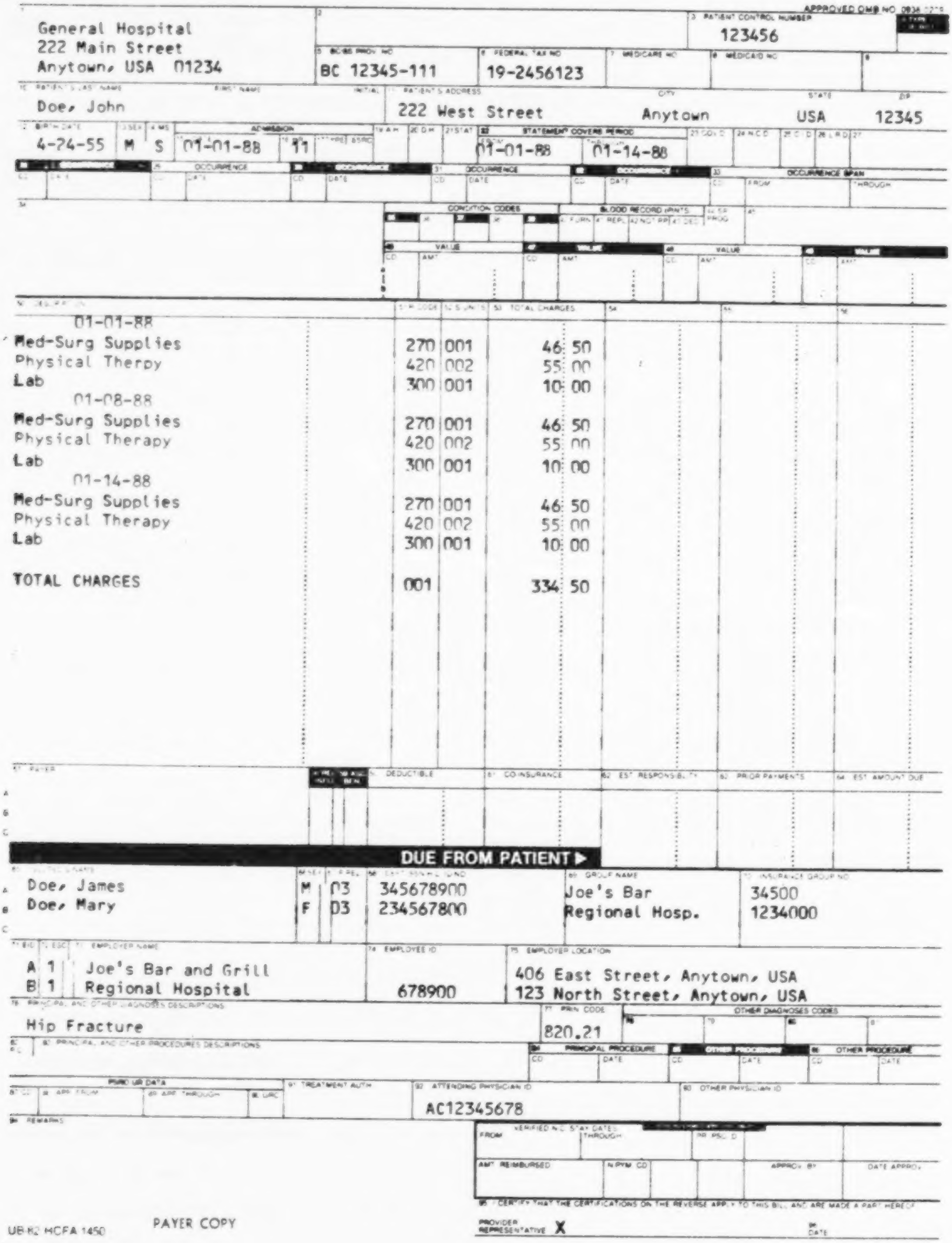
Reporting Exceptions to the Transfer Requirement.—Report the appropriate code (see §3871, Item 36) for an exception to the 30 day transfer requirement in field 65 (position 1838) of the UNIBILL. This data is applicable only to SNFs.

Exhibits

		Page
Exhibit 1	Format (1) Reporting Date of Service for Outpatient Claims	6-55
Exhibit 2	Format (2) Reporting Date of Service for Outpatient Claims	6-56

Exhibit 1

FORMAT FOR REPORTING DATE OF SERVICE FOR OUTPATIENT CLAIMS



APPROVED OMB NO.

General Hospital
222 Main Street
Anytown, USA 01234

3 PATIENT CONTROL NUMBER: 123456

5 BC/BS PROV NO: BC 12345-111

6 FEDERAL TAX NO: 19-2456123

7 MEDICARE NO:

8 MEDICAID NO:

PATIENT'S LAST NAME, FIRST NAME: Doe, John

PATIENT'S ADDRESS: 222 West Street; CITY: Anytown; STATE: USA; ZIP: 12345

BIRTH DATE: 4-24-55; SEX: M; MS: S

ADMISSION: 01-01-88; 11

STATEMENT COVERS PERIOD: FROM 01-01-88 THROUGH 01-14-88

DESCRIPTION	REV CODE	UNITS	TOTAL CHARGES
01-01-88			
Med-Surg Supplies	270	001	46.50
Physical Therpy	420	002	55.00
Lab	300	001	10.00
01-08-88			
Med-Surg Supplies	270	001	46.50
Physical Therapy	420	002	55.00
Lab	300	001	10.00
01-14-88			
Med-Surg Supplies	270	001	46.50
Physical Therapy	420	002	55.00
Lab	300	001	10.00
TOTAL CHARGES	001		334.50

57 PAYER	DEDUCTIBLE	CO-INSURANCE	EST. RESPONSIBILITY	PRIOR PAYMENTS	EST. AMOUNT DUE
A					
B					
C					

DUE FROM PATIENT ▶

	INSURED'S NAME	SEX	REL	CERT-SSN-HIC-ID NO	GROUP NAME	INSURANCE GROUP NO
A	Doe, James	M	03	345678900	Joe's Bar	34500
B	Doe, Mary	F	03	234567800	Regional Hosp.	1234000
C						

	ESC	EMPLOYER NAME	EMPLOYEE ID	EMPLOYER LOCATION
A	1	Joe's Bar and Grill		406 East Street, Anytown, USA
B	1	Regional Hospital	678900	123 North Street, Anytown, USA

PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS: Hip Fracture

77 PRIN CODE: 820.21

OTHER DIAGNOSES CODES:

PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS:

PRINCIPAL PROCEDURE / OTHER PROCEDURE / OTHER PROCEDURE

PSRO UR DATA

TREATMENT AUTH

92 ATTENDING PHYSICIAN ID: AC12345678

OTHER PHYSICIAN ID

REMARKS

VERIFIED N/C STAY DATES FROM THROUGH

AMT REIMBURSED / APPROV. BY / DATE APPROV.

I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X

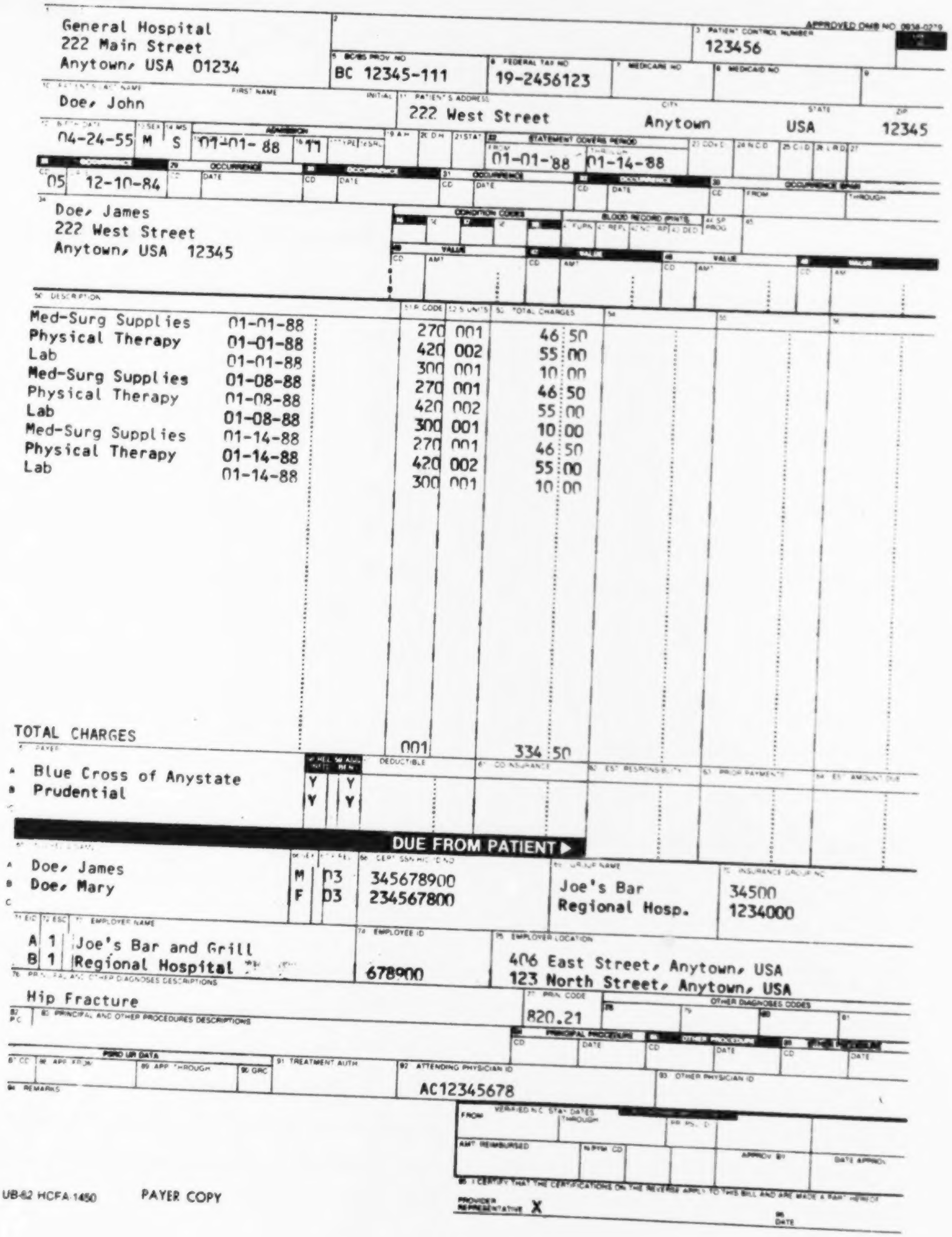
DATE

UB-82 HCFA 1450

PAYER COPY

Exhibit 2

FORMAT FOR REPORTING DATE OF SERVICE FOR OUTPATIENT CLAIMS



APPROVED OMB NO. 0938-0279

General Hospital
222 Main Street
Anytown, USA 01234

3 PATIENT CONTROL NUMBER: 123456

5 BC/BS PROV NO: BC 12345-111

6 FEDERAL TAX NO: 19-2456123

7 MEDICARE NO

8 MEDICAID NO

PATIENT'S LAST NAME / FIRST NAME / INITIAL: Doe, John

11 PATIENT'S ADDRESS: 222 West Street / CITY: Anytown / STATE: USA / ZIP: 12345

BIRTH DATE: 04-24-55 / SEX: M / MS: S / ADMISSION: 01-01- 88 / 11

22 STATEMENT COVERS PERIOD: FROM 01-01-88 THROUGH 01-14-88

OCCURRENCE: CD 05 DATE 12-10-84

34 Doe, James
222 West Street
Anytown, USA 12345

50 DESCRIPTION		51 REV. CODE	52 UNITS	53 TOTAL CHARGES
Med-Surg Supplies	01-01-88	270	001	46 50
Physical Therapy	01-01-88	420	002	55 00
Lab	01-01-88	300	001	10 00
Med-Surg Supplies	01-08-88	270	001	46 50
Physical Therapy	01-08-88	420	002	55 00
Lab	01-08-88	300	001	10 00
Med-Surg Supplies	01-14-88	270	001	46 50
Physical Therapy	01-14-88	420	002	55 00
Lab	01-14-88	300	001	10 00
TOTAL CHARGES		001		334 50

	PAYER	REL INFO	ASG BEN	DEDUCTIBLE	CO INSURANCE	EST. RESPONSIBILITY	PRIOR PAYMENTS	EST. AMOUNT DUE
A	Blue Cross of Anystate	Y	Y					
B	Prudential	Y	Y					
C								

DUE FROM PATIENT ▶

	INSURED'S NAME	SEX	REL	CERT. SSN HIC ID NO	GROUP NAME	INSURANCE GROUP NO
A	Doe, James	M	03	345678900	Joe's Bar	34500
B	Doe, Mary	F	03	234567800	Regional Hosp.	1234000
C						

EIC	ESC	EMPLOYER NAME	EMPLOYEE ID	EMPLOYER LOCATION
A	1	Joe's Bar and Grill		406 East Street, Anytown, USA
B	1	Regional Hospital	678900	123 North Street, Anytown, USA

PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS: Hip Fracture

77 PRIN. CODE: 820.21

OTHER DIAGNOSES CODES

PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS

PRINCIPAL PROCEDURE / OTHER PROCEDURE

PSRO UR DATA / APP FROM / APP THROUGH / GRC

91 TREATMENT AUTH

92 ATTENDING PHYSICIAN ID: AC12345678

93 OTHER PHYSICIAN ID

REMARKS

VERIFIED N.C. STAY DATES: FROM / THROUGH

AMT REIMBURSED / APPROV BY / DATE APPROV

I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X

DATE

UB-82 HCFA-1450 PAYER COPY

3606. FORM HCFA-1450 CONSISTENCY EDITS

In order to be paid correctly and promptly, a bill must be completed accurately. Edit all Medicare required fields for alphabetic or numeric characters as shown below. In addition, apply the MCE edits described in §3656.1 on diagnoses and procedures. If a bill fails these edits, return it to the provider for correction. If you edit bill data online, the edits are included in your software. When you receive magnetic tape or paper bills, either directly or through a billing service, ensure that these edits are made. Depending upon special services billed to you, you may require additional edits.

Item 4. Type of Bill. Must be three-position numeric. In addition, must be a valid code for hospital billing. Valid codes are:

a. First Digit - Type of Facility

1 - Hospital

NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing nonhospital services:

2 - Skilled Nursing
3 - Home Health
4 - Christian Science (Hospital)
5 - Christian Science (Extended Care)
7 - Clinic (see special coding for second digit below)
8 - Special Facility (see special coding for second digit below)

b. Second Digit - Classification (if first digit is 1-5)

1 - Inpatient (Part A)
2 - Inpatient (Part B)
3 - Outpatient
4 - Other (Part B - includes home health bills not containing visit charges or where the plan of treatment is no longer in effect, or for nonpatient diagnostic clinical laboratory services

Second Digit - Classification (first digit is 7)

1 - Rural Health
3 - CORF or other rehabilitation facility

Second Digit - Classification (first digit is 8)

2 - Hospice (Hospital-based)

c. Third Digit - Frequency

0 - No payment
1 - Full billing (payment)
2 - First interim
3 - Continuing interim
4 - Final interim
5 - Late charge valid only with classification code "3"
7 - Correction
8 - Void/Cancel

d. For PPS bills, if the first and second positions of this item are "1," "2, 3 and 4" may not be entered in the third position.

Item 7. Medicare Provider Number.

a. Minimum six-position alpha/numeric field.

b. Cannot exceed eight positions.

c. Left - justified.

Item 11. Patient's Address.

a. The address of the patient must include:

City
State (P.O.'Code)
ZIP

b. Valid ZIP code must be present if the first and second digits of item 4 are "1."

c. Cannot exceed 48 positions.

Item 12. Birthdate.

a. Must be valid if present.

b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

Item 13. Sex.

a. One alpha position.

b. Valid characters are "M" or "F."

c. Must be present.

Item 15. Admission Date.

a. Must be valid if present.

b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

c. Present only if the first position of item 4 is "1, 2, 4, or 5" and the second position is "1;" or the first and second positions are "3" or the first position is "8" and the second position is "2."

d. Cannot be later than the "From" portion of item 22.

Item 17. Type of Admission.

a. One numeric position.

b. Required only if the first and second digits of item 4 are "1."

c. Valid codes are:

1 - Emergency
2 - Urgent
3 - Elective
4 - Newborn
9 - Information unavailable

Item 18. Source of Admission.

a. One numeric position.

b. Required only if the first and second digits of item 4 are "1."

c. Valid codes are:

1 - Physician referral
2 - Clinic referral
3 - HMO referral
4 - Transfer from a hospital
5 - Transfer from a SNF
6 - Transfer from another health care facility
7 - Emergency room
8 - Court/Law enforcement
9 - Information not available

Item 21. Patient Status.

a. Two numeric positions.

b. Present only if first position of item 4 is "1, 2, 4 or 5" and the second position is "1" or the first position is "3 or 4" or the first position is "8" and the second position is "2."

c. Valid codes are:

01 - Discharged to home/self care (routine charge)
02 - Discharged/transferred to other short-term general hospital
03 - Discharged/transferred to SNF
04 - Discharged/transferred to ICF
05 - Discharged/transferred to another type of institution (including distinct parts)

06 - Discharged/transferred to home care of organized home health service organization
07 - Left against medical advice
20 - Expired (did not recover - Christian Science patient)
30 - Still patient

d. The following codes are valid only if the first position of item 4 is "8" and the second is "2:"

40 - Expired at home
41 - Expired in a medical facility such as a hospital, SNF, ICF, or freestanding hospice
42 - Expired - place unknown

Item 22. Statement Covers Period (From-Through).

a. Cannot exceed eight positions in either "From" or "Through" portion allowing for separations (nonnumeric characters) in the third and sixth positions.

b. The "From" date must be a valid date which is not later than the "Through" date.

c. The "Through" date must be a valid date which is not later than the current date.

d. The number of days represented by this period must equal the sum of the covered days (item 23) and noncovered days (item 24), if the first position of item 4 is "1, 2, 4 or 5" and the second position is "1."

Item 23. Covered Days.

a. Cannot exceed three numeric positions.

b. Cannot exceed 150 if the first position of item 4 is "1 or 4" and the second position is "1."

c. Cannot exceed 100 if the first position of item 4 is "2 or 5" and the second position is "1."

d. When added to the number in item 24 (noncovered days) the sum must equal the number of days represented by the billing period in item 22.

Item 24. Noncovered Days.

a. Cannot exceed three numeric positions.

b. When added to the number in item 23 (covered days) the sum must equal the number of days represented by the billing period in item 22, unless entitlement to Medicare follows admission date.

Item 25. Coinsurance Days.

a. Cannot exceed two numeric positions.

b. Cannot exceed 30 if the first position of item 4 is "1 or 4" and the second position is "1."

c. Cannot exceed 80 if the first position of item 4 is "2 or 5" and the second position is "1."

d. Cannot exceed the number in item 23 (covered days).

Item 26. Lifetime Reserve Days.

a. Cannot exceed two numeric positions.

b. Cannot exceed 60.

c. Cannot exceed the number in item 23 (covered days).

Items 28, 29, 30, 31, 32. Occurrence Codes and Dates.

a. All dates must be valid.

b. Each code must be accompanied by a date.

c. All codes are two numeric positions.

d. Valid codes for hospital claims are 01-99.

e. If code 20, 21, 22, 23 or 26 is entered, the second digit in item 4 (Type of Bill) must be a "1."

f. If code 27 is entered, the first digit in item 4 must be "3" and the second digit "3" or the first digit must be "7" and the second digit "3."

g. If code 42 is entered, the first digit in item 4 must be "8" and the second digit "2."

h. If 02, 03 or 04 is entered, Medicare cannot be the primary payer, i.e., Medicare related entries cannot appear on the "A" lines of items 65-70.

i. If code 20 is entered:

- o Must either be earlier than admission date (item 15) or later than "Through" date (item 22).
- o Must be less than 13 days after the admission date (item 15) if "From" date is equal to admission date (less than 14 days if billing dates cover the period 12/24 through 1/2).
- o If admission date (item 15) and "From" date (item 22) are not equal, "Covered Days" (item 23), if present, must not exceed 12 days (13 days if the billing dates covered the period 12/24 through 1/2).

- This date plus the "Covered Days" (item 23) less the coinsurance (item 25 and noncovered days (item 24) cannot be greater than the "Statement Covers Period" Through date (item 22) (plus 1 if item 21 code 30 is completed).

j. If code 21 is entered:

- Cannot be later than "Statement Covers Period" Through date.
- Cannot be more than 3 days prior to the "Statement Covers Period" From date.

k. If code 22 or 23 are entered, they must be within the billing period shown in item 22.

Item 33. Occurrence Span Code and Dates.

a. Dates must be valid.

b. Code entry is two numeric positions.

c. Code must be accompanied by dates.

d. Valid codes are:

70
71
72
74
75
76
77

e. If code 70 is entered, the first digit of item 4 must be "2 or 5" and the second digit must be "1."

f. If code 70 is entered, the first digit of item 4 must be "1, 2, 4 or 5" and the second digit must be "1."

g. If code 72 is entered, the first digit of item 4 must be "1, 3 or 7" and the second digit msut be "3 or 4."

h. If code 75 is entered, the first digit of item 4 must be "1 or 4" and the second digit must be "1."

Items 35, 36, 37, 38, 39. Condition Codes.

a. Each code is 2 numeric digits.

b. Valid codes for Medicare are:

02
04
07
17 - (Not needed for EMC because of 4-position year of birth.)
20
36
37
38
39
40
55
56
57
60
61
62
63
64
65
66
71
72
73
74
75
76

c. If code 07 is entered, type of bill must not be hospice ("82X").

d. Invalid for PPS, codes 36, 37, 38 or 39 are entered and the first and second digits in item 4 are "1s."

e. If code "40" is entered: the "From" and "Through" dates in item 22 must be equal, and there must be a "0 or 1" in item 23 (Covered Days).

Item 40-43. Blood.

a. Entries for items 40, 41, and 42 cannot exceed two numeric positions.

b. Entry for item 43 is one numeric position.

- If the blood usage data is present, "Pints Furnished" must be numeric and greater than zero.
- Cannot exceed three pints minus the number of pints replaced.

Item 44. Special Program Indicator.

Only valid entry is "06."

Items 46, 47, 48 and 49. Value Codes and Amounts.

a. Each code must be accompanied by an amount.

b. All codes are two numeric digits.

c. Amounts may be up to eight numeric positions. (000000.00)

d. The valid codes are:

04-16
31
40

e. If code 05 is entered, the first and second digits of item 4 must be "1."

f. If code 06 is entered, there must be entries in items 40 and 43.

g. If codes 08 and 10 are entered, there must be an entry in item 26.

h. If codes 09 and 11 are entered, there must be an entry in item 25.

i. If codes 12, 13, 14, 15 or 16 are entered, data pertaining to Medicare cannot be entered in line A of item 57-70.

Item 51. Revenue Code.

a. Three numeric positions.

b. Should be listed in ascending numeric sequence except for the final entry which must be "001."

c. There must be an entry adjacent to each entry in item 53.

Item 52. Units of Service.

a. Up to three numeric positions.

b. There must be an entry in this column if revenue code series 10X, 11X, 12X, 13X, 14X, 15X, 20X, 21X, 45X, 51X, 52X, 54X, 55X, 56X, 57X, 58X, 59X, or 80X are entered in item 51. Revenue code series 41X, 42X, 43X, 44X, 91X and 943 require an entry only if the second digit of item 4 is "4."

c. Accommodation units must equal covered days (item 23).

Item 53. Total Charges.

a. Up to eight numeric positions (000000.00).

b. There must be an entry adjacent to each entry in column 51.

c. The last amount must be the sum of all the entries above it.

Items 57A, B, C. Payer Identification.

a. "Medicare" must be entered on one of these lines depending upon whether it is the primary, secondary or tertiary payer.

b. See item 46 i. above.

Items 60A, B, C. Deductible.

a. Each entry is up to eight numeric positions (000000.00).

b. May be blank.

c. There must be an entry if there is an 06 or 07 entered in Items 46, 47, 48 or 49.

Items 61A, B, C. Coinsurance.—Each entry is up to eight numeric positions (000000.00). May be blank.

There must be an entry if there is an entry in Item 25 or 26 or an 08, 09, 10 or 11 is entered in Items 46, 47, 48 or 49.

Items 65A, B, C. Insured's Name.—On the line corresponding to the line on which "Medicare" was entered in Item 57, the patient's name must be entered as it appears on his HI card. See Item 46 i. above.

Item 66A, B, C. Insured's Sex.—If present, must be "M" or "F."

Items 68A, B, C. Certificate/Social Security Number/HI Claim/Identification Number.—On the line corresponding to the line on which "Medicare" was entered, the patient's HICN must be entered.

It must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position ten, the second in position eleven, etc. The first three numbers must fall within the range of: 001 through 588, or 700 through 729 only.

The alpha suffix must be A through F, H, J, K, M, T or W. Alpha suffixes A and T must not have a numeric subscript. Alpha suffixes B, D, E, M and W may or may not have a numeric subscript.

If the alpha suffix is H, it must be followed by A, B or C in position eleven. The numeric subscript (position twelve) must conform with the particular above for the A, B, or C suffix employed.

The RRB claim number must contain either six or nine numeric characters, and must have one, two or three character alpha prefix.

For prefixes H, MH, WH, WCH, PH and JA only a six numeric field is permissable. For all other prefixes, a six or nine numeric field is permissable.

A nine numeric character claim number has the same ranges as the SSA nine position claim number.

Item 77. Principal Diagnosis Code.—Must be four or five positions left justified with no decimal points. Validate with the MCE program in accordance with §3656.1.

Items 78-81. Other Diagnosis Codes.--If present, must be four or five positions, left justified with no decimal points. Validate with the MCE.

Item 83. Principal and Other Procedure Descriptions.--If Medicare is the only payor indicated in Item 57, this item should be blank. Otherwise, ignore.

Item 84. Principal Procedure Code and Date.--Not always required, but if present, date must be present and valid. Validate with the MCE.

Date must fall before the "Through" date in Item 22. (In some cases it may be before the admission date, i.e., where complications and admission ensue from outpatient surgery.)

For implants October 1, 1987 and later when ICD-9-CM Codes 37.70 - 37.77 and 37.80 - 37.89 are encountered or CPT-4 Codes 33200 - 33208, 33212, 33216, 33218, 33219, and 33232 pacemaker registry information is required. (See §3678 --Editing Pacemaker Records.)

Items 85, 86. Other Procedure Codes and Dates.—If present, apply edits for Item 84.9

Item 87. PRO/UR Approval Indicator.—One numeric position. Must be present if the first and second digits of Item 4 (Type of Bill) are "1".

Valid codes are:

1 Approved by the Medical Review Agent as billed
2 Automatic approval as billed based on focused review
3 Partial approval
4 Admission denied
5 Postpayment review applicable
6 Preadmission authorization

Items 88 and 89. PRO/UR Approved Stay Dates.—Must be present only if Item 87 contains a "3."

Neither the From nor the Through portion can exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions of each field.

Item 90. Number of Grace Days.—Must be present if item 87 contains a "3" or "4." If present, it is one numeric digit.

Item 92. Attending Physician I.D.

a. May be alpha or numeric.

b. Must be present if the first and second digits of item 4 are "1."

Items 93. Other Physician I.D.

a. May be alpha or numeric.

b. Must be present if the first and second digits of item 4 are "1" and a procedure is shown in item 84-86.

c. Will identify the physician performing the principle procedure.

d. If item 84 is blank, this item will also be blank.

Intermediary Use Only Area.--Validate admitting diagnosis with the MCE program.

3610. HOSPITAL INPATIENT BILLS - GENERAL

A. Background.—The Social Security Amendments of 1983 (P.L. 98-21) provided for the establishment of PPS for Medicare payment of inpatient hospital services. Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs. Beneficiary cost-sharing is limited to statutory deductibles, coinsurance, and payment for noncovered items and services.

The statute excludes several types of hospitals and hospital units from the PPS. These include psychiatric, long-term, children's and rehabilitation hospitals, as well as psychiatric and rehabilitation units operating as distinct parts of acute care hospitals. Hospitals located outside the 50 States and the District of Columbia are also excluded. In addition to these categorical exclusions, the statute provides other special exclusions, such as hospitals that are covered under approved State reimbursement control systems. These excluded hospitals and units are reimbursed on the basis of reasonable costs subject to the target rate of increased limits.

Hospitals and distinct part hospital units that specialize in alcohol/drug dependency treatments are included under PPS effective with the first day of their cost reporting period beginning on or after October 1, 1987. There is no special payment transition period for them. Treat bills for inpatients admitted prior to and discharged after the PPS implementation date as transition cases; not as transfer or discharge/readmissions. (See §3610.4 for instructions.)

As the facilities' cost reporting period ends, terminate alcohol/drug hospitals in the 1200-1299 series, and then establish them as short-term hospitals in the 001-0899 series using the next available provider number. If a hospital previously had a short-stay number, reactivate this number. The special identifer code is no longer needed for alcohol/drug units, and the"V" code must also be terminated.

The PPS standardized payment amounts are developed according to urban/rural descriptions in each of nine divisions and for the nation. The resulting 20 average standardized amounts are further divided into labor and nonlabor portions and are collectively referred to as the Federal portion of the rate.

For discharges occurring on or after April 1, 1988, separate standardized payment amounts are established for large urban areas, urban areas and rural areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. In addition, any New England County Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

Regional payment floors for the PPS standardized amounts are established for discharges occurring on or after April 1, 1988 and before September 30, 1990. The regional payment floor equals the higher of the national standardized amount or the sum of 85 percent of the national standardized and 15 percent of the regional standardized amounts.

There is a transition period where payment is based upon a blend of the Federal rate developed for the DRG and an individual hospital's specific rate. At the end of the transition period, the prospective payment will be based on national DRG payment rates. (See HCFA Pub. 15-1, §§280ff.) These DRG payment rates will be updated annually. The relative proportions of the hospital specific rate and the Federal rate during the transition period are:

PPS Transition Schedule

Summary of Hospital-Specific/Federal Percentages

Cost Reporting Periods Beginning on or After	Hospital-Specific Target Rate Percentage	Federal Rate Percentage
October 1, 1983	75	25
October 1, 1984	50	50
*October 1, 1985		
+ for the first 7 months	50	50
+ for the remaining 5 months	45	55
October 1, 1986	25	75
November 21, 1987	-	100

NOTE: The FY 1987 transition period blended rate (i.e., 75 percent Federal rate/25 percent hospital specific rate) remains in effect for the first 51 days of a hospital's cost reporting period beginning during FY 1988.

Summary of Regional and National Percentages of the Federal Portion

Federal Fiscal Year Beginning	(Regional/National Blend)	
October 1, 1983	(100)	(0)
October 1, 1984	(75)	(25)
*October 1, 1985	(75)	(25)
October 1, 1986-November 20, 1987	(50)	(50)
November 21, 1987	——	(100)

*An exception to this provision has been made for Oregon hospitals, which will continue under the transition schedule as defined prior to COBRA. For the first 7 months of cost accounting years beginning in FY 1986, Oregon hospitals were paid on 50 percent HSP and 50 percent Federal rates. Beginning with the 8th month, Oregon hospitals were paid a blend that is 25 percent HSP and 75 percent Federal. The composition of the Federal rate remained at 75 percent regional and 25 percent national for discharges occurring from October 1, 1985 through April 30, 1986. It changed to 50 percent regional and 50 percent national for discharges occurring between May 1, 1986 and September 30, 1986. For discharges on or after October 1, 1986, there is no regional component to the Federal rate for hospitals in Oregon. The Pricer program makes this distinction based upon the provider numbers.

B. Situations Requiring Special Handling.—

o Pay Sole Community Hospitals in accordance with the methods used to establish the prospective rates for the first year of the PPS transition. The 75 percent hospital-specific rate and the 25 percent Federal rate are applied by the Pricer program in accordance with the current values for the appropriate Federal year.

o Hospitals have the option to continue to be reimbursed on a reasonable cost basis subject to the target ceiling rate or to be reimbursed under PPS if the following are met:

— Recognized as of April 20, 1983, by the National Cancer Institute as Comprehensive Cancer Centers or Clinical Research Centers;

— Demonstrating that the entire facility is organized primarily for treatment of, and research on, cancer; and

— Having a patient population that is at least 50 percent of the hospital's total discharges with a principal diagnosis of neoplastic disease.

This decision is made at the beginning of the hospital's FY and continues until the hospital requests a change. If the provider selects reasonable cost subject to the target ceiling, it can later request PPS. No further option is allowed.

o Regional and national referral centers within short-term acute care hospital complexes. Rural hospitals which meet the criteria have their prospective rate determined on the basis of the urban, rather than the rural, adjusted standardized amounts, as adjusted by the applicable DRG weighting factor and the hospital's area wage index. (See §3610.15.)

o Hospitals in Alaska and Hawaii have the nonlabor related portion of the wage index adjusted by their appropriate cost-of-living factor. These calculations are made by the Pricer program and are included in the Federal specific portion of the rate.

o Kidney and heart acquisition costs are treated as an adjustment to provider payments. The payments are adjusted in each cost reporting period to compensate for the reasonable expenses of the acquisition and are not included in determining the prospective payment.

o Christian Science Sanatoria are paid on the basis of a predetermined fixed amount per discharge. Their reimbursement is based upon their historical operating costs per discharge and is not calculated by Pricer.

o Transferring hospitals with discharges assigned to DRG 385 (Neonates, Died or Transferred) or DRG 456 (burns, transferred to another acute care facility) have their payments calculated by the Pricer program on the same basis as those receiving the full prospective payment. They are eligible for both cost and day outliers.

o Nonparticipating hospitals furnishing emergency services are not affected by the legislation. They continue to be reimbursed upon their existing basis.

o VA hospitals are generally excluded from participation. Where payments are made for Medicare patients, the payments are determined in accordance with 38 U.S.C. 5053(d).

o Effective April 1, 1988, a Health Maintenance Organization (HMO) or a competitive medical plan (CMP) that receives Medicare payments on a risk basis, may no longer choose to have you make payment directly to the hospital. Hospitals and SNFs are required to accept as payment in full from HMO/CMPs the amount that would have been paid for the same services furnished to nonenrollees under Medicare reimbursement principles. (See §3555 for determining payment jurisdiction.) This does not, however, release you from the requirements of processing HMO paid bills for TEFRA risk HMOs.

o A hospital that loses its urban area status as a result of the Executive Office of Mangement and Budget redesignation occurring after April 20, 1983 may qualify for special consideration by having its rural Federal rate phased-in over a 2 year period. The hospital will receive, in addition to its rural Federal rate in the first cost reporting period, two-thirds of the difference between its rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status. In the second reporting period, one-third of the difference is applied. The adjustment is applied for two successive cost reporting periods beginning with the cost reporting period in which HCFA recognizes the reclassification.

o The payment per discharge under the PPS for hospitals in Puerto Rico is the sum of:

— 75 percent of the Puerto Rico discharge weighted urban or rural standardized rate.

— 25 percent of the national discharge weighted standardized rate.

(The special treatment of referral centers and sole community hospitals does not apply to prospective payment hospitals in Puerto Rico.)

o There are special criteria that facilities must meet in order to obtain approval for payment for heart transplants and special processing procedures for these bills. (See §3613.) Facilities that wish to obtain coverage of heart transplants for their Medicare patients must submit an application and documentation showing their initial and ongoing compliance with the criteria. For facilities which are approved, Medicare covers under Part A all medically reasonable and necessary inpatient services.

C. DRG Classification.— The DRGs are a patient classification system which provides a means of relating type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from waiver States, long-term care facilities, and excluded units are classified by the Grouper software program (see §3656.2) into one of 475 diagnosis related groups.

1. DRG No. 468.—Represents a discharge with possibly valid data but the surgical procedure is unrelated to the principal diagnosis. This DRG has a weight assigned and is paid. However, PROs will review all DRG 468 cases.

2. DRG No. 469.—Represents a discharge with a valid diagnosis in the principal diagnosis field, but one not acceptable as a principal diagnosis. Examples include diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. The diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for DRG assignment purposes. Return the claim to have the provider enter the correct principal diagnosis for proper DRG assignment.

3. DRG No. 470.—Represents discharges with invalid data. Return the claim for correction of data elements affecting proper DRG assignment.

When the bills are processed in conjunction with the MCE (see §3656.1) coding inconsistencies in the information and data are identified.

Where the MCE is run on-line or as a front-end process, inconsistencies are identified before the bills are processed through the Grouper. Corrections before Grouper eliminate inconsistencies that generate DRGs 469 and 470.

D. Physician Attestation.—The attestation requirement consists of two distinct parts: the certification statement which appears in each patient's medical record, and the annual penalty notice which must be achknowledged in writing by the hospital's physicians.

The certification statement in the medical record requires the attending physician shortly before, at, or shortly after, discharge (but before the claim is submitted), to attest in writing to the narrative descriptions of the principal diagnosis, secondary diagnoses, and the major procedures performed.

The signed acknowledgement that the physician has received the notice containing the penalty statement is kept on file at the hospital and verified by the PRO. The hospital is required to:

- o Obtain a signed acknowledgement for this penalty notice from the physicians. Acknowledgements must be dated within the year prior to the submission of the claim.
- o Renew this signed acknowledgement each year.

Where the PRO determines that claims are to be denied because the signed acknowledgements were either not on file, were not current, or the medical records had not been certified, initiate recovery against the hospital for all bills that you paid under the assumption that the certifications and acknowledgements were on file. Written notification will be supplied by your RO for the method and time frames associated with each recovery.

3610.1 Charges to Beneficiaries by PPS Hospitals.--A beneficiary's liability for payment is governed by the waiver of liability notification rules in §3440.1 where the admission is found not to be reasonable and necessary and no payment may be made for the stay under waiver of liability. A hospital receiving payment for a covered hospital stay (or one that includes at least one covered day, or one treated as covered under guarantee of payment or waiver of liability) may charge the beneficiary for items and services furnished during the stay only as described in subsections A through H.

A. Deductible and Coinsurance.—The hospital may charge for your applicable deductible and coinsurance amounts. The deductible is satisfied only by charges for covered services. Deduct the deductible and coinsurance amounts from your payment. Where the deductible exceeds the payment amount, apply the excess to a subsequent payment to the provider.

B. Blood Deductible.—The Part A blood deductible provision applies and reporting of the number of pints is applicable to both PPS and non-PPS hospitals.

C. Inpatient Hospital Care No Longer Required.—The hospital may charge for services which are not reasonable and necessary or which constitute custodial care, furnished on or after the third day following the date of the notification discussed after the second bullet when the following requirements are met:

o The hospital (acting directly or through its URC) determined that the beneficiary no longer required inpatient hospital care. (For this purpose, a beneficiary is considered to require inpatient hospital care if he needed a SNF level of care but an SNF-level bed was unavailble.)

o The attending physician agreed with the hospital's determination in writing, i.e., by issuing a written discharge order. If the hospital believed that the beneficiary did not require inpatient hospital care but is unable to obtain the physician's agreement, it requested an immediate review by the PRO. Concurrence by the PRO to the hospital's determination serves in lieu of the physician's agreement.

o Prior to charging for the noncovered period the hospital (acting directly or through the URC) notified the beneficiary (or person acting on his behalf) in writing that:

— In its opinion and with the concurrence of the attending physician (or of the PRO), the beneficiary no longer requires inpatient hospital care; or

— Customary charges will be made for continued hospital care beginning with the third day following the date of the notice.

o The beneficiary may request that the PRO make a formal determination on the validity of the hospital's finding if the beneficiary remains in the hospital after he/she becomes liable for charges. If the beneficiary wants an immediate review by the PRO, he/she must request it within 3 days of receiving the hospital's notice;

- The determination of the PRO may be appealed if it is unfavorable to the beneficiary in any way; and

- To the extent that a finding is made that the beneficiary required continued hospital care beyond the point indicated by the hospital, the charges for the continued care will be invalidated and any money paid by the beneficiary, or on his behalf, refunded.

The manner in which the hospital gives the notice to the beneficiary is in §3440.

If a hospital furnishing covered inpatient hospital services is able to determine in advance that the beneficiary will not require inpatient hospital care as of a certain date, it may give the notice in advance of that date, but ordinarily no earlier than 3 days before that date. If a hospital determines, however, that a beneficiary needs (or by the third day thereafter, will need) only a SNF-level of care but a SNF bed is not or will not be available, it may notify the beneficiary (or his representative) that he will be subject to charges beginning with the third day after the date of the notice that the SNF bed becomes available.

The beneficiary has the same right to appeal the PRO's determination that he no longer required inpatient hospital care as of a certain date as applies to PRO determinations regarding medical necessity. The hospital also has the right to appeal a PRO's determination which is unfavorable to the beneficiary.

When the hospital appeals in such cases the following entries are required on the bill:

- Occurrence code 31 (and date) to indicate the date the hospital notified the patient in accordance with the first bullet above;

- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which it is charging the beneficiary;

- Occurrence span code 77 (and dates) to indicate the period of noncovered care for which the provider is liable, when it is aware of this prior to billing; and

- Value code 31 (and amount) to indicate the amount of charges it may bill the beneficiary for days for which inpatient care was no longer required. They are included as noncovered charges on the bill.

D. Change in the Beneficiary's Condition.--If the beneficiary remains in the hospital after receiving notice as described in subsection C, and the hospital, the physician who concurred in the hospital's determination, or the PRO, subsequently determines that the beneficiary again requires inpatient hospital care, the hospital may not charge the beneficiary or other person for services furnished after he again required inpatient hospital care until the conditions in subsection C. are again met. If a patient who needs only a SNF level of care remains in the hospital after the SNF bed becomes available, and the bed ceases to be available, the hospital may continue to charge the beneficiary. It need not provide the beneficiary with a subsequent notice when the patient chose not to be discharged to the SNF bed.

E. Admission Denied.—If the entire hospital admission is determined to be not reasonable or necessary:

- If the beneficiary was notified in writing prior to, or upon admission, the hospital may charge for the entire period of hospitalization.

- If the beneficiary was notified in writing on the day following the admission or subsequently, the hospital may charge the beneficiary for the hospitalization beginning with the day following the day the written notice was given. In this circumstance, the provider is liable for the period between admission and the day after the beneficiary was notified.

- The notice to the beneficiary must state:

  - The basis of the determination that inpatient hospital care is not necessary or reasonable (e.g., coverage exclusions);

  - That customary charges will be made for hospital care beginning with the day following the day on which the notice is given to either the beneficiary or to a representative on his behalf;

  - The beneficiary may request that the PRO make a formal determination on the validity of the hospital's finding if the beneficiary remains in the hospital. If the beneficiary wishes immediate PRO review, it must be requested within 3 days of receiving the hospital's notice;

  - The determination of the PRO may be appealed by the beneficiary if it is unfavorable to the beneficiary in any way. The hospital also has the right to appeal a PRO's decision; and

  - If a finding is made that the beneficiary required the hospitalization, the charges for the hospital stay will be invalidated, and money paid by the beneficiary or on his behalf will be refunded.

In such cases the following entries are required on the bill:

- Occurrence code 31 (and date) to indicate the date the hospital notified the beneficiary.

- Occurrence span code 76 (and dates) to indicate the period of noncovered care for which the hospital is charging the beneficiary.

- Occurrence span code 77 (and dates) to indicate any period of noncovered care for which the provider is liable (e.g., the period between issuing the notice and the time it may charge the beneficiary) when the provider is aware of this prior to billing.

- Value code 31 (and amount) to indicate the amount of charges the hospital may bill the beneficiary for hospitalization which was not necessary or reasonable. They are included as noncovered charges on the bill.

F. Procedures, Studies and Courses of Treatment That Are Not Reasonable or Necessary.--If diagnostic procedures, studies, therapeutic studies and courses of treatment are excluded from coverage as not reasonable and necessary (even though the beneficiary requires inpatient hospital care) the hospital may charge the beneficiary or other person for the services or care under the following circumstances:

o If the beneficiary was notified in writing prior to receipt of the care or services that the hospital may charge for the excluded care or services; and

o The notice to the beneficiary must state:

— The basis of the determination that inpatient hospital care is not necessary or reasonable (i.e., coverage exclusions);

— The determination is the hospital's opinion. (If the hospital obtained concurrance from you or the PRO this may be stated);

— Customary charges will be made if he receives the services;

— The beneficiary may request you, or the PRO when medical necessity is involved, make a formal determination on the validity of the hospital's finding if the beneficiary receives the items or services. If the beneficiary wants immediate PRO review, he/she must request it within 3 days of receiving the hospital's notice;

— Your determination, or the PRO's where a medical necessity determination is involved, may be appealed by the beneficiary if unfavorable to the beneficiary in any way. The hospital also has the right to appeal your or the PRO's decision; and

— The charges for the services will be invalidated and refunded if they are found to be covered.

The hospital may consult with you (on coverage exclusions) or the PRO (on medical necessity determinations) prior to issuing the notice to the beneficiary.

The following bill entries apply to these circumstances:

o Occurrence code 32 (and date) to indicate the date the hospital provided the notice to the beneficiary.

o Value code 31 (and amount) to indicate the amount of such charges to be billed to the beneficiary. They are included as noncovered charges on the bill.

G. Nonentitlement Days and Days after Benefits Exhausted.--If a hospital stay exceeds the day outlier threshold, the hospital may charge for some, or all, of the days on which the patient is not entitled to Medicare Part A, or after the Part A benefits are exhausted (i.e., the hospital may charge its customary charges for services furnished on those days). The hospital may charge the beneficiary the lesser of:

- o The number of days on which the patient was not entitled to benefits or after benefits were exhausted; or
- o The number of outlier days.

If the number of outlier days exceeds the number of days on which the patient was not entitled to benefits or after benefits were exhausted, the hospital may charge the beneficiary for all days on which the patient was not entitled to benefits or after benefits were exhausted. If the number of days on which the beneficiary was not entitled to benefits, or after benefits were exhausted, exceeds the number of outlier days, the hospital determines the days for which it may charge by starting with the last day of the stay (i.e., the day before the day of discharge) and identifying and counting off in reverse order, days on which the patient was not entitled to benefits or after the benefits were exhausted, until that number equals the number of outlier days. The days counted off are the days for which the hospital may charge.

H. Services Excluded from Coverage for Reasons Other than Absence of Medical Necessity, Provision of Custodial Care, Nonentitlement to Part A, or Exhaustion of Benefits.--In addition to receiving the basic prospective and day outlier payment, the hospital may charge the beneficiary for any services that are excluded from coverage for reasons other than, or in addition to, absence of medical necessity, provision of custodial care, nonentitlement to Part A, or exhaustion of benefits. For example, the hospital may charge for most cosmetic and dental surgery.

I. Private Room Care.--Payment for a medically necessary private room is included in the prospective payment. Where the beneficiary requests private room accommodations, the hospital must inform the beneficiary of the additional charge. (See §3101.1.)

J. Deluxe Item or Service.--Where a beneficiary requests a "deluxe" item or service, i.e., an item or service which is more expensive than is medically required for the beneficiary's condition after the hospital informs him of the additional charge, the hospital may collect the additonal charge. That charge is the difference between the customary charge for the item or service most commonly furnished by the hospital to private pay patients with the beneficiary's condition, and the charge for the more expensive item or service requested by the beneficiary. If the beneficiary believes that the more expensive item or service was medically necessary, he has a right to a determination and may file an appeal.

3610.2 Payment for Ancillary Services.--Part A payments include ancillary services for inpatient stays. However, this does not apply where the beneficiary is not entitled, benefits are exhausted prior to admission, or the admission is denied without waiver. The hospital may bill covered ancillary services under Part B.

3610.3 Outpatient Services Treated As Inpatient Services.--When an individual is furnished outpatient hospital services and is thereafter admitted as an inpatient of the same hospital before midnight of the next day, the outpatient hospital services furnished him are treated as inpatient services unless the patient does not have Part A coverage. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

Where this provision applies, services provided are included in the applicable DRG and not billed separately. See §3670 for requirements for duplicate checking in such cases.

3610.4 Admission Prior to and Discharge After PPS Implementation Date.--Two bills are needed on claims involving beneficiaries admitted before the implementation of DRG and discharged on, or after, the effective date of payment under DRG. During the period that a hospital becomes subject to PPS, some patients will have been admitted in the prior cost reporting period and discharged in the subsequent PPS period. Reduce prospective payments for these patients for the cost of the stay occurring in the prior period. Make the adjustment by subtracting from the prospective payment the hospital's interim reimbursement (before any deduction for deductible or coinsurance) for the inpatient operating costs applicable to the days in the prior period. Adjust the interim reimbursement applicable to the prior period to exclude estimated costs related to capital and direct medical education, kidney acquisition costs, and for bad debts for uncollectible deductible and coinsurance. Make an estimate if necessary.

For hospitals previously receiving interim reimbursement on the basis of an average cost per diem or under PIP, determine and remove a per diem amount for the excluded costs for that period from the interim payments before reducing the prospective payment amount applicable to the discharge in the subsequent period under PPS. Similarly, for hospitals which received a percentage of billed charges, remove the portion of the percentage applicable to the excluded cost items. Apply the net percentage to the charges billed in the prior period (cutoff bill). Subtract the resulting amount from the DRG payment applicable to the discharge in the subsequent period.

In paying transition claims, reimbursement must not exceed the higher of what would have been paid under the DRG including the outlier adjustment or any earlier cost payment. Do not reduce the final amount to less than zero. No further adjustments are appropriate.

The interim payments used to reduce the prospective payment amounts fairly repesent the inpatient operating costs incurred, and fair reimburement for the portion of the stay occcurring in the prior period. The adjustment is final and not subject to further modification. On bills covering two cost reporting periods:

- Each bill includes charges and covered days that apply to the period covered.

- The cutoff bill for the cost period is completed per §3604.

- The DRG bill contains principal diagnosis and surgical procedures for the entire stay.

- The DRG bill shows the admission date but the period covered begins with the first day of the new accounting year.

- Where discharge is on the first day of the new accounting year, a DRG bill is still due. Some payment may be due the provider, and the open admission must be closed on HCFA's records. There are no accommodation charges on the day of discharge; ancillary charges for the day of discharge are reported on the prior bill.

- Coinsurance days and related amounts are applied separately to each bill, i.e., the proper deduction for coinsurance days reported on the second bill is taken from that bill.

3610.5 Transfers Between Hospitals.--Where a patient is admitted to a hospital and is subsequently transferred to another for additional treatments once the patient's condition has stablized or a diagnosis established, the following procedures apply. See §3656.3 for proper Pricer coding to assure that these requirements are met.

A. Transfers Between PPS Hospitals.--Since the final discharging hospital generally provides the greater portion of the patient's treatment, pay it at the full prospective payment rate. Pay the transferring hospital based upon a per diem rate (i.e., the prospective payment rate divided by the average length of stay for the specific DRG into which the case falls) and the patient's length of stay at the transferring hospital. If less than 1 day, pay for 1 day. Count a day if the patient was admitted with the expectation of staying overnight. A per diem payment is appropriate. However, this day does not count against the patients' Medicare days (utilization days), since this Medicare day will be applied at the receiving hospital. Deductible or coinsurance, where applicable, is also charged against days at the receiving hospital. (See §3620, Item 6.) If the patient is treated in the emergency room without being admitted and then transferred, only Part B billing is appropriate.

The prospective payment rate paid to each hospital is the rate specific for that hospital. The rate is composed of the Federal portion and the hospital specific portion. Similarly, the wage indexes and any other adjustments are those which are appropriate for each. Where a transfer case results in treatment in the second hospital under a DRG different than the DRG in the transferring hospital, base payment to each hospital on the DRG under which the patient was treated. Outlier payments are payable based upon the admission and discharge dates. The transferring hospital may be paid a cost outlier payment but may not be paid a day outlier payment.

An exception to this policy applies to DRGs 385 and 456. The weighting factors for them assume that the patient will be transferred, since a transfer is part of the definition. Therefore, pay a hospital which transfers a patient classified into one of these DRGs the full amount of prospective payment associated with the DRG rather than the per diem rate, plus any outlier payment, if applicable.

B. Transfers to Hospital or Units Excluded from PPS.—When patients are transferred to hospitals or units excluded from prospective payment, make the full prospective payment to the transferring hospital. Pay the receiving hospital on the basis of reasonable costs.

Make a per diem payment to the transferring hospital when patients are transferred to hospitals that would ordinarily be paid under prospective payment, but are excluded because of special reimbursement rules (such as Maryland, New Jersey, and Rochester and Finger Lakes areas of New York). Also, make a per diem payment where a patient is transferred to a hospital or hospital unit that has not been officially determined as being excluded from PPS.

3610.6 Split Bills.—Under PPS, split billing is not needed for cost reporting purposes. For admissions prior to a provider's cost reporting year under PPS with a discharge after the beginning of the prospective payment year (see §3610.4). Split bills are not needed at the end of the government's FY or the calendar year as changes in DRG prices are determined by the date of discharge. However, it is necessary to show on the bill the coinsurance days in each calendar year for proper application of the coinsurance amount. Section 3604, value codes 09 and 11 describe how hospitals show this in locators 46-49.

PPS days on the cost report are allocated to the year of the discharge. Providers not on PPS continue to submit split bills at the end of their FYs and allocate the days to the provider year in which they occurred.

3610.7 Outliers.—In addition to the basic prospective payment rates, payments are made for discharges involving day and cost outliers. "Outliers" are cases which although classifiable into a specific DRG, have an unusually long length of stay or exceptionally high cost. Outlier payments may not be less than 5 percent nor more than 6 percent of total payments projected to be made based upon the prospective payment rates in any year.

Outliers are not applicable to non-PPS hospitals. The Pricer program (see §3656.3) makes all outlier determinations except for the medical review determination. Outliers are usually reviewed by the PRO on a post-payment sample basis. If the PRO determines the claim should be partially or completely denied, it will inform you. Prepare an adjustment bill. (See §3664.)

Where experience with a specific hospital indicates prepayment medical review on outlier bills would be appropriate, the PRO may require it to obtain medical review approval before payment of outliers. In such cases, pay for the outlier only where code "1" or "3" is reported in Item 87. You may suspend payment of the entire bill pending outlier review if appropriate for your system.

The PPS standardized amounts are reduced separately for hospitals located in urban and rural areas. The adjustments are based upon the estimated proportion of total DRG payments attributable to outlier payments. Consequently, instead of a uniform percent reduction factor applying to all standardized amounts, the reduction varies, depending upon whether the hospital is classified as rural or urban.

Cost outlier payment must be requested by the hospital. Treat the absence of code 66 in Items 35-39 of the bill as a request by the hospital for any cost outlier payment due. Hospitals are allowed to request cost outlier payments when they submit bills. Cost outlier cases are subject to post-payment review.

A. Day Outliers.--The cutoff point for the day outlier for the following Federal FYs are:

- For FY 1988 the lesser of 18 days or 2.0 standardized deviations.

- For FY 86 and FY 87 the mean length of stay for the specific DRG, plus 17 days or 1.94 times the standard deviation, whichever is lower. The effective date was May 1, 1986.

- For FY 84 and 85 20 days or 1.94 times the standard deviation and 22 days or 1.94 times the standard deviation respectively. The FY 85 cut-off point remained in effect through April 30, 1986.

The Pricer program determines the cutoff points and outlier amounts. A table showing the specific cutoff point for each DRG is in the Pricer implementation guide.

The PRO determines whether the claim is medically necessary on a post-payment sample basis.

The outlier per diem payment is the hospital's Federal rate for the DRG divided by the geometric mean length of stay for the applicable DRG times 60 percent of the Federal rate percentage, i.e., 25, 50, 75, or 100 percent.

Day outlier status is based upon the total length of the stay and day outlier payment upon the number of covered days.

B. Cost Outliers.--A hospital may request you to determine an appropriate additional payment for inpatient hospital services where its charges for covered services furnished to the beneficiary, adjusted for cost:

- In FY 88, exceeded the greater of $14,000 or 2 times the Federal DRG rate adjusted for area wage differences.

- In FY 86 and FY 87, exceeded the greater of $13,500 or 2 times the Federal DRG rate adjusted for area wage differences.

The Emergency Extension Act of 1985 extended the FY 85 payment amounts beyond September 30, 1985. They remained in effect through April 30, 1986. The FY 1986 payment amounts were effective May 1, 1986.

- In FY 85, exceeded the greater of $13,000 or 2 times the Federal DRG rate adjusted for area wage differences.
- In FY 84, exceeded $12,000 or 1 1/2 times the adjusted Federal DRG weight.

Cost is deemed to be 66 percent of total covered charges (excluding any kidney acquisition charges) and adjusted to exclude an estimate of indirect teaching costs. Except as provided below, do not pay a cost outlier if the stay qualifies as a day outlier.

The PRO reviews the claim on a pre or post-payment sample basis.

The additional payment amount is the applicable Federal rate percentage times 60 percent of the difference between the hospital's cost for the discharge and the threshold criteria established for the applicable DRG.

Where both split billing (during the hospital's transition to PPS) and a cost outlier are involved, the hospital includes the charges from the cost based bill in the Remarks sections of the HCFA-1450 of the prospective payment (DRG) bill.

The transferring hospital may be paid a cost outlier but not a day outlier payment. In these cases only, a cost outlier may be paid regardless of the day outlier criteria.

C. Special Outlier Payments for Burn Cases.--Special payments are provided for outlier cases classified in DRGs relating to burns. The percentage factor to apply in determining outlier payments is 90 percent. Thus, burn cases which stay beyond the appropriate day outlier threshold receive 90 percent of the applicable per diem for each outlier day. Cost outliers in burn DRGs receive 90 percent of the cost of care above the cost outlier threshold. This reimbursement level applies to discharges occurring during the period April 1, 1988 through September 30, 1990.

The six DRGs relating specifically to burn cases are:

DRG	Name
456.................	Burns, transferred to another acute care facility
457.................	Extensive burns w/o O.R. procedure
458.................	Nonextensive burns with skin graft
459.................	Nonextensive burns with wound debridement or other O.R. procedure
460.................	Nonextensive burns w/o O.R. procedure
472.................	Extensive burns with O.R. procedure

D. Adjustments Where the PRO Denies Days or Cost.--Where a PRO's decision changes previously processed bills, prepare and process an adjustment bill in accordance with §3664.

E. Pricer Coding for Outlier Cases.--Follow these guidelines for using the Pricer program to determine outlier status and payment amount.

- If the Pricer return code is 59 (day outlier met), send the case back to Pricer with review code 01. This will pay the day outlier.

- If the return code is 63 (cost outlier met), determine if condition code 66 is present. In its absence, the hospital is requesting cost outlier payment. Send the case back to Pricer with review code 02. This will pay the cost outlier. If condition code 66 is present, send the case back to Pricer with review code 04. This will pay the nonoutlier portion of the bill.

Send transfer cases as code 03.

- If the return code is 63 (cost outlier met), determine if condition code 66 is present.

- If it is, send the case back to Pricer with review code 06. This will pay the per diem payment.

- If condition code 66 is absent, send the case back to Pricer with review code 05. This will pay the cost outlier.

3610.8 Adjustment Bills.—Under prospective payment (DRG), bill adjustments are required from hospitals where errors occur in diagnoses and procedure coding that change the DRG, or where the deductible or utilization are affected. Hospitals are allowed 60 days from the date of your payment notice to submit adjustment bills where diagnostic or procedure coding was in error. Adjustments reported by the PRO have no corresponding time limit. Adjust them automatically without requiring the hospital to submit an adjustment bill. However, if diagnostic and procedure coding errors have no effect upon the DRG, do not submit adjustment bills. (See S3816.1, A and B.)

Where reimbursement is handled through cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. Maryland inpatient hospital providers also keep a log of late charges when the amount is under $500. They submit the log with their cost reports. After cost reports are filed, make a lump sum payment to cover these charges as shown on the summary log. The provider uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland. (See S3816A.)

Maryland and cost providers are required to meet the 27-month timeframe for timely filing of claims, including late charges.

3610.9 Waiver of Liability.—Charges paid to the provider under waiver are considered covered charges by the PS&R system. Therefore, process such charges as covered charges on the bill. Similarly, process days related to charges paid under waiver as Medicare patient and utilization days. See SS3430 and 3630 for application of waiver of liability provisions.

3610.10 Effects of Guarantee of Payment.—Process days and charges paid under this provision as Medicare patient days and covered charges. However, do not charge utilization beyond the days remaining in the benefit period. See §3106C for guarantee of payment.

Also count guarantee of payment days as outlier days for determining day outlier status or payment amount.

3610.11 Remittance Advice to the Hospital.—Determine what additional data to include in the remittance advice to the hospital. As a minimum, include the DRG number and an indication of whether the bill was paid as an outlier. Where the hospital cannot determine the DRG before submitting the bill, you may use the remittance advice to identify potential outlier cases.

3610.12 Noncovered Admission Followed by Covered Level of Care.—Where a beneficiary receives noncovered care at admission, and is notified as such, but subsequently is furnished covered level of care during the same hospital stay, pay as if the admission occurred at the point that covered services were medically needed and rendered. This is applicable to PPS and non-PPS billings.

The following bill entries identify this situation:

o The admission date (not the deemed date) is in Items 15 and 22.

o Occurrence code "31" and the date the hospital provided notice to the beneficiary are in Items 28-32.

o Occurrence span code 76 indicates the noncovered span from admission date through the day before covered care started.

o Value code 31 is shown to indicate the amount which was charged the beneficiary for services if less than the covered level of care in Items 46-49.

o Charges related to noncovered services are shown as noncovered.

o The principal diagnosis shown is the diagnosis for the covered period of care.

o Only procedures performed during the covered level of care are shown.

If you have processed a no payment bill for the noncovered level of care, process a new, initial bill coded in UNIBILL as above.

3610.13 Billing for Alcohol and Drug Related Services.--

A. Alcohol and Drug Detoxification Characteristics.--Detoxification is the medically supervised process of facilitating the elimination of alcohol and other psychoactive drugs from patients in a manner which minimizes the risk of development of medical, surgical, or psychiatric complications of such drug use and withdrawal. Detoxification involves:

- Placement of the patient in a safe physical environment with appropriate staff to allow monitoring of physical and mental health status;

- The provision of supportive and symptomatic, medical, surgical, or psychiatric treatments; and

- Specific pharmacologic protocols necessary to minimize the risk of adverse medical or psychological complications of alcohol and other drug withdrawal in accordance with accepted standards of care.

B. Alcohol and Drug Rehabilitation Treatment Characteristics.--Rehabilitation treatment is a discrete, intensive, coordinated program to help patients:

- Recover from the recent effects of alcohol and other drugs;

- Understand the medical, social, and psychological aspects of alcohol and drug dependence, generally, and their dependence, specifically;

- Develop motivation to comply with individually determined treatment recommendations; and

- Develop necessary knowledge, attitudes, and skills to avoid or minimize risk of return to medically unnecessary use of alcohol or other psychoactive drugs.

Rehabilitation treatment includes identification and treatment of related and/or coexisting medical, surgical, and psychiatric problems when necessary and reasonable.

Rehabilitation treatment procedures include the following, which are provided in accordance with individualized assessment of a patient's medical, surgical, and psychological needs:

- Intense educational activities such as lectures, films, reading assignments, and discussion.

- Staff-supervised group therapy.

best copy available

- Individual medical and psychological procedures necessary for diagnosis or treatment of alcohol or drug dependence and its complications or coexisting disorders.

- Involvement of family and others in educational and other appropriate program activities where feasible. (This is intended to encourage involvement of the family in the educational and limited group therapy programs. It does not imply Medicare coverage of such participation.)

- Intensive discharge planning, including efforts to involve patients and family members in appropriate outpatient follow-up therapies with physicians, counselors, and other health care personnel specifically trained in alcohol, drug dependence, and its complications. In addition, efforts are made to involve appropriate patients and families in support groups such as Alcoholics Anonymous, ALANON, Narcotics Anonymous, etc., in their communities where appropriate. Where such efforts are deemed inappropriate, there is documentation of the rationale as to why.

C. Completion of Billing Form for Alcohol and Drug Related Services.--If an alcohol and drug related ICD-9-CM code listed in subsection D is listed as a principal diagnosis, the provider uses the following procedures to indicate whether rehabilitation or detoxification services were furnished.

- Rehabilitation services provided as treatment contain the ICD-9-CM diagnosis code, V57.89, as an additional diagnosis.

- Detoxification services provided as treatment contain the ICD-9-CM procedure code 94.25, as one of the procedures.

- If both rehabilitation and detoxification services were provided, both the V57.89 code as an additional diagnosis and the 94.25 code as one of the procedures are present.

- If neither detoxification nor rehabilitation services were provided to the patient, no additional coding is included.

If the additional code(s) is not present, the Grouper groups claims as if no rehabilitation or detoxification services were furnished.

D. PRINCIPAL DIAGNOSES THAT MUST BE ACCOMPANIED BY A SECONDARY DIAGNOSIS OR PROCEDURE CODE TO INDICATE REHAB. AND/OR DETOX.

2910	DELIRUM TREMENS
2911	ALCOHOL AMNESTIC SYND
2912	ALCOHOLIC DEMENTIA NEC
2913	ALCOHOL HALLUCINOSIS
2914	PATHOLOGIC ALCOHOL INTOX
2915	ALCOHOLIC JEALOUSY
2918	ALCOHOLIC PSYCHOSIS NEC
2919	ALCOHOLIC PSYCHOSIS NOS
2920	DRUG WITHDRAWAL SYNDROME
29211	DRUG PARANOID STATE
29212	DRUG HALLUCINOSIS
2922	PATHOLOGIC DRUG INTOX
29281	DRUG-INDUCED DELIRIUM
29282	DRUG-INDUCED DEMENTIA
29283	DRUG AMNESTIC SYNDROME
29284	DRUG DEPRESSIVE SYNDROME
29289	DRUG MENTAL DISORDER NEC
2929	DRUG MENTAL DISORDER NOS
30300	AC ALCOHOL INTOX-UNSPEC
30301	AC ALCOHOL INTOX-CONTIN
30302	AC ALCOHOL INTOX-EPISOD
30303	AC ALCOHOL INTOX-REMISS
30390	ALCOH DEP NEC/NOS-UNSPEC
30391	ALCOH DEP NEC/NOS-CONTIN
30392	ALCOH DEP NEC/NOS-EPISOD
30393	ALCOH DEP NEC/NOS-REMISS
30400	OPIOID DEPENDENCE-UNSPEC
30401	OPIOID DEPENDENCE-CONTIN
30402	OPIOID DEPENDENCE-EPISOD
30403	OPIOID DEPENDENCE-REMISS
30410	BARBITURATE DEPEND-UNSPEC
30411	BARBITURATE DEPEND-CONTIN
30412	BARBITURAT DEPEND-EPISOD
30413	BARBITURAT DEPEND-REMISS
30420	COCAINE DEPEND-UNSPEC
421	COCAINE DEPEND-CONTIN
30422	COCAINE DEPEND-EPISODIC
30423	COCAINE DEPEND-REMISS
30430	CANNABIS DEPEND-UNSPEC
30431	CANNABIS DEPEND-CONTIN
30432	CANNABIS DEPEND-EPISODIC
30433	CANNABIS DEPEND-REMISS
30440	AMPHETAMIN DEPEND-UNSPEC
30441	AMPHETAMIN DEPEND-CONTIN
30442	AMPHETAMIN DEPEND-EPISOD
30443	AMPHETAMIN DEPEND-REMISS
30450	HALLUCINOGEN DEP-UNSPEC
30451	HALLUCINOGEN DEP-CONTIN
30452	HALLUCINOGEN DEP-EPISOD
30453	HALLUCINOGEN DEP-REMISS
30460	DRUG DEPEND NEC-UNSPEC
30461	DRUG DEPEND NEC-CONTIN
30462	DRUG DEPEND NEC-EPISODIC
30463	DRUG DEPEND NEC-IN REM
30470	OPIOID/OTHER DEP-UNSPEC
30471	OPIOID/OTHER DEP-CONTIN
30472	OPIOID/OTHER DEP-EPISOD
30473	OPIOID/OTHER DEP-REMISS
30480	COMB DRUG DEP NEC-UNSPEC
30481	COMB DRUG DEP NEC-CONTIN
30482	COMB DRUG DEP NEC-EPISOD
30483	COMB DRUG DEP NEC-REMISS
30490	DRUG DEPEND NOS-UNSPEC
30491	DRUG DEPEND NOS-CONTIN
30492	DRUG DEPEND NOS-EPISODIC
30493	DRUG DEPEND NOS-REMISS
30500	ALCOHOL ABUSE-UNSPEC
30501	ALCOHOL ABUSE-CONTINUOUS
30502	ALCOHOL ABUSE-EPISODIC
30503	ALCOHOL ABUSE-IN REMISS
30520	CANNABIS ABUSE-UNSPEC
30521	CANNABIS ABUSE-CONTIN
30522	CANNABIS ABUSE-EPISODIC
30523	CANNABIS ABUSE-IN REMISS
30530	HALLUCINOG ABUSE-UNSPEC
30531	HALLUCINOG ABUSE-CONTIN
30532	HALLUCINOG ABUSE-EPISOD
30533	HALLUCINOG ABUSE-REMISS
30540	BARBITURATE ABUSE-UNSPEC
30541	BARBITURATE ABUSE-CONTIN
30542	BARBITURATE ABUSE-EPISOD
30543	BARBITURATE ABUSE-REMISS
30550	OPIOID ABUSE-UNSPEC
30551	OPIOID ABUSE-CONTINUOUS
30552	OPIOID ABUSE-EPISODIC
30553	OPIOID ABUSE-IN REMISS
30560	COCAINE ABUSE-UNSPEC
30561	COCAINE ABUSE-CONTINUOUS
30562	COCAINE ABUSE-EPISODIC
30563	COCAINE ABUSE-IN REMISS
30570	AMPHETAMINE ABUSE-UNSPEC
30571	AMPHETAMINE ABUSE-CONTIN
30572	AMPHETAMINE ABUSE-EPISOD
30573	AMPHETAMINE ABUSE-REMISS
30580	ANTIDEPRESS ABUSE-UNSPEC
30581	ANTIDEPRESS ABUSE-CONTIN
30582	ANTIDEPRESS ABUSE-EPISOD
30583	ANTIDEPRESS ABUSE-REMISS
30590	DRUG ABUSE NEC-UNSPEC
30591	DRUG ABUSE NEC-CONTIN
30592	DRUG ABUSE NEC-EPISODIC
30593	DRUG ABUSE NEC-IN REMISS
7903	EXCESS BLOOD-ALCOHOL LEV

3610.14 Repeat Admissions and Leave of Absence.--A patient who requries followup care or surgery may be discharged and readmitted or may be placed on a leave of absence.

Providers may place patients on a leave of absence when readmission is expected and the patient does not require a hospital level of care during the interim period. Examples include, but are not limited to, situations where surgery could not be scheduled immediately, a specific surgical team was not available, bilateral surgery was planned, or when further treatment is indicated following diagnostic tests but cannot begin immediately.

PROs review acute hospital admissions occurring within 7 days of discharge from an acute care hospital if both hospitals are in the PRO's area and if it appears that the two confinements could be related. Two separate payments would be made for these cases unless the PRO denies a readmission to the same hospital.

NOTE: PROs review and may deny the second admission to the same hospital no matter how many days have elapsed since the discharge from the same hospital.

Placing a patient on a leave of absence will not result in the two payments. Only one bill is prepared and one DRG payment is made. PROs do not consider leave of absence bills two admissions but may select such bills for review.

PPS providers submit one bill for covered days and days of leave when the patient is discharged. Non-PPS providers may submit an interim bill when a patient is placed on a leave of absence, with code 30, still patient in Item 21, Patient Status.

Providers bill for covered days with days of leave included in Item 24, Noncovered Days. Noncovered charges for leave of absence days (holding a bed) may be omitted from the bill or may be shown under revenue code 18x. Instruct providers which billing method to use. Even though the program may not be billed for days of leave, a provider may not charge a beneficiary for them.

An adjustment bill should be submitted (see S3816) where a patient:

o Is on leave of absence from a non-PPS provider;

o Was shown as "still patient" on an interim bill; and

o Has not returned within 60 days (14 days for a SNF) including the day leave began; or

o Has been admitted to another institution.

The day the patient left the facility is the date of discharge.

NOTE: Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required unless the above events occurred.

3610.15 Additional Payment Amounts for Hospitals With Disproportionate Share of Low Income Patients.--Adjustments are made in the Federal portion of the DRG payment to achieve increased payments to hospitals serving a disproportionate share of low income patients. The additional payment equals the Federal portion of the DRG payment and outlier payments (but excluding any additional payments for the costs of indirect medical education) multiplied by an adjustment percentage.

If a hospital meets the disproportionate share hospital (DSH) definition as prescribed in the law, an additional payment is made for discharges occurring on or after May 1, 1986 and before October 1, 1989. The DSH adjustment is applied only to the Federal portion of the DRG payment (including the outlier payments). It is basically a year-end lump sum adjustment. Identify those hospitals that are eligible to receive the DSH adjustment and make interim payments subject to a year-end settlement based upon the hospital's actual DSH percentage for the cost reporting period. The DRG payment includes the interim DSH payment (but excludes the indirect teaching adjustment).

The DSH percentage is the sum of:

o The percentage of a hospital's total Medicare Part A patient days attributable to Medicare patients who are also SSI recipients (this percentage is supplied to you by HCFA). Since the SSI/Medicare percentages are determined by HCFA on a FY basis, hospitals will be afforded the option (for settlement purposes) of determining their SSI/Medicare percentage based upon data from their own cost reporting periods. A hospital that avails itself of this option must furnish to you, in a manner and format prescribed by HCFA, data on its Medicare patients for its cost reporting period. These data will be matched by SSA to determine those patients dually entitled to Medicare Part A and SSI for the hospital's cost reporting period.

o The percentage of the hospital's total patient days attributable to Medicaid patients. (Medicaid days and total days are available on the hospital's cost report.)

A hospital qualifies for a DSH adjustment if it has a DSH percentage:

-- At least 15 percent for an urban hospital with 100 or more beds;

-- At least 40 percent for an urban hospital with fewer than 100 beds;

-- At least 45 percent for a rural hospital; or

-- At least 15 percent, if the hospital is located in a rural area and has 500 or more beds. (Applicable for discharges occurring on or after October 1, 1986 and before October 1, 1989.)

For purposes of the DSH determination, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, excluding beds assigned to newborns, custodial care, and PPS excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

Hospitals which meet the DSH percentage criteria are entitled to adjustments to the Federal portion of their DRG payments (including the Federal portion of outlier payments) as follows:

o Urban hospitals with 100 or more beds and rural hospitals with 500 or more beds -- the lesser of 15 percent or the percentage determined using the following formula:

(DSH % - 15)(.5) + 2.5

EXAMPLE: a. Hospital A is an urban hospital with 200 beds and has a DSH percentage of 21 percent. Its DSH payment factor is computed:

(21 - 15)(.5) + 2.5 = 5.5%
DSH adjustment factor = 5.5% (.0550)

b. Hospital B is an urban hospital with 250 beds and has a DSH percentage of 45 percent. Its DSH payment adjustment factor is computed:

(45 - 15)(.5) + 2.5 = 17.5%
DSH adjustment factor = 15% (.1500) (the maximum adjustment under the law).

2. Urban hospitals with fewer than 100 beds -- 5 percent.

3. Rural hospitals -- 4 percent.

Compute the amount of the DSH adjustment by multiplying the Federal portion of the hospital's DRG revenues by the appropriate DSH adjustment factor.

EXAMPLE: Hospital A's DSH payment adjustment factor is 5.5 percent (or .0550). The Federal portion of its DRG revenues (including appropriate outlier payments, but excluding any payments for indirect medical education costs) equals $100,000.

Federal DRG revenues x DSH adjustment factor = DSH adjustment amount
$100,000 x .055 = $5,500

Accumulate a record in your PS&R of the DSH amount paid, the Federal portion of the DRG and any outlier amount for all hospitals for discharges to use at cost settlement.

DSH Exception

The law also contains a provision whereby a hospital can qualify for a DSH adjustment of 15 percent if it meets the following criteria:

o It is located in an urban area and has 100 or more beds.

o It demonstrates that during its cost reporting period, more than 30 percent of its total inpatient care revenues is derived from State and local government payments for indigent care furnished to patients not covered by Medicare or Medicaid.

The following are some types of care that are not to be included by the hospital as indigent care:

o Free care furnished to satisfy the hospital's Hill-Burton obligation.

o Free care or care furnished at reduced rates to its employees or by a government hospital to any category of public employees.

o Funds furnished to the hospital to cover general operating deficits.

NOTE: The adjustment is a year-end adjustment for which hospitals have to apply annually. The adjustment is not automatic from year to year once an initial approval is granted.

Documentation should include the complete audited financial statements along with the accompanying notes. The hospital should also provide detailed schedules related to State and local revenue appropriations as well as outlining their purpose. Unless the appropriations are specifically earmarked for indigent patient care, assume that a portion of these funds was intended to cover the costs of other uncompensated care such as bad debts for nonindigent patients, free care to employees, etc., as well as to cover general operating deficits. In order to determine the portions, calculate the percentage of charity care included in all uncompensated care. Apply this percentage to the appropriated funds. The resulting figure is the amount appropriated for charity care.

Require adequate documentation supporting amounts claimed as indigent patient care. This includes a copy of hospital procedures for determining indigency, steps to verify a patient's financial information, and methods used to distinguish bad debts from indigency.

Intermediary Review

It is your responsibility to review the documentation submitted in support of the provider's request for a disproportionate share adjustment under §412.106(b)(2) of the regulations. This review can be accomplished in conjunction with the audit/settlement of the cost report for the period subject to the adjustment. At a minimum, perform the following steps:

- o Verify total inpatient revenues;
- o Verify that State and local government appropriations on the financial statements are consistent with amounts contained in governmental appropriations bills;
- o Review, on the basis of a sample of cases, the provider's implementation of procedures for identifying indigent patients. Ensure that amounts for "indigent" patients do not include charges associated with:
  - Titles XIX and XVII patient care;
  - Hill-Burton care;
  - Free care to employees; and
  - Bad debts for patients who are not indigent.

3610.16 Rural Referral Centers (RRCs).--The law provides for exceptions and adjustments to the standardized prospective payment amounts to take into account the special needs of RRCs. The adjustment allowed for approved RRCs is that they are paid based upon the urban, rather than rural, prospective payment rates as adjusted by the applicable DRG weighting factor and the rural area index.

The rates in Pricer include a reduction in the adjusted standardized amounts for all hospitals to ensure that total PPS payment neither increase nor decrease as a result of the increase in payments to RRCs.

A hospital can qualify as a RRC by meeting two mandatory criteria (i.e., case-mix index and number of discharges) and at least one of three optional criteria (speciality composition of medical staff, source of inpatient, or volume of referrals), in addition to beding located in a rural area.

The two mandatory criteria for designation as a RRC are:

- o The case-mix index for each region is equal to the median case-mix index for urban hospitals in each census region (excluding hospitals with approved teaching programs).
- o The national number of discharges criterion is at least 5,000 discharges per year, or if fewer, the median number of discharges for urban hospitals in the census region is which the hospital is located.

The revised regional case-mix criteria and the median number of discharges for a hospital based upon its discharges subject to prospective payment occurring during Federal FY 1988 are:

Region	Case Mix (Federal FY 1986)	Median Discharges (Hospital Fiscal Year Beginning During Federal FY 1986)
1..............	1.1261	7,385
2..............	1.1021	8,192
3..............	1.1355	6,611
4..............	1.1224	8,171
5..............	1.0912	5,456
6..............	1.1450	5,879
7..............	1.1442	4,706
8..............	1.1733	6,948
9..............	1.1737	4,742

To qualify for the RRC adjustment for FY 1988, a hospital's case-mix index for Federal FY 1986 must have been at least equal to the above appropriate regional value or the national value of 1.1572. In addition, the hospital must have met the appropriate national or regional discharge criterion for its cost reporting period beginning during Federal FY 1986.

Hospitals classified as RRCs as of October 21, 1986 retain that status through the end of their cost reporting periods beginning before October 1, 1989.

3612. KIDNEY TRANSPLANT - GENERAL

A major treatment for patients with ESRD is kidney transplantation. This involves removing a kidney, usually from a living relative of the patient or from an unrelated person who has died, and surgically placing the kidney into the patient. After the beneficiary receives a kidney transplant, Medicare reimburses the transplant (implanting) hospital for the transplant and appropriate standard acquisition charges. Special provisions apply to payment.

A transplant hospital may acquire cadaver kidneys by:

- Excising kidneys from cadavers in its own hospital;
- Having its kidney procurement team excise kidneys from cadavers in other hospitals;
- Arrangements with participating community hospitals, whether they excise kidneys on a regular or irregular basis;
- Arrangements with a kidney procurement organization which services the transplant hospital as a member of a network; and
- Arrangements with a free-standing kidney procurement organization which provides cadaver kidneys to any transplant hospital.

When the transplant hospital also excises the cadaver kidney, the cost of the procedure is included in its kidney acquisition costs and is considered in arriving at its standard cadaver kidney acquisition charge. When the transplant hospital excises a kidney to provide another hospital, it may use its standard cadaver kidney acquisition charge or its standard detailed departmental charges to bill that hospital.

When the excising hospital is not a transplant hospital, it bills its customary charges for services used in excising the cadaver kidney to the transplant hospital or organ procurement agency.

When the provider excising the kidney is a community hospital that does not participate in the Medicare program, its charges for the kidney are subject to screens of $1,200 (provider cost) and $400 (physicians' services). Organs may be accepted from a nonparticepating hospital only if they cannot be obtained from any other source.

If the transplanting hospital's organ procurement team excises the cadaver kidney at another hospital, the cost of operating such a team is included in the transplanting hospital's kidney acquisition costs, along with the reasonable charges billed by the other hospital of its services.

3612.1 The Standard Kidney Acquisition Charge.--There are two basic standard charges which must be developed by transplant hospitals from costs expected to be incurred in the acquisition of kidneys:

- The standard charge for acquiring a live donor kidney; and
- The standard charge for acquiring a cadaver kidney.

The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge which reflects the average cost associated with each type of kidney acquisition.

3612.2 Billing for Kidney Transplant and Acquisition Services.--The HCFA-1450 is completed in accordance with §3604 for the beneficiary who receives a kidney transplant. Applicable standard kidney acquisition charges are identified separately in item 51 by revenue code 811 (Living Donor Kidney Acquisition) or 812 (Cadaver Donor Kidney Acquisition). Where interim bills are submitted, the standard acquisition charge appears on the billing form for the period during which the transplant took place. This charge is in addition to the hospital's charges for services rendered directly to the Medicare recipient.

Deduct kidney acquisition charges for PPS hospitals for processing through Pricer. These costs incurred by approved kidney transplant hospitals, are not included in the prospective payment DRG 302 (kidney transplant). They are reimbursed on a reasonable cost basis. Interim payment is paid as a "pass through" item. (See Provider Reimbursement Manual, Part 1 §2802, B.8.) Include kidney acquisition charges under the appropriate revenue code in UNIBILL.

3612.3 Charges for Kidney Acquisition Services.--Applicable services (see §§3179-3179.19) are billed from the excising hospital to the transplant (implant) hospital). A billing form is not submitted from the excising hospital to you. The transplant hospital keeps an itemized statement that identifies the services rendered, the charges, the person receiving the service (donor/recipient), and whether this is a potential transplant donor or recipient. These charges are reflected in the transplant hospital's kidney acquisition cost center and are used in determining the hospital's standard charge for acquiring a live donor's kidney or a cadaver's kidney. The standard charge is not a charge representing the acquisition cost of a specific kidney; rather, it is a charge which reflects the average cost associated with each type of kidney acquisition. Also, it is an all inclusive charge for all services required in acquisition of a kidney, i.e., tissue typing, post-operative evaluation, etc.

3612.4 Notifying Carriers.--To inform carriers when immunosuppressive drugs are reimbursable, make an extra copy of the Medicare Benefit Notice that gives the date of discharge for kidney transplants. Send the copy to the carrier specializing in immunosuppressive drug reimbursement.

- If the beneficiary lives west of the Mississippi or in Minnesota send the copy to:

- TransAmerica Occidental
  Life Insurance Company
  Medicare Immuno Drug Claims
  P.O. Box 60848 Terminal Annex
  Los Angeles, Ca 90060

o If the beneficiary lives east of the Mississippi, excluding Minnesota, send the copy to:	o Blue Cross and Blue Shield of South Carolina Medicare Immunosuppressive Drug Unit Pen Claims P.O. Box 102401 Columbia, SC 29224

See §3718.1 for the message about immunosuppressive drug reimbursement to include in the notice.

3613. HEART TRANSPLANTS

A. Background.--On April 6, 1987, HCFA Ruling 87-1, "Criteria for Medicare Coverage of Heart Transplants" was published in the *Federal Register*. For Medicare coverage purposes, heart transplants are medically reasonable and necessary when performed in facilities that meet certain criteria. Facilities that wish to obtain coverage for their Medicare patients submit an application and documentation showing their initial and ongoing compliance with each criterion.

The facility mails the application to the address below in a manner which provides it with documentation that it was received, e.g., return receipt requested.

Administrator
Health Care Financing Administration
c/o Office of Executive Operations
Room 777 East High Rise
6325 Security Blvd.
Baltimore, MD 21207

If you have any questions concerning the effective or approval dates of your hospitals, contact your RO.

B. Artificial Hearts and Related Devices.--An artificial heart can be used either as a permanent replacement for a human heart or as a temporary life-support system (bridge to transplant) until a human heart becomes available. Ventricular assist devices also are used as temporary support systems. Charges for artificial heart ventricular assist devices and related services are reported as noncovered. (See §65-15 of the Coverage Issues Manual.)

C. Drugs.--Effective January 1, 1987, Medicare covers immunosuppressive drugs up to 1 year following a covered transplant. (See §3660.8.)

D. Noncovered Transplants.--Medicare does not cover transplants or retransplants in facilities which have not been approved as meeting the facility criteria. If a beneficiary is admitted for and receives a heart transplant from a facility that is not approved, neither physicians services nor inpatient services associated with the transplantation procedure are covered.

When a beneficiary has received a heart transplant from a hospital (which has not been approved as meeting the facility criteria) and later requires medical and hospital services as a result of the noncovered transplant, the services are covered when they are reasonable and necessary in all other respects.

E. Bill Review Procedures.—Take the following actions to process heart transplant bills. You may accomplish them manually or you may modify your MCE and Grouper interface programs to handle the processing.

F. Change MCE Interface.—The MCE creates an exception for procedure code 375 (heart transplant). Where this procedure code is identified by MCE, check the provider number to determine if the provider is an approved transplant center. Check the effective approval date. If payment is appropriate (i.e., the center is approved and the service is on or after the approval date) override the noncovered OR procedure edit.

G. Grouper.—If the discharge is October 1, 1987 or later, process the bill through Grouper and Pricer. If the discharge is before October 1, 1987, Pricer does not have the proper DRG weight. Assign a weight of 14.9944 and process to payment. Use a 51 day outlier threshold for discharges before October 1, 1987.

H. Handling Heart Transplant Billings From Nonapproved Hospitals.—Where a heart transplant and covered services are provided by a nonapproved hospital, the bill data processed through Grouper and Pricer must exclude transplant procedure codes and related charges. (See §3656.1.)

I. Effective Dates.—Coverage is effective for discharges no earlier than October 17, 1986 for facilities which applied by July 6, 1987.

HCFA informs the hospital of the effective date in the approval letter. You will receive a copy.

J. Approved Heart Transplant Facilities.—The facilities listed below have been approved as Medicare heart transplant facilities. The effective date for each is shown. If you have any questions, contact your RO.

List of Approved Medicare Heart Transplant Centers

Name & Address	Effective Date
Medical College of Virginia 11th and Marshall Sts. Richmond, VA 23298	October 17, 1986
Stanford University, University Hospital Stanford University Medical Center Stanford, CA 94305	October 17, 1986

University of Minnesota Hospital and Clinic 420 Delaware Street, S.E. Minneapolis, MN 55455	October 17, 1986
University Medical Center at the Arizona Health Sciences Center 1501 N. Campbell Av. Tuscon, AZ 85724	October 17, 1986
The Johns Hopkins Hospital 600 N. Wolfe St. Baltimore, MD 21205	October 17, 1986
Foster G. McGaw Hospital Loyola University Medical Center 2160 South First Av. Maywood, IL 60163	October 17, 1986 (revised date)
Methodist Hospital/Baylor College of Medicine The Methodist Hospital System 6535 Fannin, M.S. 101 Houston, TX 77030	October 17, 1986
Methodist Hospital of Indiana 1701 North Street Blvd. Indianapolis, IN 46202	October 17, 1986
Presbyterian University Hospital Desoto at O'Hara Sts. Pittsburgh, PA 15213	October 17, 1986
Washington University (Barnes Hospital) 4949 Barnes Hospital Plaza St. Louis, MO 63110	September 16, 1987
St. Louis University Hospital 3556 Caroline St. St. Louis, MO 63104	October 17, 1986
University Hospital University of Utah 50 North Medical Dr. Salt Lake City, UT 84132	October 17, 1986

Temple University Hospital Broad and Ontario Sts. Philadelphia, PA 19140	January 1, 1987
Pacific Presbyterian Medical Center 2333 Buchanan St. San Francisco, CA 94115	July 15, 1987
Brigham & Women's Hospital 75 Francis St. Boston, MA 02115	June 20, 1987
University Hospital University of Alabama Birmingham University Station Birmingham, Al 35294	October 17, 1986
St. Luke's Episcopal Hospital (Texas Heart Institute) P.O. Box 20269 Houston, TX 77225-0269	October 17, 1986
Jewish Hospital 217 East Chestnut St. Louisville, KY 40202-1886	April 7, 1988
The Cleveland Clinic Foundation 9500 Euclid Av. Cleveland, OH 44106	June 13, 1988
The Oregon Health Sciences University 3181 S.W. Sam Jackson Park Rd. Portland, OR 97201	June 15, 1988
Henry Ford Hospital 2799 West Grand Blvd. Detroit, MI 48202-2689	August 2, 1988
Latter Day Saints Hospital Eighth Ave and C St. Salt Lake City, UT 84143	April 14, 1988
Tampa General Hospital Davis Island P.O. Box 1289 Tampa, FL 33601	August 19, 1988

3613.1 Notifying Carriers.—To inform carriers when immunosuppressive drugs are reimbursable, make an extra copy of the Medicare Benefit Notice that gives the date of discharge for heart transplants. Send the copy to the appropriate carrier shown in §3612.4.

3618. PAYMENTS OF NONPHYSICIAN SERVICES HOSPITALS OBTAIN FOR HOSPITAL INPATIENTS

A. Services Included in PPS Payment.--The following medical items, supplies, and services furnished to hospital inpatients are covered as hospital services under Part A. Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A for hospitals excluded from prospective payment.

- Laboratory services (excluding anatomic pathology services);
- Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips;
- Radiology services, including computed tomography (CT) scans furnished to inpatients by a physician's office, other hospital or radiology clinic; and
- Total parenteral nutrition (TPN) services.
- Transportation including transportation by ambulance to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient. Hospitals include the cost of these services in the appropriate ancillary service cost center, i.e., in the cost of the diagnostic or therapeutic service. They are not shown separately under revenue code 540.

Exceptions

- Pneumococcal Vaccine

  Pneumococcal vaccine is payable under Part B only and is billed by the hospital on the HCFA-1450.

- Ambulance Service Other Than That Described in §3660.1

  For purposes of this section "hospital inpatient" means a beneficiary who has been formally admitted. It does not include a beneficiary who is in the process of being transferred from one hospital to another. Where the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable only under Part B. If transportation is by a hospital owned and operated ambulance, the hospital bills separately on form HCFA-1450. Similarly, if the hospital arranges for transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if the hospital does not assume any financial responsibility, the billing is to the carrier by the ambulance operator or beneficiary, as appropriate.

- Anesthetist Services "Incident to" Physician Services

  If a physician's practice was to employ anesthetists and to bill on a reasonable charge basis for these services and that practice was in effect as of the last day of a hospital's most recent 12 month cost reporting period ending before September 30, 1983, the physician may continue that practice through cost reporting periods beginning October 1, 1984. However, if the physician chooses to continue this practice, the hospital may not add the costs of the anesthetists' service to its base period costs for purposes of determining the hospital specific portion of its transition payment rates.

- Part B Inpatient Services

  Where Part A benefits are not payable, payment may be made to the hospital under Part B for certain medical and other health services.

Carriers are responsible for ensuring that they do not pay for nonphysician services provided to hospital inpatients. This requires coordination and data exchange between you and carriers. Send the carrier a duplicate of the PROBILL record that you furnish the PRO. (See §3770.1.) Furnish the carrier a record file with the same frequency with which you furnish the PROBILL file to the PRO. The carrier will process this in accordance with §3672.

B. Exception/Waiver.—The provisions of "A" above may be waived until cost reporting periods beginning on or after October 1, 1986, if the criteria contained in §2804 of the Provider Reimbursement Manual (HCFA Pub. 15-1) are met. Hospitals that believe they qualify for a waiver apply to the RO through you. Under prospective payment, approved waivers require you to deduct the Part B reasonable charges for services furnished by the outside suppliers from payments made to a PPS hospital.

C. Waiver is Approved for PPS Hospitals.—Carriers will notify you of claim payments so that an appropriate adjustment can be made to the Part A reimbursement. They provide the following information:

- Beneficiary's HICN
- Name
- Sex
- Hospital Provider Number
- Supplier ID Number
- Type and dates of service
- Amount allowed before application of deductible and coinsurance

Work out the specific format with the carriers. Use the information they provide to deduct the appropriate payment amount from a future payment to the hospital. It is not necessary to adjust the individual DRG payment, whether already made or not. However, make such deductions within 30 days of receipt of the carrier's notification. If the hospital contests the deduction, determine whether the deduction is appropriate, and if not, inform the carrier to recover its overpayment and to educate the supplier.

3620. DETERMINING COVERED/NONCOVERED DAYS AND CHARGES

Whether a day or charge is recorded as covered or noncovered is important because:

- o Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations from the program, including days paid by Medicare and days for which a provider was held liable.

- o The provider may claim credit on its cost report only for covered accommodations days and charges for which actual payment is made (i.e., provider liable days and charges are not included). Data from the bill payment process is used in preparing the cost report.

- o The number of days and charges provided to the Pricer program affects the day and cost outlier determination.

It is possible on a single bill to use a different number of days for each of the above purposes.

The provider enters on the bill the number of days it thinks are claimable as Medicare patient days on the cost report. Verify the accuracy and adjust the days if you determine fewer days are claimable (e.g., as a result of review by you or the PRO).

You must also determine the proper number of days to charge utilization to the beneficiary and the proper number of days for the length of stay used by Pricer.

The following factors affect the calculation of days for cost report, utilization record, and Pricer.

1. Admission Date Prior to Entitlement.—Do not count the days before entitlement for any of the cost report, utilization or Pricer.

2. Benefits Exhausted Pricer to Outlier Threshhold.—Count the days up to benefits exhausted for all three purposes. Do not count any days after benefits exhausted.

3. Provider Liable Days.—Charge utilization but do not count as cost report Medicare patient days or for Pricer.

4. Guarantee of Payment Days.—Do not charge utilization (there is no coverage left), but count for Medicare patient days and Pricer.

5. Day of Admission.—Count the day of admission for all three purposes.

6. Days of Discharge, Death, or Beginning a Leave of Absence.—Do not count this day for utilization, the cost report, or Pricer unless the admission and discharge are on the same day. In that case count it for all three purposes, unless the patient's

discharge status is 02 (transfer to another short-term hospital) or 03 (transfer to an SNF). If the discharge status is 02 or 03, no utilization day is taken. The receiving facility will take both the utilization day and any applicable deductible or coinsurance. If the patient is admitted with the expectation that he will remain overnight but is discharged, dies, or is transferred to a nonparticipating provider or nonparticipating distinct part of the same provider (discharge status 05) before midnight, the day counts as a utilization day, cost report day, and Pricer day.

7. Primary Payer Makes Partial Payment.--Where the primary payer paid part but not all of the bill count the days for the cost report and Pricer but see §§3679-3689 for instructions on calculating utilization. Where the primary payers paid the entire bill do not count the days for any of utilization, cost report, or Pricer.

3622. SPELL OF ILLNESS

Make spell of illness determinations in accordance with §3035, and these special instructions.

A. Beginning a Spell of Illness in a Nonparticipating Provider.—The noncovered services furnished by a nonparticipating provider can begin a spell of illness only if the provider is a qualified provider. A qualified provider is a hospital (including a psychiatric hospital) or a SNF which meets all requirement in the definition of such an instruction even though it may not be participating. (See §§3010, 3015, 3016, 3020, and 3035. For beginning a spell of illness for purposes of qualifying for posthospital home health benefits, see §3121.1A.)

It is most unlikely that a nonparticepating hospital which is not accredited by JCAH, or a nonparticipating SNF would satisfy the conditions of participation, particularly with regard to utilization review. Therefore, for spell of illness purposes, assume that nonparticipating providers are not "qualified providers" in the absence of evidence to the contrary. Situations which might constitute such contrary evidence include cases where the provider recently dropped out of the program, or after a survey by the State agency, decided not to participate even though the conditions of participation were met. Hospitals accredited by JCAH are deemed to meet all requirements except utilization review. For such a hospital, determine through the RO whether it has a utilization review plan in effect.

B. Continuing a Spell of Illness.—For purposes of continuing a spell of illness the hospital or SNF in which the stay occurs need not meet all requirements that are necessary for starting a spell of illness. (See §3035C.) An inpatient stay in a facility or part of a facility that is certified solely as an ICF, or licensed by the State solely at, or below, an ICF level of care, does not continue a spell of illness. If there has been a stay in an institution which might continue the spell of illness, and you cannot ascertain its status, contact the RO which maintains a list of all medical facilities and their status.

When adjudicating claims from hospitals and SNFs located in Maine, Massachusetts, New Hampshire, Rhode Island, Connecticut, Vermont, New York, New Jersey, Puerto Rico, the Virgin Islands, Delaware, Pennsylvania, Kentucky, Michigan, Ohio, and Tennessee for which a determination, either initial or a reconsideration, is made on or after January 1, 1985, the special definition of "inpatient" described in §3035.B.2 must be met to extend a spell of illness. This special rule also applies to determinations received by the beneficiary, or the beneficiary's representative, on or after August 7, 1982, for claims from hospitals and SNFs in Maine, New Hampshire, Vermont, Massachusetts, Connecticut, and Rhode Island. If the applicable skilled level of care standards were not met during a prior SNF stay after application of the presumptions outlined in §3035, the prior SNF stay does not continue a spell of illness.

NOTE: When reviewing cases where a prior SNF stay could affect spell of illness status, a proper sequence of consideration is:

- o Determine if the inpatient stay was in a facility or part of a facility certified solely as an ICF or licensed solely at, or below, an ICF level of care.

- o If the facility is determined to be a SNF, the spell of illness is continued with current utilization available to the beneficiary.

- o If the facility is determined to be an ICF, the spell of illness is not continued. A new spell of illness will restore full utilization and impose a cash deductible.

Only intermediaries adjudicating SNF or hospital claims from 16 jurisdictions, i.e., Maine, Massachusetts, New Hampshire, Rhode Island, Connecticut, Vermont, New York, New Jersey, Puerto Rico, the Virgin Islands, Delaware, Pennsylvania, Kentucky, Michigan, Ohio, and Tennessee, apply the special prior stay SNF inpatient rules to determine if the applicable skilled level of care standards for determining the definition of "inpatient," is met.

Application of the special rule and presumptions regarding SNF "inpatient" status is based strictly on the location of the SNF or hospital whose Medicare inpatient claims is being adjudicated (i.e., it applies to claims from SNFs and hospitals in the 16 jurisdictions). Application of the rule is not determined by the location of the SNF where any prior stay occurred.

Use the seven presumptions, and the instructions for their application, outlined in S3035 to determine whether the skilled level of care standards were met during a prior SNF stay. Apply the presumptions in sequence, i.e., if presumption 1 is applicable do not consider the others. If presumption 1 is not applicable, consider presumption 2, etc.

Some of the presumptions require a knowledge of Medicaid's claims processing involvement with the prior SNF claim. Use current bill data, accompanying documentation, bill history files, and telephone contacts with the prior stay facility and/or the Medicaid agency to develop the Medicaid aspects. Do not continue Medicaid development beyond a telephone contact. Conclude your consideration of the presumption at this point based upon the Medicaid information available.

- o If the applicable skilled level of care standards were met during a prior SNF stay, the spell of illness is continued with current utilization available to the beneficiary.

- o If the applicable skilled level of care standards were not met during a prior SNF stay, the spell of illness is not continued. A new spell of illness restores full utilization and imposes a cash deductible.

- o Presumptions 1 through 4 cannot be rebutted by the beneficiary while presumptions 5 through 7 can. Where the presumptions are rebuttable (i.e., (5) through (7)), rebuttal showings are permitted at your level and at the reconsideration level. Evaluate rebuttal documentation even if the presumption being rebutted was triggered by a Medicare denial. (See S3035.)

- o Presumptions 5 through 7 require you to send a special spell of illness notice to the beneficiary. Forms HCFA-1954 and HCFA-1955 are designated for some of the required notices. See SS3722.1 and 3722.12. The EOMB form or a special form may be used for other notices displayed in S3719.1C.

If necessary, use the new benefit period initializer code (used for Kron cases) to begin a new benefit period. See §3880.2, position 62. Do not submit dates of a noncovered stay if the stay does not begin or continue a spell of illness.

3624. PROCESSING NO-PAYMENT BILLS

A. General.—The benefit days available to a beneficiary depend upon the status of his utilization of services during the "spell of illness" and the lifetime reserve days described in §3106. Submission of bills by providers for all stays, including those for which no-payment can be made, is required to enable you and HCFA to maintain utilization records and determine remaining eligibility on subsequent claims.

Hospitals and SNFs prepare bills covering inpatient services in situations in subsection B in which no-payment can be made. Where payment may be made for part of the services, one bill is prepared covering payable and nonpayable days and services.

Do not permit providers to submit interim no-payment bills, unless they are submitted via EMC. (This avoids unnecessary data entry and processing expense.) Only one bill is needed for no-payment cases, regardless of the length-of-stay. It is submitted upon discharge or death.

See §3894.4 for counting no-payment bills on your workload report.

B. Nonpayment Codes.—Nonpayment codes are required in inpatient UNIBILL records for the hospital and SNF situations shown below where no-payment is made. (Outpatient bills and inpatient bills where partial payment is made do not require nonpayment codes.) These codes alert HCFA to bypass edits in UNIBILL processing that are not appropriate in nonpayment cases. Enter the appropriate code in location 1853 of the UNIBILL record if the no-payment situation applies to all services covered by the bill. Do not enter the nonpayment code if partial payment is made. Also, do not enter the nonpayment code when payment is made in full by an insurer primary to Medicare. When you identify such situations in your development or processing of the bill, adjust the bill data the provider submitted and prepare an appropriate UNIBILL record.

1. Benefits Exhausted Before "From" Date on Bill - Nonpayment Code B.—Benefits exhausted and either lifetime reserve days were also exhausted or the beneficiary elected not to use them.

2. Provider Liable Bills - Nonpayment Code R (All charges are shown as noncovered but utilization is charged.).—

- PRO denies admission and no-payment under waiver provisions is available (includes denials for no physician certification).
- You deny all SNF inpatient services.
- Time limitation for filing expired before billing and provider is at fault.
- Provider failed to submit needed information.
- Patient refused to request benefits.

3. Denials Without Provider Liability - Nonpayment Code N (neither utilization nor cost report days reported).

- o Services not covered under Part A (e.g., dental care, cosmetic surgery).
- o Time limitation for filing expired before billing and provider not at fault.
- o Waiver of liabilty decision finds beneficiary at fault.
- o Inpatient psychiatric reduction (150 days) used before admission. (See §3104.)
- o All services after active care ended in psychiatric (or tuberculoses) hospital.
- o All services after the date covered level of care ended (general hospital or SNF).
- o MSP cost avoidance denials. (See §3899.8.)

4. No Payment Situations Not Requiring Nonpayment Code.—

- o Payment cannot be made because deductible/coinsurance exceed the payment amount.
- o EGHP, LGHP, auto medical or no-fault insurance, WC (including BL), NIH, PHS, VA, other governmental entity or liability insurance paid for all covered services.
- o Services provided to HMO enrollee for which the HMO has jurisdiction for payment. Option code B or C in R trailer.

C. Intermediary Processing.—Providers complete all items on a no-payment bill in accordance with instructions for completing payment bills except that all charges may be summarized and reported as one revenue code (001). You must provide a complete UNIBILL record, indicating the appropriate number of utilization and cost report days to record. Charges on UNIBILL may be summarized under revenue code 001 (total and noncovered). Charge utilization for all days for which the beneficiary received program benefits, including days for which the provider is liable and days for which the HMO paid directly to the provider. Record cost report days for days which the provider may count as Medicare days in the cost report. Do not charge either utilization or cost report days where the beneficiary is liable. Enter the appropriate nonpayment code as described in subsection B.

If charges are covered by Medicare, they are carried on the cost report, but if the charges are not covered, they are not shown.

NOTE: Charges for services paid by risk HMOs are not included in the PS&R system. Therefore, charges are shown as covered to avoid edit exception.

3626. HOSPITAL BILLING FOR INPATIENT PART B AND OUTPATIENT SERVICES

3626.1 Inpatient Part B Services.—Participating hospitals use form HCFA-1450 to bill for the following services furnished directly or under arrangements to inpatients whose benefit days are exhausted or who are otherwise not entitled to have payment made under Part A. (See S3110.)

- o Diagnostic X-ray tests, diagnostic laboratory, and other diagnostic tests.
- o X-ray, radium, and radioactive isotope therapy, including materials and services of technicians. (See S3146.)
- o Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations. (See S3110.3.)
- o Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement or repair of such devices. (See S3110.5.)
- o Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or change in the patient's physical condition. (See S3110.5.)
- o Outpatient physical therapy services furnished inpatients. (See SS3147ff.)
- o Outpatient speech pathology services furnished inpatients. (See SS3147ff.)
- o Outpatient occupational therapy services furnished inpatients. (See SS3147ff.)

Part B coverage for services furnished by a participating hospital to its inpatients is limited to the above items and services.

3626.2 Outpatient Services.—Section 3604 contains general instructions for review of form HCFA-1450. Hospitals use this form to bill for covered outpatient services (type of bill 13). (See S3112.1 for definition of outpatient.)

If the patient is admitted as an inpatient on the day he received outpatient services or before midnight of the following day, the services are considered part of the inpatient services.

Hospitals do not put charges for Part B services for separate cost accounting years on the same bill. Separate bills are prepared with each including charges for each year.

No bill is submitted if:

- o The patient is not enrolled under Part B;

- Only noncovered services were provided; or

- Payment in full was made by a primary payer. (See §§3679-3685 for a description of such payers and the exception that requires billing to credit the deductible in EGHPs.)

Deny any bills received in the above situations.

3626.3 Calculating the Part B Payment.--Under Part B, the patient is responsible for a cash deductible for covered services and a blood deductible for blood furnished in a calendar year. After the deductibles are met, the patient pays 20 percent (coinsurance) of the reasonable charges (e.g., billed charges) for covered services.

You must query your deductible met file and/or HCFA's central records to determine deductible status. (See §3500 for related procedures.)

To determine the coinsurance amount, exclude any charges for clinical diagnostic lab services and deduct the unmet deductible from the covered charges. Multiply the remainder by 20 percent. The result is the coinsurance applicable to the claim.

3626.4 Reporting Outpatient Surgery and Other Services.—

A. General.—Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 (OBRA), P.L. 99-509 requires that beginning July 1, 1987 (i.e., the "from date" on the bill), hospitals must report outpatient services provided to Medicare beneficiaries using HCPCS. HCFA developed HCPCS by using the American Medical Association's Current Procedural Terminology, 4th Edition (CPT-4) for physician services and adding HCFA developed codes for certain nonphysician services. All of the CPT-4 is contained within HCPCS.

Hospitals will use the CPT-4 portion of HCPCS to report significant outpatient surgical procedures (clinical diagnostic lab services had been and continue to be coded using HCPCS) and use revenue codes, with some expansion to three digit codes, for all other services.

One bill is required for all services provided on the day the procedure(s) is performed. (An exception is allowed for hospital bills that include preoperative services. That is, preoperative services provided prior to the day of surgery may be included on the same bill.)

B. Reporting Surgery.—

1. Definition of Surgery.—Hospitals are required to report HCPCS codes for all significant surgical procedures. Significant surgery is defined as incision, excision, amputation, introduction, repair, destruction, endoscopy, suture or manipulation. This is the current definition in the Intermediary and Hospital Manuals and is consistent with the Uniform Hospital Discharge Data Set. The codes for surgery are in the CPT-4 portion of HCPCS beginning with 10000 and ending at 69979. Hospitals will report procedures performed in this section except for specific out-of-scope procedures (e.g., venipuncture, catheter insertion, and physician global fee codes) listed in Addendum F.

Except for these out-of-scope procedures, hospitals use HCPCS codes for all surgical procedures performed on outpatients, including both ASC approved surgical procedures and other significant non-ASC surgical procedures. If out-of-scope procedures are reported, the OCE program and the ASC Pricer program will identify them and establish the correct bill type. Therefore, do not return bills with incorrect bill codes 83x or 13x because of these surgical procedures.

2. Type of Bill.—Hospitals use Form HCFA-1450 to bill for outpatient surgical and other procedures. Section 3604 contains general instructions for bill review. Report bill type 83x to the PS&R system for claims subject to the ASC payment limit. This bill type permits separate identification of revenue code charges for the PS&R when these surgical procedures are involved. The OCE program will tell you whether bill type 83x or 13x is applicable for the PS&R system. Therefore, it is not necessary for your claims processing, for the hospital to enter the correct bill type.

If the hospital reports 83x but not a designated procedure, develop to determine whether the type of bill is incorrect or a procedure code is missing.

3. Selecting and Reporting Procedure Codes.—Using medical records as basic sources, hospitals report HCPCS surgical procedure codes for outpatient surgery in Item 50 (to the right of the dotted line) adjacent to the revenue code for the operating room or other room used for the surgery. The bill includes the hospital's charges for the surgery as well as all other services provided on the day the procedure was performed.

Usually only one surgical procedure is entered on a bill. However, upon occasion, more than one outpatient surgical procedure might be rendered at the same session. In such cases, all significant surgical procedures are reported in Item 50. However, hospitals will not allocate charges among procedures. Only one charge for each room used to perform a procedure appears on the bill. When more than one procedure is reported, the accommodation revenue code is repeated as often as necessary. The revenue code for each procedure is repeated with "O" charges in Item 53 and with a HCPCS code in Item 50.

Install an edit in your system to require at least one HCPCS code when revenue code 36x (operating room) is billed unless diagnosis code V64.1, V64.2, or V64.3 is present indicating that the procedure was not carried out. Do not use the additional revenue codes listed in subsection C for this edit unless there are special SUBC instructions which require HCPCS codes with other revenue codes.

a. ASC Procedures.—Effective for hospital cost reporting periods beginning on or after October 1, 1987, reimbursement for the covered ambulatory surgical center procedures performed on an outpatient basis and identified in Addendum F is based in part on what the program would pay for the same surgical procedure if it were performed in an approved ASC. The aggregate payment for these surgical procedures is the lesser of:

o The amount that would be paid under the traditional Medicare reasonable cost/customary charge methodology for outpatient services; or

o An amount based on a blend of the hospital payment under reasonable cost/customary charge reimbursement methodology and the ASC payment. For cost reporting years beginning during FY 1988, the blend is 75 percent cost/customary charge payment and 25 percent ASC rate. For cost reporting years beginning FY 1989 (and subsequent years), the blend is 50 percent cost/customary charge payment and 50 percent ASC rate.

If any ASC covered procedure listed in Addendum F is performed, it must be reported to permit application of the new payment system.

When more than one significant procedure is performed in one operative session, the hospital reports all surgical procedures on the bill. The order in which procedures are reported is not material. The ASC Pricer program determines which procedures are covered by the ASC limits and arrays them in the proper order for calculating payment.

For cost reporting periods beginning on or after October 1, 1987, the payment amounts for ASC surgical procedures performed on an outpatient basis is based in part on the ASC rates (see subsection C). Maintain a rate file; determine the procedure price on a bill-by-bill basis; and when necessary, apply 100 percent of the rate to the most expensive ASC listed procedure and 50 percent of the rate for other ASC listed procedures.

The final payment for ASC surgical procedures is handled through the cost settlement process. Therefore, as bills are processed, the PS&R accumulates facility charges attributable to ASC procedures (by identifying the charges billed under certain revenue codes) and the ASC payment rate for each procedure, based upon the HCPCS code. Periodically review the payment data accumulated in the PS&R (see subsection E) and make any necessary adjustments to the outpatient interim rate to determine if the hospital's charges or costs are substantially higher than the ASC rate. This avoids program overpayment.

b. Special Payment Rate Extension for Eye and Eye and Ear Specialty Hospitals.—A hospital is allowed an extension of the blended payment of 75 percent of the Medicare reasonable cost/charge reimbursement amount and 25 percent ASC amount if it meets specific requirements. This extension is applicable for cost reporting periods beginning in Federal FYs 1989 and 1990 (i.e., hospital cost reporting periods beginning on or after October 1, 1988 and before October 1, 1990). The requirements are:

o The hospital specializes in eye, or eye and ear services to the extent that more than 50 percent of its total Medicare inpatient DRGs during the cost reporting period are DRGs 36 through 74;

o It receives more than 30 percent of its total revenues from outpatient services; and

o It met the criteria for an eye, or eye and ear specialty hospital on October 1, 1987.

The hospital must demonstrate to you that it meets these criteria based on its cost reporting period beginning on or after October 1, 1986 and ending before October 1, 1987. Advise the RO of any hospitals meeting the criteria.

For cost reporting periods beginning on or after October 1, 1990, the blended payment amount reverts to a 50 percent reasonable cost/charge reimbursement amount and a 50 percent ASC amount.

Apply the blended payment calculation during cost settlement. No changes are required in your claims processing operation, the ASC Pricer or the PS&R.

A hospital in a State receiving payment under a State reimbursement control system under §1814(b)(3) or 1886(c) of the Act uses inpatient data comparable to the DRG data cited above to demonstrate that it meets the requirements.

A hospital which believes it qualifies as an eye, or eye and ear, specialty hospital, but which is not subject to PPS, may meet the first criterion by demonstrating to you that more than 50 percent of its inpatient revenues are attributable to admissions pertaining to eye, or eye and ear, diagnoses.

In addition to meeting these requirements, the hospital must submit a written request to you as soon as possible before the beginning of its first cost reporting period beginning on or after October 1, 1988. After reviewing the request, notify the hospital of your decision.

c. Non-ASC Surgical Procedures.--HCPCS surgical codes are required for billing outpatient hospital surgical procedures that are not included in the ASC listing. Continue to use bill type 13x.

d. Unlisted Service or Procedure.--There may be services or procedures performed that are not found in HCPCS. These are typically services that are rarely provided, unusual, variable, or new. A number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure code is used, an operative report desciribing the service is submitted with the claim. Pertinent information includes a definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service.

When you receive a claim with an unlisted procedure code, review it to verify that there is no existing code that adequately describes the procedure. If you determine that an adequately descriptive code is contained in codes 10000-69979 of the CPT-4 portion of HCPCS, advise the hospital of your determination and process the claim. If your review determines that no existing code is sufficiently descriptive, pay the claim and forward a copy and the operative report to CO for a code determination. When you receive a determination from CO, inform the hospital of the correct code for future reporting.

Health Care Financing Adminstration
Office of Program Operations Procedures, BPO
1-H-3 Meadows East Bldg.
6325 Security Blv.
Baltimore, MD 21207

NOTE: If the claim was submitted via EMC or identified after the bill has been processed, an operative report, the provider number, revenue codes, and charges are sufficient.

The "Unlisted Procedures" and accompaning codes for surgery are:

15999 Unlisted procedure, excision pressure ulcer
17999 Unlisted procedure, skin, mucous membrane and Subcutaneous tissue
19499 Unlisted procedure, breast
20999 Unlisted procedure, musculoskeletal system, general
21499 Unlisted orthopedic procedure, head
21899 Unlisted procedure, neck or thorax
22899 Unlisted procedure, spine
22999 Unlisted procedure, abdomen, musculoskeletal system
23929 Unlisted procedure, shoulder
24999 Unlisted procedure, humerus or elbow
25999 Unlisted procedure, forearm or wrist
26989 Unlisted procedure, hands or fingers
27299 Unlisted procedure, pelvis or hip joint
27599 Unlisted procedure, femur or knee
27899 Unlisted procedure, leg or ankle
28899 Unlisted procedure, foot or toes
29799 Unlisted procedure, casting or strapping
29909 Unlisted procedure, arthroscopy
30999 Unlisted procedure, nose
31299 Unlisted procedure, accessory sinuses
31599 Unlisted procedure, larynx
31899 Unlisted procedure, trachea, bronchi
32999 Unlisted procedure, lungs, and pleura
33999 Unlisted procedure, cardiac surgery
36299 Unlisted procedure, vascular injection
37799 Unlisted procedure, vascular surgery
38999 Unlisted procedure, hemic or lymphatic system
39499 Unlisted procedure, mediastinum
39599 Unlisted procedure, diaphragm
40799 Unlisted procedure, lips
40899 Unlisted procedure, vestibule of mouth
41599 Unlisted procedure, tongue, floor of mouth
41899 Unlisted procedure, dentoalveolar structures
42299 Unlisted procedure, palate, uvula
42699 Unlisted procedure, salivary glands or ducts
42999 Unlisted procedure, pharynx, adenoids, or tonsils
43499 Unlisted procedure, esophagus
43999 Unlisted procedure, stomach
44799 Unlisted procedure, intestine

44899 Unlisted procedure, Meckel's diverticulum and the mesentery
45999 Unlisted procedure, rectum
46999 Unlisted procedure, anus
47399 Unlisted procedure, liver
47999 Unlisted procedure, biliary tract
48999 Unlisted procedure, pancreas
49999 Unlisted procedure, abdomen, peritoneum, and omentum
53899 Unlisted procedure, urinary system
55899 Unlisted procedure, male genital system
58999 Unlisted procedure, female genital system nonobstetrical
59899 Unlisted procedure, maternity care and delivery
60699 Unlisted procedure, endocrine system
64999 Unlisted procedure, nervous system
66999 Unlisted procedure, anterior segment of eye
67299 Unlisted procedure, posterior segment
67399 Unlisted procedure, ocular muscle
67599 Unlisted procedure, orbit
67999 Unlisted procedure, eyelids
68399 Unlisted procedure, conjunctiva
68899 Unlisted procedure, lacrimal system
69399 Unlisted procedure, external ear
69799 Unlisted procedure, middle ear
69949 Unlisted procedure, inner ear
69979 Unlisted procedure, temporal bone, middle fossa approach

C. Determining ASC Payment Rate.—

1. Payment Categories.—Covered ASC surgical procedures (see Addendum F) are grouped into four categories for Medicare reimbursement purposes. Surgical procedures not included in Addendum F are not covered under these payment limitation provisions. Payment for facility services furnished on an outpatient basis by a hospital is based, in part, on the rates that would be paid for the facility services if the procedure had been performed by an approved ASC. This is accomplished through the cost settlement process. Procedures performed in an ASC are paid at one of four group rates, adjusted for the regional wage index. The current rates, published in the June 1, 1987 *Federal Register* are:

- Group 1..............$274
- Group 2..............$326
- Group 3..............$351
- Group 4..............$399

2. Services Included in Facility Cost.—The rate for ASC surgical procedures listed in Addendum F includes all facility services directly related to the procedure(s) that are provided on the day of surgery. In general, "facility services" include, but are not limited to nursing and technician services, use of the facility, drugs, biologicals, surgical dressings, splints, casts and equipment directly related to provision of the surgical procedure,

materials for anesthesia, administrative, recordkeeping and housekeeping items and services. Facility services do not include items and services such as physicians' services, laboratory, X-rays, or diagnostic procedures (other than those directly related to the performance of the surgical procedure), prosthetic devices, ambulance services, leg, arm, back, and leg braces, artificial limbs, and DME for use in the patient's home.

Separate payment is not made for the following services directly related to the surgery. Services reported under the following revenue codes (where surgery identified by Addendum F is reported) are subject to the ASC payment limitation.

a. The Use by the Patient of Hospital Facilities.--This includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to the patient's relatives in connection with surgical procedures. It includes all services in connection with covered procedures furnished by nurses, technical personnel and others involved in patient care.

Whenever a surgical procedure is performed, one or more of the following revenue centers is used to reflect the charges for items and services provided in connection with the procedure:

- 25x Pharmacy
- 270 Medical/surgical supplies-devices (general)
- 272 Sterile supply
- 36x Operating Room Services;
- 37x Anesthesia
- 38x Blood
- 39x Blood storage and processing
- 45x Emergency Room;
- 49x Ambulatory Surgical Care;
- 51x Clinic;
- 52x Free-Standing Clinic;
- 70x Cast Room;
- 71x Recovery Room;
- 75x Gastro-Intestinal Services;
- 76x Treatment or Observation Room;
- 920 Other Diagnostic Services General;
- 929 Other Diagnostic Services, other (codes 921-925 are excluded and may be used to report nonfacility services);
- 940 Other Therapeutic Services, General; and
- 949 Other Therapeutic Services, other (codes 941-945 are excluded and may be used to report nonfacility services).

These revenue codes include diagnostic or therapeutic items and services furnished by the hospital staff in connection with a covered ASC surgical procedure. With respect to diagnostic tests, some providers perform simple tests just before surgery, primarily urinalysis and blood hemoglobin or hematocrit. To the extent that they are provided by the hospital on the day of surgery and the charges have been included in the operating room or comparable revenue center, they are included in the definition of outpatient hospital facility services.

b. Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment.--This includes all supplies and equipment commonly furnished by the ASC in connection with surgical procedures (see subsection D for certain exceptions). Drugs and biologicals are limited to those which cannot be self-administered. (See §3112.4.)

Medicare coverage for surgical dressings is limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions on the skin or on openings to the skin required as the result of surgical procedures. Primary dressings are usually applied first by a physician. In the hospital outpatient setting, these dressings are included as facility services. Items such as Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are generally used as secondary coverings and, are not subject to the ASC payment limitation. These items should be billed under a revenue code other than those listed in (a).

Other covered supplies, splints, and casts include only those furnished by the hospital at the time of the surgery. Additional covered supplies and materials furnished later are generally furnished as "incident to" a physician's service, not as a hospital service. The term supplies includes those required for both the patient and hospital personnel, i.e., gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

The hospital revenue code for drugs is:

- o 25x Pharmacy

For hospitals that use the classification other than 0 - General classification, the following codes are included:

- o 251 Generic Drugs;
- o 252 Nongeneric Drugs;
- o 257 Nonprescription;
- o 258 IV Solutions;
- o 259 Other Pharmacy.

Because drugs and biologicals coverage is limited to those which cannot be self-administered, revenue code 253 is not included. Revenue code 256 is also excluded as experimental drugs are not covered.

In order to identify the supplies and equipment commonly furnished in connection with surgical procedures in a manner comparable to their identification for inclusion in the ASC facility services, it is necessary to code at the third digit level. If hospitals report items described in revenue codes 273-279 under 270, they may lower the hospital's total reimbursement by making these charges or applicable cost subject to the blended payment amount limitation. Therefore, hospitals are encouraged to report all services at the detail level.

The codes for supplies included in the ASC payment limitation are:

- o 270 Medical Surgical Supplies;
- o 272 Sterile Supply.

c. Blood, Blood Plasma, Platelets, Etc..—Revenue codes include:

- o 38x Blood;
- o 39x Blood Storage and Processing.

d. Materials for Anesthesia.—These include the anesthetic itself and any necessary materials, whether disposable or reusable. Covered ASC facility services do not include the services of a certified registered nurse anesthetist (CRNA). Separate identification of these services is not necessary as they can be determined at cost settlement.

The revenue code for anesthesia services is:

- o 37x Anesthesia

Hospitals that use the classification other than "0-General Classification," revenue code 379 is included in the definition of outpatient hospital facility services while revenue code "374-Acupunture" is not, since it is not covered by Medicare.

D. Services Not Included In the Definition of Outpatient Hospital Facility Services.-Revenue codes not described in subsection C are excluded from the ASC payment limitation because the services they describe are not facility services for purposes of establishing the ASC payment rates. A discussion of the most commonly used codes follows. Where these, or other services not described in subsection C are reported on a bill for services covered by the ASC payment limitation, the ASC Pricer program provides you data to accumulate separate transactions for the PS&R system. See §3656.4 for the ASC Pricer program.

The sale, lease or rental of DME to ASC patients for use in their homes is excluded from the covered ASC facility services payment. When the hospital supplies DME in connection with a covered procedure, the charges are excluded from the definition of outpatient hospital facility services. The code for DME is:

- o 29x Durable Medical Equipment

Some ASCs perform simple diagnostic tests just before surgery, primarily urinalysis and blood hemoglobin or hematocrit, which are generally included in their facility charges. These simple tests, included in the ASC's facility charges, are considered facility services.

However, in most cases, diagnostic tests performed directly by an ASC are not considered ASC facility charges. If hospitals are presently performing these simple tests just before surgery and not submitting separate charges under the laboratory revenue codes, that practice should continue. However, except for the limited number and type of diagnostic tests noted above, charges for laboratory services are excluded from the definition of outpatient hospital facility services. Clinical diagnostic laboratory services are paid under the lab fee schedule. The revenue codes for these services are:

- 30x Laboratory
- 31x Laboratory Pathological

If an ASC furnishes ambulance services, they are not included in the ASC facility payment. Therefore, they are not included in the definition of outpatient hospital facility services. The revenue code for ambulance services is:

- 54x Ambulance

Prosthetic devices, whether implanted, inserted, or otherwise applied by covered surgical procedures are covered, but are not included in the ASC facility payment amount. Therefore, they are not included in the definition of hospital outpatient facility services that are subject to the ASC payment limitation. If hospitals report items described in revenue codes 273-279 under 270, the effect maybe to lower the hospital's total reimbursement by making these charges subject to the ASC limitation. Therefore, hospitals are encouraged to report such services at the detail level. The revenue code for prosthetic devices is:

- 274 Prosthetic Devices

Leg, arm, back, and neck braces as well as artificial legs, arms, and eyes are not considered part of an ASC facility service and are not included in the ASC facility payment rate. Charges for these items or equipment are, therefore, not included in the definition of hospital outpatient facility services for calculating the ASC payment limitation. Note that all revenue codes in the series 27x are excluded except "272 -Sterile Supply" which is included. Code 270, if used, is assumed to be sterile supply and subject to the ASC payment limitation.

Other categories in 27x not included in the ASC payment limitation are:

- 273 Take Home Supplies;
- 274 Prosthetic Devices;
- 275 Pacemaker;
- 277 Oxygen - Take Home;
- 278 Other Implants; and
- 279 Other Devices.

NOTE: There is no 271.

Physician services furnished in connection with a covered procedure are not subject to the ASC payment limitation. Hospitals continue to bill for these services as they do now.

E. Payment Rates.—You will be provided an ASC Pricer program to calculate payment rates for ASC surgical procedures. (See §3656.4.) Install this program before the beginning of the cost reporting year for the first hospital(s) in your service area beginning on or after October 1, 1987. In calculating the appropriate rate, the adjustment program performs the following.

1. Adjustment of Payment Rates.—A wage index has been developed by HCFA and the BLS is used to adjust ASC payment rates. The same wage index is used to calculate the payment limitation for hospitals. (See §3656.4.)

The ASC Pricer program uses the following procedure for adjusting the National ASC payment rates:

o Locates the appropriate wage index number for each MSA in a State, and for rural areas in a State.

o Divides the rate into labor (one-third) and nonlabor (two thirds) components for each payment rate.

o Multiplies the labor component of the rate by the appropriate wage index number.

o Adds the adjusted labor component to the unadjusted nonlabor component.

The sum is the adjusted payment rate.

EXAMPLE: Adjustment of group 4 rate ($399) for an ASC located in Baltimore, MD. The appropriate index number is 1.1698.

Adjusted Rate = [($399 x 1/3) x 1.1698] + ($399 x 2/3)
= ($133 x 1.1698) + $266
= $155.58 + $266
= $421.58

2. Calculating ASC Limitation for Multiple Procedures.—Where a beneficiary has more than one ASC surgical procedure performed in the same operative session, special payment rules apply. The ASC Pricer program calculates the full rate for the procedure classified in the highest payment group when two or more ASC procedures are performed. Any other ASC procedures furnished in the same session are paid at 50 percent of their applicable rate. If the procedures are in the same group, the adjustment program calculates the payment at the full rate for one, and 50 percent of the rate for the other procedures.

EXAMPLE: A beneficiary receives a group 4 and a group 1 procedure in the same session. Total payment is calculated as follows:

Adjusted Rate for Group 4 = [($399 x 1/3) x 1.1698] + ($399 x 2/3)
= ($133 x 1.1698) + $266
= $155.58 + $266
= $421.58

Adjusted Rate for Group 1 = 1/2 x $274
= [($137 x 1/3) x 1.1698] + ($137 x 2/3)
= ($45.66 x 1.1698) + $91.32
= $53.41 + $91.32
= $144.73

Total Adjusted Payment For
Both Procedures = $421.58 + $144.73
= $566.31

With one exception, all covered ASC procedures listed in Addendum F are considered single procedures. Therefore, payment is made at the same rate, as an example, inguinal herniorrhaphy, without respect to whether the procedure is furnished unilaterally or bilaterally. Bilateral procedures requiring a separate incision that are performed at the same operative session are identified separately, using the appropriate five digit code. The use of modifier codes to identify bilateral procedures is not acceptable. The only exceptions to this rule are CPT-4 code 66983 (intracapsular cataract extraction with insertion of intruocular lens posthesis) and 66984 (extracapsular cataract removal with insertion of intracocular lens prosthesis). These codes are considered as two procedures. As such, payment is made at 150 percent of the applicable group 4 rate ($598.50 plus or minus local wage adjustment).

3. Handling Non-ASC Services.—

a. Procedures.—When all procedures on the bill are non-ASC procedures, the bill is exempt from the ASC payment limitation. Also, when there is a mix of ASC and non-ASC procedures, the bill is not subject to the ASC payment method.

NOTE: Procedures listed in Addendum F, i.e., out-of-scope procedures, do not remove a bill from the ASC limitation.

b. Revenue Codes.—Where revenue codes are included on the bill for services not included in the ASC facility services, the ASC Pricer program prepares separate transaction records for the PS&R. It accumulates ASC revenue code charges applicable to facility services and revenue code changes applicable to nonfacility services (i.e., medical and other health services) under different bill types. ASC facility services are accumulated under bill type 83x and nonfacility services under bill type 13x. See §3656.4 for a description of the ASC Pricer program.

Preparation of separate transactions occurs after your preparation of UNIBILL and does not affect the UNIBILL record.

F. Coinsurance and Deductibles.—Coinsurance and deductibles are applicable to ambulatory surgery services.

G. Reporting of Other Outpatient Services.—The UB-82 (HCFA-1450) revenue codes are used for the billing of significant procedures (other than surgery) and for other outpatient hospital services. No additional coding entries beyond the revenue codes is required.

H. Relationship of Lab Fee Schedules.—The fee schedule for clinical diagnostic lab services applies to bill type 13x, 14x, and 83x. (See §3628.) Lab services furnished in connection with surgery on the ASC list are not included in the ASC facility services. Hospitals continue to bill for lab services as now.

I. Editing Procedures Codes on Outpatient Bills.—Process all outpatient bills through the OCE. (See §3656.5.) Installation of the program is required by July 15 to process bills for services provided on or after July 1. Do not return bills prepayment for coding correction until October 1, 1987. In October, you may return bills based on any of your receipt date, your OCE run processing date, or the from date on the bill.

During July, August, and September 1987 prepare and distribute to each hospital a report describing its coding performance as reported by the OCE. Prepare the report no less frequently than monthly. Weekly is preferable. The first report is due August 10 for bills processed by OCE through July 31. Use the error condition codes in §3656.5, and furnish a copy of the edits description contained therein.

J. EMC Formats.—

1. Standard Tape Format.—Record type 61 is used to report outpatient services. Record type, sequence number, patient control number (if used), revenue code, HCPCS procedure code, units, charges, and noncovered charges are required. Modifiers and dates of service are not. The date of service will be determined from the "from" and "through" dates shown in record 20. Include other record types as appropriate.

2. Direct Data Entry.—You are responsible for determining where to locate the HCPCS procedure code on your data entry screen.

K. UNIBILL.—Report the surgical procedure codes in the financial data section (field 32-40). Include revenue code, HCPCS, revenue units, and covered charges in the record. Where more than one HCPCS procedure is applicable to a single revenue code, the hospital shows all ASC procedure charges and revenue code units on the first line and repeats the revenue code with zero charges and units as often as necessary to include each HCPCS code on a separate line. If the procedure is done more than once, it is listed once for each occurrence in the UNIBILL report as above. Use override code 4 in field 40 to by-pass HCFA edits requiring charges with revenue codes.

The ASC rate is not required in UNIBILL. The rate is determined after UNIBILL preparation.

L. Medical Review of Ambulatory Surgery.—Effective with PRO contracts entered into or renewed on or after January 1, 1987, PROs will be required to review some or all of the ambulatory surgical procedures provided in hospital outpatient departments (and ASCs). Plan now to furnish the PRO a UNIBILL record for outpatient surgery when review becomes operational. Include initial bills, adjustments, and RTI corrections. See §3770.1A for data required by the PRO and intermediary editing required. Attending physician and operating physician identification numbers are required data elements. Admission type, admission source, admitting diagnosis, and readmission indicators are not required for outpatient bills. All other data and edit requirements apply. Your outpatient medical review processes continue. However, instead of receiving ICD-9-CM codes and dates in Items 84-86, you will receive HCPCS codes without dates in column 50.

M. Relationship to Inpatient Services.—The rule for treating outpatient services furnished to an individual who is subsequently admitted to the same hospital as an inpatient before midnight of the next day as Part A inpatient services is unaffected. (See §3610.3.) These provisions are not applicable to payment under Part B for medical and other health services provided to hospital inpatients when Medicare Part A benefits are not payable. (See §3110.)

N. Excluded Hospitals.—The following hospitals and distinct part hospital units are not subject to the ASC payment limitation. However, they must comply with the coding and billing requirements described in subsection B.

- Hospitals participating in a HCFA approved demonstration project or State reimbursement control system applicable to outpatient services. Areas receiving this waiver are Maryland and Rochester, New York.

- Indian Health Service hospitals that qualify under §1880(a) of the Act.

3627. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

HCPCS is based upon the American Medical Association's (AMA) Physicians' Current Procedural Terminology, Fourth Edition (CPT-4). It includes three levels of codes and modifiers. There is an upward progression of codes from the lowest (local assignment) to the highest level (national assignment). HCFA monitors the system to ensure uniformity. Level I contains only the AMA's CPT-4 codes with the exception of anesthesiology services. This level consists of all numeric codes. The second level contains the codes for physician and nonphysician services which are not included in CPT-4, e.g., ambulance, DME, orthotics and prosthetics. These are alphanumeric codes maintained jointly by HCFA, the Blue Cross and Blue Shield Association and the Health Insurance Association of America.

The AMA updates and republishes CPT-4 annually and provides HCFA with a magnetic tape containing the updated data. HCFA updates the alphanumeric (Level II) portion of HCPCS and incorporates the updated AMA material to create the HCPCS file. The file is duplicated and distributed to Medicare contractors and State agencies in hardcopy and on magnetic tape using the format shown in Exhibit 2. The local codes are also alphanumeric, but are restricted to the series beginning with W, X, Y, and Z. To the extent that you have required providers to use Level II coding (e.g., HHAs for DME claims), furnish them copies of the codes and definitions, or refer them to the GPO for their purchase at:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402

For credit card order, call (202) 783-3232

Level III (local assignment) contains the codes for services needed by individual contractors or State agencies to process Medicare and Medicaid claims. They are used for items and services not having the frequency of use, geographic distribution or general applicability needed to justify a code assignment at a higher level.

Issuance of Level III codes is coordinated by the RO, which in turn notifies CO of the codes assigned. Part B carriers are the only Medicare contractors authorized to make Level III coding assignments. Medicaid State Agencies are authorized to assign Level III codes for items and services unique to their programs, i.e., no other third party payer makes reimbursement for these items.

Local codes needed by you and Medicaid State Agencies for items and services reimbursable by multiple third party payers are to be requested through the local Part B carrier. Carriers may establish reasonable criteria for code assignments, such as a minimum frequency of occurence of a service. It is not appropriate to request assignment of codes for items rarely furnished. The occasional service is correctly reported in a miscellaneous code (ending in "99") generally referred to as "not otherwise classified" (NOC). Use discretion in requesting assignment of local codes, remembering that there are finite numbers of codes available for local assignment, that once issued a number cannot be reused for a minimum of three years, and that all parties involved with the coding system have to maintain and update their systems to reflect current coding assignments. (See §3627.2.)

If the Part B carrier is not responsive to a request for Level III assignment, refer the matter to the HCPCS coordinator in the RO. Do not delay claims processing (except for laboratory claims) pending a local code assignment. Use the appropriate NOC code. See §3628H for special considerations involved in assignment of local codes for laboratory services. See §3626.4C. for action required in processing outpatient claims with unlisted procedure codes.

3627.1 Use and Maintenance of CPT-4 in HCPCS.--The text contains over six thousand service codes, and descriptors plus titles and modifiers and is copyrighted by the AMA. The AMA entered into an agreement with HCFA which states:

o The AMA permits HCFA, its agents, and other entities participating in programs administered by HCFA, to use CPT-4 codes and terminology in HCPCS;

o HCFA shall adopt and use CPT-4 in connection with HCPCS for reporting services under Medicare and Medicaid;

o HCFA agrees to include a statement in HCPCS that participants are authorized to use the copies of CPT-4 material in HCPCS only for purposes directly related to participating in HCFA programs and that permission for any other use must be obtained from the AMA;

o HCPCS shall be prepared in format(s) approved in writing by the AMA which include(s) appropriate notice(s) to indicate that CPT-4 is copyrighted material of the AMA;

o Both AMA and HCFA will encourage health insurance organizations to adopt CPT-4 for the reporting of services to achieve the widest possible acceptance of the system and the uniformity of services reporting consistent therewith; and

o The AMA recognizes that HCFA and other users of CPT-4 may not provide reimbursement under their programs for certain procedures identified in CPT-4. Accordingly, HCFA and other health insurance organizations may independently establish policies and procedures governing the manner in which the codes are used within their operations.

o The AMA Editorial panel has the sole responsibility to revise, update, or modify CPT-4 codes.

You may edit and abridge CPT-4 data within your claims processing area. You are not allowed to publish, edit, or abridge versions of CPT-4 for distribution outside of your claims processing structure. This would violate copyright laws. You may print the codes and approved narrative descriptions in newsletters that instruct providers in how and when to use certain codes when reporting services on claims forms, e.g., services subject to ASC limitation, out-of-scope services, need for documentation of services, handling of unusual circumstances, reporting new and changed codes. However, your newsletter must show "CPT-4 Copyright AMA" in close proximity to listed CPT codes and descriptors. You may also print the code and approved narrative description in development requests relating to individual cases.

3627.2 Addition, Deletion and Change of Local Codes.--When you determine that there is a service or procedure which appears to require a HCPCS Code, but does not have one, see §3628H, if it is a laboratory procedure and §3626.4 if it is a surgical procedure performed in the outpatient department of a hospital.

A suggested format for local code proposals is in Exhibit 1. If a local code is necessary:

o Identify the component making the request and its address, i.e., contractor name and number.

o Provide the descriptor or terminology to be used.

o Describe the reason the code assignment is requested e.g., received on claim, request from hospital. This provides background that helps HCFA in deciding whether or not a national code may be required.

o Describe any coverage, utilization, or reimbursement limits placed upon the service.

o Forward the material to the local carrier for review to determine whether the code duplicates an existing HCPCS code. If appropriate, the carrier proposes a local code assignment and forwards the material to the RO for review. Follow up in 15 days after your request, and send a copy to the RO.

If the proposed code is approved by the RO, it will forward the data to CO. If the RO disagrees with the local code assignment, it will resolve the issue with you and the local carrier. If the issue cannot be resolved, the code and appropriate supporting documentation are forwarded to CO for resolution. Necessary supporting documentation depends upon the situation and a matter of professional judgement. ROs may or may not specify standards.

3627.3 Use and Acceptance of HCPCS Codes.--Use the CPT-4 portion of HCPCS for ambulatory surgical procedures, and clinical diagnostic lab services. Also, use HCPCS alphanumeric codes for coding DME.

HCPCS is updated annually to reflect changes in the practice of medicine and provision of health care. HCFA provides a tape and/or transaction listing of the updated HCPCS codes, a computer system specifications chart, and a listing of changed and deleted codes 90 days in advance of the implementation of the annual update. Update your HCPCS file and map all new or deleted codes to appropriate reimbursement information no later than 3 months after receipt of the update.

3627.4 HCPCS Manuals.--Providers use the CPT-4 manual published by the AMA as a coding source. It is your responsibility to supply providers with HCFA's alpha-numeric codes and with your local codes.

Inform providers when the annually updated HCPCS becomes available and effective in your claims processing system.

3627.5 Fee Schedule and Diagnostic Lab and DME.--Fee schedules are established by carriers on a carrier-wide basis. The carrier furnishes you copies of fee schedules, national limitation amounts and HCPCS updates. The fee schedule amounts are adjusted periodically to reflect changes in the Consumer Price Index (CPI) for all urban consumers (U.S. city average).

There may be procedures for which hospitals bill outpatient lab services that are not included. Where gaps occur, the carrier is responsible for developing codes and prices. Work out procedures with the carrier to receive the missing information. If you are unable to do this, request assistance from the RO. Codes which are assigned to fill gaps are valid until replaced by permanent codes in an annual update.

Providers may bill for DME on the HCFA-1450. If coding is used to describe DME, only HCPCS alpnanumeric coding is acceptable.

3627.6 Public Relations.--Establish a knowledgeable person as a focal point for provider inquiries. This person must be able to address coding and reimbursement questions.

When codes change, are added or deleted, or when general problems arise, send appropriate bulletins to providers.

Providers obtain new volumes of CPT-4 annually at:

AMA, Order Department
Box 10946
Chicago, IL 60610-0946

Since local changes can occur throughout the year, continue your professional relations work to provide as much information as possible to providers.

3627.7 HCPCS Training.--A large number of changes to HCPCS may necessitate the training of provider personnel. If this is necessary, schedule the sessions in conjunction with the State medical records association or the State hospital association. In issuing the invitations, ensure that the people who complete the bills attend. In the training, emphasize the use of the new manuals and the proper completion of the claim forms.

Be alert to a provider having difficulty with HCPCS. Provide follow up training geared to the individual situation. Review and discuss specific billing problems over the phone or by mail. If a volume of problems develop with a specific provider, schedule a visit to provide the specific training needed. Training is your responsibility.

Exhibit 1

HCPCS CODE REQUEST

Local Code Request:

Description of item or service:

Rationale for Needing Local Code:

Projected Volume:

Closest HCPCS Code(s):

Code	**Full Narrative Description**

Exhibit 2

HCPCS TAPE FILE FORMAT

FIELD NUMBER	FIELD TYPE	STARTING POSITION FIELD	ENDING POSITION FIELD	DESCRIPTION
FD-01 Indent Code	X	1	1	Title Record 1 = No indent, No PRT PROC Code. 2 = Indent, No PRT PROC Code. Procedure Record 3 = First line of Proc Record also contains a detail information pos 94-167. Indent PRT Proc Code 4 = 2nd, 3rd, 4th, etc., description of Proc Record. No detail in pos 94-167. 5 = Indent, Control Statement. Indent no PRT Proc code.
FD-02 PROC CODE	X(5)	2	6	A five digit CPT-4 code. (See Appendix B of the CPT-4 text for HCFA code ranges.)
FD-03 SEQ NUMBER	9(5)	7	11	Sequence number by 100. Groups procedure codes together.
FD-04	X(1)	12	12	Controls spacing of reports. T = Top of page B = Space before A = Space after 2 = Space before and after BLANK = single spacing
FD-05 Asterisk	X(1)	13	13	An asterisk (*) in position 8 indicates a procedure which includes variable pre and postopertative services. See the surgery guidelines -1985 CPT-4.
FD-06 Procedure Description	X(80)	14	93	Description of physician's services.

CAUTION: Of the fields that follow, only FD-09 ILC, FD-14 X-REF, FD-20 CNTS, FD-21 M/D and FD-22 AC have been updated by HCFA. Other fields may contain correct information. Verify them before use. HCFA will update all fields in the 1988 update.

FIELD NUMBER	FIELD TYPE	STARTING POSITION FIELD	ENDING POSITION FIELD	DESCRIPTION
FD-07 BCS	X(5)	94	98	Blue Cross/Blue Shield cross reference number.
FD-08 COV	X(1)	99	99	Coverage M = Noncovered Medicare B N = Noncovered Medicaid T = Noncovered Medicare and Medicaid
FD-09 ILC	X(12)	100	111	Independent Laboratory Certification - A field containing 4 groups of 3 positions; each classifies laboratory procedures according to the specialty certification categories listed by HCFA. Any generally certified laboratory (e.g., 100) may perform any of the tests in its subgroups, e.g., 110, 120). The categories are: 010 Histocompatibility testing 100 Microbiology 120 Mycology 130 Parasitology 140 Virology 150 Other Microbilogy 200 Serology 210 Syphillis 220 Other Serology 300 Clinical Chemistry 310 Routine Chemistry 320 Urinalysis 330 Other Clinical Chemistry 400 Hematology 500 Immunohematology 510 Blood Groupin & RH Typing 520 RH Titers 530 Cross Matching 540 Other Immunohematology 600 Pathology 610 Histopathology 620 Oral Pathology

Exhibt 2(Cont.)

FIELD NUMBER	FIELD TYPE	STARTING POSITION FIELD	ENDING POSITION FIELD	DESCRIPTION
				630 Exfoliative Cytology 700 Physiological Testing 710 EKG Services 800 Radiobioassas 900 Procedures which may be performed by any certified independent laboratory.
FD-10 IC	X(1)	112	112	Individual Consideration TAG - A one position alpha field containing the following elements: R = Medicaid - suspend for medical review S = Medicare - suspend for medical review U = Medicare and Medicaid - suspend for medical review
FD-11 SP	X(1)	113	113	Speciality Procedures - A one position alpha code identifying procedures that can be performed by a physician or a provider limited to a certain speciality. The following elements are used: A = Procedure performed by a podiatrist or a chiropractor; B = Procedure that can be performed by a podiatrist or a dentist; C = Procedure that can be performed by a chiropractor; D = Procedure that can be performed by a dentist; E = Procedure that can be performed by a chiropractor, dentist or podiatrist; F = Procedure that can be performed by a chiropractor or a dentist;

FIELD NUMBER	FIELD TYPE	STARTING POSITION FIELD	ENDING POSITION FIELD	DESCRIPTION
				P = Procedure that can be performed by a podiatrist; or X = Procedure that can be performed by x-ray suppliers.
FD-12 RI	X(1)	114	114	Reimbursement Information - A code denoting the following elements: I = Drugs that can be given intravenously; P = Primary code for reimbursement purposes. Payment may be made under this code. The related secondary code is in Field 6. If there is more than one secondary code, the most frequently used one is in Field 6. Use the appropriate modifier when a secondary code is changed to a primary code. For reimbursement, Code P, Field 14 must contain a valid HCPCS code; R = Listed procedure reimbursed 100 percent by Medicare B; e.g., clinical laboratory services paid on a fee schedule basis, and certain surgical procedures performed in an independent ambulatory surgical center (ASC), or in a hospital affiliated ASC; S = Secondary code for reimbursement purposes. Payment for this procedure is made under the primary code shown

Exhibit 2(Cont.)

FIELD NUMBER	FIELD TYPE	STARTING POSITION FIELD	ENDING POSITION FIELD	DESCRIPTION
				in Field X-Ref 6. Use the appropriate modifier when a procedure is changed for reimbursement purposes. For reimbursement code S, Field X-Ref must contain a valid HCPCS code.
FD-13	X(5) 999V99	115	119	Relative Value Units - Decimal point is assumed between third and fourth positions. Values are considered guidelines and are not mandatory: - a five position code containing any of the following: BR - (BY REPORT) These procedures are too variable to permit the assignment of unit values. Documentation is required in order to justify reimbursement. RNE - (RELATIVITY NOT ESTABLISHED) These services are either too recently developed or infrequently performed for a determination of appropriate allowance. Documentation is required to justify reimbursement. BLANK - No relative values available.
FD-14 X-REF	X(25)	120	144	Cross Reference - Contains 5 groups of 5 positions, each identifies a crosswalk to an alpha-numeric or CPT-4 code to relate services previously or currently coded in HCPCS. For CPT, refer to Appendix B of the CPT-4 text.

FIELD NUMBER	FIELD TYPE	STARTING POSITION FIELD	ENDING POSITION FIELD	DESCRIPTION
FD-15 MCM	X(6)	145	150	Medicare Carriers Manual Reference - A six position numeric field; two position for chapter and four positions for section code.
FD-16 ANE VAL	X(3) (99V9)	151	153	Anesthesia Value - A three position numeric field containing anesthesia base values. A decimal point is assumed between the second and third position. Values are considered guidelines and are not mandatory.
FD-17 SLHA	X(1)	154	154	Sex/Life Procedure/History Procedure/Age - A one position field containing one of the following: 1 = Male only 2 = Female only 3 = Once in a lifetime procedure 4 = Once in a history procedure 5 = Aged (over 65 years of age) 6 = Male-once in lifetime or history procedure 7 = Female-once in lifetime or history procedures
FD-18SA	X(1)	155	155	Surgical Assist - A one position field. "Y" indicates procedures for which a surgical assistant may be reimbursed. Can be annotated by you.

Exhibit 2(Cont.)

FIELD NUMBER	FIELD TYPE	STARTING POSITION FIELD	ENDING POSITION FIELD	DESCRIPTION
FD-19 F/D	X(3)	156	158	Follow-up Days - a three position numeric field for global surgical procedures indicating the number of days for normal uncomplicated follow-up care that will be covered by the surgical procedure reimbursement. To be entered by the carrier.
FD-20 CNTS	X(4)	159	162	Control Statement - 4-digit number to footnote comments at the end of the alpha-numeric section.
FD-21 M/D	X(4)	163	166	Maintenance Date - Month and year an action is taken on the coding system, this is computer generated date.
FD-22 AC	X(1)	167	167	Action Code - the type of action taken on the coding system. Show the type of action - either A, C, D, E or I with any update of the code: A = Add C = Substantial Change D = Delete E = Editorial Change I = Under investigation. Code being reviewed for duplication and acceptance in national coding system. NOTE: A blank in this field indicates an original code. No maintenance activity.
FD-23	X(1)	168	168	BLANK

3628. CLINICAL DIAGNOSTIC LABORATORY SERVICES OTHER THAN TO INPATIENTS

Clinical diagnostic laboratory tests are paid on the basis of fee schedules.

Hospital laboratories billing for either outpatient or nonpatient claims bill you directly. Neither deductible nor coinsurance applies to either outpatient or nonpatient lab tests paid under the fee schedule. Verify eligibility for Part B using a Part B status query or a deductible met file.

A hospital outpatient is a person who has not been admitted as an inpatient but is registered on the hospital's records as an outpatient and receives services (rather than supplies alone). Where a tissue sample, blood sample, or specimen is taken by personnel who are not employed by the hospital and is sent to the hospital for tests, the tests are nonpatient hospital services since the patient does not directly receive services from the hospital. Where the hospital uses the category "day patient," i.e., an individual who receives services during the day and is not expected to be lodged in the hospital at midnight, the individual is classified as an outpatient.

Individual laboratory tests are identified using the HCFA HCPCS codes and terminology.

A. Fee Schedules.—The fee schedules were established by the Medicare carriers on a carrier wide basis (not to exceed a statewide basis) and furnished to you.

COBRA requires national limitation amounts to be applied to payments for clinical diagnostic laboratory services. Effective for services on or after April 1, 1988, a national limitation amount of 100 percent of the median of all the fee schedules for each clinical lab procedure (HCPCS code) is established. Separate limitation amounts are set for the 60 and 62 percent fee schedules.

- Prior to April 1, 1988 for outpatient tests performed by a hospital for its own outpatients, the fee was set at 60 percent of the prevailing charge, unless the tests were performed by a qualified hospital laboratory. In this case, the fee was set at 62 percent. A qualified hospital laboratory is one which provides some clinical diagnostic laboratory tests 24 hours a day, 7 days a week, in order to serve a hospital's emergency room which is available to provide services 24 hours a day, 7 days a week. To meet this requirement, a hospital must have physicians physically present or available within 30 minutes through a medical staff call roster to handle emergencies 24 hours a day, 7 days a week. Hospital laboratory technologists must be on duty or on call at all times to provide testing for the emergency room.

- Effective for hospital outpatient tests furnished on or after April 1, 1988, to receive the 62 percent fee, the hospital must also be a sole community hospital which meets the qualifications listed in the paragraph above. In all other cases the fee is set at 60 percent of the prevailing charge.

Use the same determination you used for PPS purposes to determine whether a hospital qualifies as a sole community hospital. Sole community hospitals are indicated as codes 01 and 11 in your PPS Pricer File. (See S3656.3D, "Provider Type Field.")

- For tests to hospital nonpatients, the fee is set at 60 percent.

B. Application of Fee Schedule.—You are responsible for applying the correct fee schedule for payment of clinical diagnostic laboratory tests by determining which hospitals meet the criteria for payment at the 62 percent fee schedule. Only sole community hospitals with qualified hospital laboratories as defined in subsection A are eligible for payment under the 62 percent screen.

Pay the lower of the applicable current fee schedule, the actual charge, or the national limitation amount. This applies to all clinical diagnostic laboratory tests except:

- Laboratory tests furnished to a hospital inpatient whose stay is covered under Part A. These are included in the DRG for PPS hospitas or are paid on a cost basis for non-PPS hospitals. Laboratory tests for hospital inpatients covered under Part B (due to lack of Part A coverage) are reimbursed on a reasonable cost basis.

- Laboratory tests furnished by hospital-based or independent dialysis facilities that are included under the ESRD composite rate payment. Laboratory tests reimbursed in addition to the composite rate payment are subject to the fee schedule limits. These are at the 60 percent rate unless furnished by a qualified hospital laboratory in a sole community hospital. In this case the 62 percent rate applies.

- Laboratory tests furnished by hospitals in Maryland as long as a waiver of Medicare reimbursement principles applies for outpatient services. However, instructions in subsection D apply for bill preparation for these hospitals.

- Laboratory tests furnished to inpatients of a hospital with a waiver under S602(k) of the 1983 Amendments to the Act. Under the waiver, an outside supplier may bill Part B for laboratory and other nonphysician services furnished to inpatients that would otherwise be reimbursed only through the hospital. Part B payment to the outside supplier for laboratory tests furnished to inpatients under the 602(k) waiver is at 80 percent of the reasonable charge if unassigned, or at 100 percent if assigned. However, the fee schedule applies to any tests furnished by the outside supplier to hospital outpatients and to nonhospital patients.

- Laboratory tests performed by a SNF for its own inpatients and reimbursed under Part A or Part B, and any laboratory tests furnished under arrangements to a SNF inpatient with Part A coverage. Such tests are reimbursed on a reasonable cost basis. All other tests furnished by a laboratory other than the SNF's own are reimbursable only to the laboratory under the fee schedule. Therefore, laboratory tests for SNF inpatients without Part A coverage are not reimbursed to the SNF under arrangements unless the test was referred by a SNF with its own laboratory. Patients occupying beds in non-Medicare certified areas of a SNF are not considered inpatients for the purposes of this exception. Tests furnished to such patients are treated as tests furnished to nonpatients.

- o Laboratory tests furnished to patients of RHCs under an all-inclusive rate. Tests performed by the RHC lab, not included in the all-inclusive rate, are billed to the carrier or to you. Related tests by hospital labs are billed to you.

- o Laboratory tests provided by a participating HMO or HCPP to an enrolled member of the plan.

- o Laboratory tests furnished by a hospice.

C. Clinical Diagnostic Laboratory Services Subject to Fee Schedule.—For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology Fourth Edition, 1987 printing, (CPT-4). Certain tests, however, are required to be performed by a physician and are therefore exempt from the fee schedule. These include:

80500-80502	Clinical pathology consultation
85095-85109	Codes dealing with bone marrow smears and biopsies
86077-86079	Blood bank service
88000-88125	Certain cytopathology services
88160-88199	Certain cytopathology services
88300-88399	Surgical pathology services

Some CPT-4 codes in the 80000 series are not clinical diagnostic laboratory tests. They include codes for blood products such as whole blood, various red blood cell products, platelets, plasma, and cryoprecipitates. Other codes for tests primarily associated with the provision of blood products are also not considered to be clinical diagnostic tests. These include the various blood crossmatching techniques.

Exclusion codes are paid under reasonable costs to the extent they are covered.

The following codes are never subject to fee schedule limitations:

85060
86012
86013
86016-86019
86024
86026
86028
86034
86068
86069
86072-86076
86100
86120
86128
86265-86267
86455-86585
86595
89100-89105
89130-89141
89350
89360

The following codes are not subject to fee schedule limitations when submitted for payment on the same bill with charges for blood products:

86011
86014
86031-86033
86035
86080
86082
86090
86095
86096
86105

If no blood product is provided, and billed for, on the same claim, the codes are subject to the fee schedule.

The following codes that delineate organ or disease oriented panels are not subject to the national limitation amounts because laboratories do not always utilize the same array of tests in a particular panel:

80050-80099
86421-86422

The following codes for unlisted or not otherwise classified clinical diagnostic laboratory tests are not subject to the national limitation amounts:

81099
84999
85999
86999
87999
88299
88399

There may be additional valid level 3 (carrier assigned) codes to consider in any edits.

Furnish fee schedule information to your hospitals. Nomenclature may be furnished. If you furnish nomenclature, use the format shown in exhibit 1. Display the copyright at the bottom of each page.

In January, HCFA updates and distributes HCPCS codes to carriers. The carrier is responsible for supplying you with the annual HCPCS update. See subsection H. for price updating of fee schedules.

D. Billing for Diagnostic Lab Tests.—Follow requirements for review of the HCFA-1450 in §3604.

When the hospital obtains laboratory tests for outpatients or nonpatients under arrangements with independent laboratories or other hospital laboratories, either the originating hospital (or hospital lab) may bill for all tests, or the originating hospitals and the reference labs may bill for the tests they perform. The hospital may not bill for tests under arrangements if it does not operate a lab. Hospital labs bill you. Independent labs bill the carrier.

If all tests are for a nonpatient, the hospital may submit one bill and be reimbursed at 60 percent.

If the tests are for an outpatient, those referred to a reference laboratory are reimbursable at 60 percent. If a sole community hospital agrees to bill for both, it must prepare two bills: one for the laboratory tests reimbursable at 62 percent, the other for the reference laboratory tests reimbursable at 60 percent. The bill for tests performed by the reference lab include nonpatient type of bill coding.

Billing for fee schedule lab tests is included with billing for other outpatient services to the same beneficiary on a single bill except where a qualified hospital laboratory is billing for a reference lab as described above. Do not permit hospitals to submit separate bills for laboratory tests performed in different departments on the same day.

Where a SNF operates a lab that provides lab services to other than its own patients, it is functioning as an independent lab. Bills for these lab services depend upon the status of the patient (e.g., hospital inpatients, ICF patients) and the arrangements made for payment with the referring entity.

E. Specimen Collection Fee.—Separate charges made by laboratories for drawing or collecting specimens are allowable whether or not the specimens are referred to hospitals or laboratories. Do not pay the fee to anyone who has not extracted the specimen. Only one collection fee is allowed for each type of specimen (e.g., blood, urine) for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), treat the series as a single encounter. Allow a specimen collection fee in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

Special rules apply when such services are furnished to dialysis patients. The specimen collection fee is not separately payable for any patients dialyzed in the facility or for any patients dialyzed at home under reimbursement Method I. Payment for this service is included under the ESRD composite rate (§2711.1B4 of the Provider Reimbursement Manual, Part 1) for separately billable laboratory tests, as well as those included in the composite rate. Fees for taking specimens from home dialysis patients who have elected reimbursement Method II (§§2740ff. of the Provider Reimbursement Manual, Part 1) may be paid separately, provided all other criteria for payment are met. Also, fees for taking specimens in the hospital setting, but outside of the dialysis unit, for use in performing laboratory tests not included in the ESRD composite rate may be paid separately.

A specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time). Do not make payment for routine handling charges where a specimen is referred by one laboratory to another.

Allow a specimen collection when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home or homebound patient. The technician must personally draw the specimen, e.g., venipuncture or urine sample by catheterization. A specimen collection fee is not allowed the visiting technician where a patient in a facility is not confined to the facility or the facility has on duty personnel qualified to perform the specimen collection. If you have no information regarding the qualifications of the facility's personnel, assume the technician's service was necessary.

Establish the following HCPCS codes and terminology:

36415 Routine venipuncture for collection of specimen(s).
P9615 Catheterization for collection of specimen(s).

For all codes, pay the lesser of the charge or $3 per patient. Because payment is permitted for time and travel costs, the $5 fee allowed for P9605 and P9610 is discontinued effective for services January 1, 1987 and later. Specimens drawn from more than one patient during the same nursing home visit are billed under 36415 and P9615. The amount you allow should not exceed $3 per patient.

F. Travel Allowance.—In addition to a specimen collection fee allowed under subsection E, a travel allowance is payable to cover the costs of collecting a specimen from a nursing home or homebound patient. Pay the additional allowance only where a specimen collection fee is also payable: i.e., no travel allowance is made where the technician merely performs a messenger service to pick up a specimen drawn by a physician or nursing home personnel. Since a travel allowance can be paid routinely, the differential specimen collection amount provided for in subsection E when a specimen is collected from a single patient rather than multiple patients (i.e., $5 rather than $3) is discontinued.

The allowance covers the estimated travel costs of collecting a specimen and reflects the technician's salary and travel costs. The following HCPCS codes are used for travel allowances:

P9603—Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated miles actually traveled (intermediary allowance on per mile basis); or

P9604—Travel allowance - one way, in connection with medically necessary laboratory specimen collection drawn from homebound or nursing homebound patient; prorated trip charge (intermediary allowance on flat fee basis).

If you determine it is appropriate, you may apply an additional fee for travel, on the same basis as the carrier in your area, to all circumstances where travel is required. Otherwise, establish an appropriate allowance and inform the hospitals in your area. If you decide to establish a new allowance, one method is to consider:

- The current Federal mileage allowance for operating personal automobiles of $0.205 per mile, plus

- A personnel allowance per mile to cover personnel costs based upon an estimate of average hourly wages and average driving speed.

Prorate travel allowance amounts claimed by suppliers by the number of patients (including Medicare and non-Medicare patients) from whom specimens were drawn on a given trip.

EXAMPLE 1: You determine that the average technician is paid $9 per hour and estimate 45 miles per hour as the average speed driven or $.20 per mile. Including the Federal allowance of $0.205 per mile results in a total allowance of $0.405 per mile. A laboratory technician makes a trip to two nursing homes involving a total of 20 miles and collects five specimens from Medicare and non-Medicare patients. A travel allowance per Medicare claim of $1.62 can be made - 20 miles roundtrip x $0.405 per mile divided by 5 specimens.

EXAMPLE 2: You determine through a review of the laboratory records that on average, four specimens are drawn or picked up each trip and the average trip involves a 30 mile round trip. Assuming the same facts as Example 1 (i.e., $9 per hour and 45 miles per hour), you establish a flat travel allowance of $3.03. Hospitals bill code P9604 and are paid $3.03 regardless of actual distance or number of patients served.

G. Amount of Part B Payment for Clinical Laboratory Tests.—The following rules apply in determining the amount of Part B payment for clinical laboratory tests:

o If payment is made to a hospital for tests furnished for a nonpatient of that hospital (or tests furnished for an outpatient when the hospital is not a sole community hospital, the payment is the least of the actual charge, the 60 percent fee schedule amount, or the 60 percent national limitation amount. Part B deductible and coinsurance do not apply.

o If payment is made to a sole community hospital for tests furnished for an outpatient of that hospital, the payment is the least of the actual charge, the 62 percent fee schedule amount, or the 62 percent national limitation amount. (See subsection B.) Part B deductible and coinsurance do not apply.

o If payment is made to a participating hospital for tests performed for an inpatient of that hospital without Part A coverage, payment is made on a reasonable cost basis subject to Part B deductible and coinsurance.

o If payment is made to a participating SNF for tests performed by that SNF for its inpatient, payment is made on a reasonable cost basis subject to Part B deductible and coinsurance.

o If payment is made to a hospital-based or independent dialysis facility for laboratory tests included under the composite rate payment and performed for a patient of that facility, the facility's composite rate payment includes payment for these tests subject to the Part B deductible and coinsurance.

o If payment is made to a RHC for laboratory tests performed for a patient of that clinic, payment is made as part of the all-inclusive rate subject to Part B deductible and coinsurance.

o If payment is made to a hospital pursuant to a waiver of Medicare reimbursement principles for outpatient services, Part B deductible and coinsurance apply unless otherwise waived as part of the approved waiver.

o If payment is made to a participating HMO or HCPP for laboratory tests performed for a patient who is not a member, payment is the least of the actual charge, the fee schedule amount, or the national limitation amount. The Part B deductible and coinsurance do not apply.

H. Adjusted Fee Schedule.—Beginning April 1, 1988, the 1987 fee schedules for automated tests, and for tests (with the exception of cytopathology) that were subject to the LCL provision prior to July 1, 1984, are reduced by 8.3 percent. To determine the adjusted fee schedules, multiply the 1987 fee schedule by .9170 (100 percent of the 1987) fee schedule minus 8.3 percent).

The automated tests subject to the adjusted fee schedules tests are listed in codes 80002 - 80019 of the 1987 printing of the CPT-4.

The adjusted fee schedules also apply to the following tests that were subject to the LCL provision prior to the establishment of the fee schedule methodology.

Test	1987 CPT-4 Code
Cholesterol, Serum	82465
Complete Blood Count	85022 85031
Hemoglobin	85018
Hematocrit	85014
Prothrombin Time	85610
Sedimentation Rate (ESR)	85650 85651
Glucose	82947 82948
Urinalysis	81000*
Blood Uric Acid	84550
Blood Urea	84520
White Blood Cell Count	85048

*If 81002 and 81015 are both billed, pay as though the combined service (81000) had been billed.

Where these adjusted fee schedule tests are part of disease or organ panels, assure that the fee for the panel does not exceed the sum of the fees for the individual components after accounting for the reductions due to the adjustment. Get further information from your carrier.

I. Coordination With Carriers.—The carrier in your area furnishes you copies of fee schedules, national limitation amounts and HCPCS updates. The fee schedule amounts are adjusted periodically to reflect changes in the Consumer Price Index (CPI) for all Urban Consumers (U.S. city average). For laboratory tests performed on or after July 1, 1985 through December 31, 1986, the fee schedules were increased 4.1 percent. Beginning January 1, 1987, CPI adjustments are made January 1 of each year instead of July 1. The CPI increase effective for laboratory tests performed on or after January 1, 1987 is 5.4 percent. This factor was applied to the national limitation amounts on the 60 and 62 percent fee schedules furnished to you. No update is scheduled for calendar year 1988.

COBRA requires national limitation amounts to be applied to the payments for outpatient clinical diagnostic laboratory services. For services rendered on or after July 1, 1986 and prior to April 1, 1988, the national limitation amount is 115 percent of the median of all the fee schedules established for a test for each laboratory code (separately calculated for 60 and 62 percent fee schedules). For laboratory tests performed on or after January 1, 1987 through March 31, 1988, the initial national limitation amounts were increased by 5.4 percent and the results is the 1987 national limitation amount.

For laboratory tests performed on or after April 1, 1988, the national limitation amount is 100 percent of the median of all the fee schedules established for a test for each laboratory code (separately calculated for 60 and 62 percent fee schedules). The 100 percent national limitation amount for automated tests and for tests formerly subject to the LCL limit, is determined by reducing the current national limitation amount by 8.3 percent (i.e., by multiplying the national limitation by .9170) and multiplying this result by .8696 (100 percent divided by 115 percent). In a single step computation the 1987 national limitation amount is multiplied by .7974 (.9170 x .8696). For all other tests the 100 percent national limitation amount is determined by multiplying the 1987 national limitation amount by .8696 (100 percent divided by 115 percent).

There may be procedures for which hospitals bill for outpatients that are not included in the fee schedule. Where gaps occur in the fee schedule, the carrier has the responsibility for developing codes and prices. Work out procedures with the carrier to receive the missing information within a reasonable amount of time. If you are unable to do this satisfactorily, request assistance from the RO. Codes which are assigned to fill gaps are valid until replaced by permanent codes in an annual update.

J. Laboratory Tests Utilizing Automated Equipment.—Clinical laboratory tests are covered under Medicare if they are reasonable and necessary for the diagnosis or treatment of an illness or injury. In the case of multi-channel automated and/or batch automated (e.g., SMAC, CHEMICAL PROFILES, ASTRA) laboratory determinations, however, the physician may not be free to specify the tests the patient needs and there is normally only one charge for the battery of tests. The delivery of the service in this manner is much more economical than if the tests are performed individually.

National guidelines on what tests are available in automated batteries are being developed. Until completed, install edit procedures to identify situations where the provider bills individual tests where billing for the automated battery would be appropriate based upon carrier practices in your area.

K. Modification of EOMB Process.—If services other than lab services necessitate sending an EOMB to the beneficiary, add a message to explain that clinical diagnostic lab services are reimbursed at 100 percent of the fee schedule and deductible and coinsurance do not apply. Either include a stuffer with your EOMB or modify the language on the front. If a stuffer is used, use the following language:

"You are not responsible for deductible or coinsurance for outpatient clinical diagnostic laboratory tests furnished. The Medicare payment for such tests is considered payment in full to the hospital.

This payment does not affect your annual deductible amount, and the hospital may not charge you any deductible or coinsurance for such lab tests. There may be deductible or coinsurance for other tests you received."

3629. BILLING FOR DURABLE MEDICAL EQUIPMENT (DME) AND ORTHOTIC/PROSTHETIC DEVICES

Section 4062 of P.L. 100-203, the Ominbus Budget Reconciliation Act of 1987 (OBRA) requires that payment for DME furnished under the Part A home health benefit and Part B DME, orthotic and prosthetic devices be on the basis of a fee schedule for items provided January 1, 1989 and later. For inpatients with no entitlement to Part A, the fee schedule applies for items covered under Part B. HCPCS coding is required. Deductible and coinsurance apply. (See subsection C for application.) The equipment is categorized into one of six classes:

- Prosthetic and orthotic devices;
- Inexpensive or other routinely purchased DME;
- Items requiring frequent and substantial servicing;
- Customized items;
- Capped rental items; or
- Oxygen and oxygen equipment.

See subsection E for billing information for each class and Addendum H for appropriate HCPCS codes and definitions.

A. Billing for DME, Orthotic and Prosthetic Devices.--Providers other than HHAs which previously billed DME on the HCFA-1450 will bill the local carrier on the HCFA-1500. The provider must obtain a billing number from the carrier first.

HHAs bill their RHHI for DME on the HCFA-1450, except for subunits that now bill carriers as suppliers.

Return any claims you receive from your non-HHA providers for DME only. Advise them to bill the carrier for DME on the HCFA-1500. Where a claim from a non-HHA provider contains DME and other line items, you have the option of returning the claim or denying the DME portion.

All provider outpatient departments bill you for orthotic and prosthetic devices on the HCFA-1450. Apply the fee schedule. (See Addendum H for a list of HCPCS codes for these devices).

B. Fee Schedule.--The carrier establishes the fee schedule for DME, orthotics and prosthetics and furnishes it to you. Depending on the class location of a piece of equipment, base payment procedures on the particular class' fee schedule effective January 1, 1989. In subsequent years, the fee schedule will be adjusted to reflect changes in the consumer price index for all urban consumers (CPIU) (U.S. city average). For local codes, the carrier provides information on the appropriate category and pricing.

Carriers determine the fee schedule on the basis of a single locality for their service area. Where the service area includes more than one State, the schedule is based on no more than one State. Some States have more than one carrier with service areas within them. These carriers have defined service areas within the States. Apply the fee schedules based on the location of the provider.

NOTE: All codes contained in Addendum H must be paid on the basis of the fee schedule including HHA benefits furnished under a Plan of Treatment.

C. Application of Fee Schedule and Determining Payments and Patient Liability.—Apply the correct fee schedule for payment of orthotic and prosthetic devices. If you are an RHHI, you are also responsible for applying the correct fee schedule for payment of DME.

Use the following rules on determining payments and patient liability for DME, orthotics and prosthetics:

- Payment to a Provider Other Than Nominal Charge HHA.—To determine the Part B payment to a provider other than a nominal charge HHA, subtract any unmet Part B deductible from the lower of the actual charge or the fee schedule amount for the item or service and multiply the remainder by 80 percent. This is the final payment. (If the item or service is furnished by a HHA and is covered under the Plan of Treatment, the payment is determined in the same way, except that no deductible is applicable.)

- Payment to a Nominal Charge HHA.—To determine the Part B payment to a nominal charge HHA, subtract any unmet deductible from the fee schedule amount and multiply the remainder by 80 percent. This is the final payment. (If the item or service is furnished by a nominal charge HHA and is covered under the Plan of Treatment, the payment is determined in the same way, except that no deductible is applicable.) For these items and services, no providers are considered nominal charge providers other than HHAs.

- Payment to a Nominal Charge Provider Other Than a Nominal Charge HHA.—To determine the Part B payment to a nominal charge provider other than a nominal charge HHA, subtract any unmet Part B deductible from the lower of the actual charge or the fee schedule amount for the item or service and multiply the remainder by 80 percent. This is the final payment.

- Patient Liability to a HHA.—To determine the patient liability to a HHA under Part B (nominal charge or regular HHA), subtract any unmet deductible from the lower of the actual charge or fee schedule amount and mutliply the remainder by 20 percent. The result obtained plus the unmet deductible is the patient's liability. If the item or service is covered under a Plan of Treatment, the deductible does not apply.

- Patient Liability to a Provider Other Than a HHA.—To determine the patient liability to a provider other than a HHA (including nominal charge providers other than a HHA), subtract any unmet deductible from the actual charge and multiply the remainder by 20 percent. The result obtained plus the unmet deductible is the patient's liability.

D. Bill Review.—In general, but subject to specific billing and processing requirements listed in subsections G-I, follow requirements for review of the HCFA-1450 in §3604. HHA medical review requirements in §§3900ff. apply. Develop medical review criteria for outpatient services.

E. Classes of Equipment.—The following defines the six classes of equipment and indicates (by provider type) whether you or the carrier is billed. (See Addendum H for HCPCS codes for each class.)

Intermediaries other than RHHIs will only receive claims for the classes "Prosthetic and Orthotic Devices (Other Than DME)" and "Certain Customized Items."

o Prosthetic and Orthotic Devices (Other Than DME).—These items consist of all prosthetic and orthotic devices excluding: items in the classes "Certain Customized Items" and "Items Requiring Frequent and Substantial Servicing," transcutaneous electrical nerve stimulators (TENS), parenternal/enteral nutritional supplies and equipment, and intraocular lenses. Other than these exceptions, pay for prosthetic and orthotic devices on a lump-sum purchase basis using the lesser of the fee schedule amount or the actual purchase charge.

All providers bill their regular intermediary.

Orthotic and prosthetic devices are billed under revenue code 274.

For TENS, a payment of 10 percent of the purchase price less coinsurance is allowed for the first 2 months of usage for a 2 month trial period prior to purchase. This trial period permits a physician to determine whether the purchase of a TENS is medically appropriate. If so, the full purchase price is paid without an adjustment for the two monthly rental payments. Providers other than HHAs bill the carrier. HHAs bill the RHHI. The HCPCS codes for TENS are E0720 and E0730.

o Inexpensive or Other Routinely Purchased DME.—This is equipment with a purchase price not exceeding $150 or equipment which the Secretary determines is acquired by purchase at least 75 percent of the time. Payment is either through rental or purchase but the total rental amount for a particular item may not exceed the actual charge or fee for purchase. Payment is possible for maintaining and servicing purchased equipment. The rental fee includes service and maintenance.

Providers other than HHAs bill the carrier. HHAs bill the RHHI.

o Items Requiring Frequent and Substantial Servicing.—These are items such as ventilators, aspirators, IPPB machines, and nebulizers. Payment is generally made on a rental basis. For rentals, payment is made based on monthly fee schedule amounts until the medical necessity ends. However, where the beneficiary has purchased an item in this category, pay monthly installments equivalent to rental fee schedule amounts until the medical necessity ends, the fee schedule purchase price or actual charge has been reached, whichever comes first.

Providers other than HHAs bill the carrier. HHAs bill the RHHI.

o Certain Customized Items.—Due to their unique nature (custom fabrication, etc.) which makes them unsuitable for grouping together for profiling purposes, these are items for which the carrier has not established customary and prevailing charges. Other than HCPCS code E1220, the DME and orthotic/prosthetic items included in this category are not coded in HCPCS. (This includes those circumstances where an item which has a HCPCS code is modified to the extent that neither the original terminology nor the terminology of another HCPCS code accurately describes the modified item.) Pay for these items in a lump-sum based upon your considerations for each item. Also, pay for maintenance and servicing when a manufacturers' warranty no longer provides coverage. There is no listing of codes in Addendum H for this class. HHAs use HCPCS code E1399 when billing the RHHI for DME and HCPCS code L8499 when billing the RHHI for orthotics and prosthetics. Provider outpatient departments contact the carrier for appropriate codes for billing DME and use HCPCS code L8499 when billing their intermediary for orthotics and prothetics.

Providers other than HHAs bill the carrier for DME. HHAs bill the RHHI.

Provider outpatient departments bill the intermediary for orthotics and prosthetics.

o Capped Rental Items (Other Items of DME).--These are DME items not covered by the categories described above. For these items of DME, RHHIs pay on a rental or purchase basis as indicated by the revenue code. For rental items, generally pay on a monthly rental basis not to exceed 15 continuous months except where the beneficiary has purchased an item without prior rental. In such cases, pay on monthly installments equivalent to the rental fee schedule amounts until the actual charge for purchase is reached, the fee schedule amount for purchase is reached, or the medical necessity ends, whichever occurs first. Payment may be made for purchase even if the purchase was preceded by a period of rental. However, total payments for rental plus purchase may not exceed the amount that would have been paid had the equipment been continuously rented for 15 months. Therefore, if a purchase occurs during a period of continous use after 15 months of rentals have been paid, no payment may be made other than the reasonable and necessary charges for maintenance and servicing. (See subsection F for instructions on payment for maintenance and servicing and for continuous use.)

Providers other than HHAs bill the carrier. HHAs bill the RHHI.

o Oxygen and Oxygen Equipment.--Generally, payment is made on a monthly basis. However, where a beneficiary has purchased an item of oxygen equipment, pay monthly installments equivalent to the fee schedule amounts until either the medical necessity ends or the fee schedule amount for purchase of the equipment has been reached. (See subsections G and H for special processing requirements for RHHIs.)

Providers other than HHAs bill the carrier. HHAs bill the RHHI.

NOTE: For all the above classes of equipment except Capped Rental Items, payment for maintenance and servicing is made anytime the beneficiary purchases equipment. Payment is not made for maintenance and servicing if the beneficiary rents the equipment since maintenance and servicing are included in the rental payments. (See subsection H for Capped Rental Items.)

For all classes involving DME and/or oxygen except Capped Rental Items, the HHA bills for maintenance and servicing under HCPCS code E1350 and furnishes a description of what was done. All other providers use E1350 for prosthetics and orthoics and contact the carrier for appropriate HCPCS billing codes for DME. The billed amount is paid if reasonable.

F. Special Processing Rules for RHHIs.—Apply the following rules when processing DME claims:

- Replacement.—Do not pay for replacement of equipment that is not purchased. Do not pay for replacement of capped rental items where the 15-month rental period has expired. (See subsection E.)

- Plan of Treatment Requirements.—All DME must be included on the Plan of Treatment. (See §3902.1.) If items listed in the category "Need Prescription Before Delivery" which is contained in Addendum H are being billed, they must be included in the Plan of Treatment in order for payment to be made.

- Installment Payments.—Where a beneficiary is purchasing an item through installments, the HHA indicates the total price of the item on the first bill. Set up a diary to generate monthly payments equivalent to the rental fee schedule amount until the fee schedule purchase price or actual charge has been reached, whichever comes first.

- Payments During a Period of Continuous Use.--For capped rental items, payments may not exceed a period of continuous use longer than 15 months. Develop with the HHA or beneficiary to determine when this period begins. Neither a change in address nor a change in suppliers (HHAs) will extend the 15 month period. For the month of death or discontinuance of use, pay the full month. After 15 months of rental have been paid, the HHA must continue to provide the item without any charge, other than for the maintenance and servicing fees until medical necessity ends or Medicare coverage ceases. For this purpose, unless there is a break in need for at least 60 days, medical necessity is presumed to continue.

A period of continuous use allows for temporary interruptions in the use of equipment. Interruptions may last up to 60 consecutive days plus the days remaining in the rental month (this does not mean calendar month, but the 30-day rental period) in which use ceases, regardless of the reason the interruption occurs. Thus, if the interruption is less than 60 consecutive days plus the days remaining in the rental month in which use ceases, do not begin a new 15-month rental period. Also, when an interruption continues beyond the end of the rental month in which the use ceases, do not make payment for additional rental until use of the items resumes. Establish a new date of service when use resumes. Do not count unreimbursed months of interruption toward the 15-month limit.

If, however, the interruption is greater than 60 consecutive days (plus the days remaining in the rental month in which need ceases) and the HHA submits a new prescription, new medical necessity documentation, and a statement describing the reason for the interruption which shows that medical necessity in the prior episode ended, a new 15-month period begins. If the HHA does not submit this documentation, a new 15-month period does not begin.

If a 15-month rental period has already ended and a greater than 60 consecutive day interruption occurs, subject any claims purporting to be a new period of medical necessity after the interruption to a thorough MR to ensure that medical necessity did in fact end after the prior episode.

If the beneficiary changes to different, but similar, equipment, review to determine whether the beneficiary's medical needs have substantially changed and the new equipment is necessary. If so, begin a new 15-month period. Otherwise continue to count against the current 15-month limit and base payment on the less expensive medically appropriate configuration of equipment. If the 15-month period had already expired, make no additional rental payments.

If the new configuration is a modification of existing equipment through the addition of medically necessary features (for example, a special purpose back is added to a wheelchair), continue the 15-month rental period for the original equipment and begin a new 15-month rental period for the added equipment.

For purposes of computing the 15-month period for capped rental items, begin counting the first month that the beneficiary continously rented the equipment. For example, if the beneficiary began renting the equipment in July 1988, the rental month which begins in January 1989 is counted as the beneficary's 7th month of rental. Therefore, if the equipment has been continously rented prior to October 2, 1987, no further rental payments are made since the 15-month period is terminated before January 1, 1989. Payment for maintenance and servicing begins July 1, 1989.

If the beneficiary has reached (on a date of service prior to January 1989) the purchase price limitation on a rental claim, do not make any further purchase or rental payments. However, for capped rental items previously rented that have reached the purchase cap under the rent/purchase rules, pay claims for maintenance and servicing fees effective July 1, 1989.

- Maintenance and Servicing.—HHAs bill for the maintenance and servicing of DME under revenue code 299 using HCPCS code E1399 representing capped rental equipment. A description of the service is included in Item 94 "Remarks" of the HCFA-1450 or attached. Pay the reasonable and necessary charges for maintenance and servicing of purchased equipment. Do not pay for parts and labor that are covered under a manufacturer's or supplier's warranty. Pay on a lump-sum, as needed basis based on your considerations for that item. Payment may not be made for maintenance and servicing of rented equipment other than the maintenance and servicing fee established for capped rental items.

For capped rental items which have reached the 15-month rental cap, pay claims for maintenance and servicing fees after 6 months have passed from the end of the final paid rental month or from the end of the period the item is no longer covered under the supplier's or manufacturer's warranty, whichever is later. For example:

Date service begins:	1/5/88
15-month rental period ends: (1/5/88 + 15 months)	4/4/89
6-month period when no payment is made (4/5/89 + 6 months):	4/5/89 - 10/4/89
Date maintenance and servicing payment may begin:	10/5/89
Payment covers all maintenance and servicing through (10/5/89 + 6 months):	4/4/90

For capped rental DME, the maintenance and servicing fee may be paid only once every 6 months.

G. Special Requirements for Processing of Oxygen Claims by RHHIs.--Fee schedule payments for stationary oxygen system rentals are all inclusive and represent a monthly rental payment allowance per beneficiary. Accordingly, providers bill on a monthly basis for the stationary oxygen equipment rentals and contents furnished, if applicable (i.e., if HHA services are provided in addition to oxygen, the HHA will include the oxygen on the HHA bill.) An additional fee for portable add-on equipment is payable under the situations indicated in subsection H.

The monthly payment amount for stationary oxygen is subject to adjustment depending on the amount of oxygen prescribed liters per minute (LPM) and whether or not portable oxygen is also used. In order to receive the applicable payment adjustment, bills must indicate the appropriate revenue code described as follows, if applicable:

o If the prescribed amount of oxygen is less than 1 LPM, the revenue code is 294. Reduce the monthly payment amount for stationary oxygen by 50 percent.

o If the prescribed amount of oxygen is greater than 4 LPM, the revenue code is 295. Increase the monthly payment amount for stationary oxygen by 50 percent.

o If the prescribed amount of oxygen exceeds 4 LPM and portable oxygen is prescribed, the revenue code is 296. Increase the monthly payment for stationary oxygen by the higher of 50 percent of the monthly stationary oxygen payment amount or the fee schedule amount for the portable oxygen add-on.

All other oxygen is billed under revenue code 277.

Monthly bills may be submitted to you as of the first rental service date in the case of initial rentals of an oxygen system or, no sooner than 30 days after the prior rental month's service date in the case of an established oxygen patient.

Apply coverage guidelines in 60-4 of the Coverage Issues Manual.

H. Oxygen Equipment and Contents Billing Chart.—The following chart indicates what oxygen fee schedule component is billable/payable under various transaction scenarios.

A. Situation: Bene Uses a Stationary System Only

1. Rental Cases

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Concentrator	Yes	No	No	No	N/A
Gaseous	Yes	No	No	No	N/A
Liquid	Yes	No	No	No	N/A

2. Purchase Cases

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Concentrator	Yes(installment)	No	No	No	Yes
Gaseous	Yes(installment)	Yes	No	No	Yes
Liquid	Yes(installment)	Yes	No	No	Yes

B. Situation: Bene Uses Both a Stationary and Portable System

1. Rents stationary/Rents portable

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Concentrator	Yes	No	Yes	No	N/A
Gaseous	Yes	No	Yes	No	N/A
Liquid	Yes	No	Yes	No	N/A

2. Rents stationary/Owns portable

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Concentrator	Yes	No	Yes(installment)	No	No/Yes
Gaseous	Yes	No	Yes(installment)	No	No/Yes
Liquid	Yes	No	Yes(installment)	No	No/Yes

3. Owns stationary/Owns portable

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Concentrator	Yes(installment)	No	Yes(installment)	Yes	Yes/Yes
Gaseous	Yes(installment)	Yes	Yes(installment)	No	Yes/Yes
Liquid	Yes(installment)	Yes	Yes(installment)	No	Yes/Yes

4. Owns stationary/Rents portable

Concentrator	Yes(installment)	No	Yes	Yes	Yes/No
Gaseous	Yes(installment)	Yes	Yes	No	Yes/No
Liquid	Yes(installment)	Yes	Yes	No	Yes/No

C. Situation: Bene Uses a Portable System Only

1. Rents portable system

Type of System	Stationary Monthly Payment	Oxygen Content Fee	Portable Add-On	Portable Contents Fee	Purchase Payment Limit
Gaseous	No	No	Yes	Yes	N/A
Liquid	No	No	Yes	Yes	N/A

2. Owns portable system

Gaseous	No	No	Yes(installment)	Yes	Yes
Liquid	No	No	Yes(installment)	Yes	Yes

RHHIs consider the following when processing oxygen claims:

o Whenever the volume adjustment and the portable add-on both apply, only pay the higher of the two;

o Do not make additional payments for either stationary or portable contents whenever a stationary system is rented. The monthly oxygen payment amount already includes reimbursement for all required contents;

o Make payments for purchased oxygen equipment on an installment basis (equal to the fee for rental) until either medical necessity ends or, the fee schedule amount for purchase or, the actual purchase price is reached, whichever comes first; and

o The portable content fee is never payable in addition to the "regular" content fee. The regular content fee already includes portable content reimbursement.

I. Reporting Units of Service.—Provider outpatient departments report under item 52 "Units of Service" the number of items being billed for orthotic and prosthetic devices.

RHHIs report under item 52 the number of purchased items being billed under DME (excluding oxygen) or the number of months for rental. For oxygen, RHHIs report under item 52 the number of months being billed.

J. Coordination Between Intermediaries and Carriers.--The carrier(s) will furnish you copies of fee schedules and updates. They will provide schedule updates at least 30 days prior to selected implementation. Use the fee schedules as indicated in subsection A to pay for covered items supplied by providers. Consult with carriers on filling gaps in fee schedules. Carriers will make the final decision on gap-filling amounts.

K. EMC Formats.--Utilize one of the following:

o Standard Tape Format - Record type 61 is used to report outpatient and home health services. Record type, sequence number, patient control number (if used), revenue code, HCPCS procedure code, units, charges, and noncovered charges are required. Modifiers and dates of service are not. The date of service will be determined from the "from" and "through" dates shown in record 20. Include other record types as appropriate.

o Direct Data Entry - You are responsible for determining where to locate the HCPCS procedure code on your data entry screen.

L. UNIBILL Requirements - Report the procedure codes in the financial data section (field 32-40). Include revenue code, HCPCS, units, and covered charges in the record. Where more than one HCPCS procedure is applicable to a single revenue code, the provider reports each HCPCS and related charge on a separate line. The revenue code is reported. Report the payment amount before adjustment for beneficiary liability in field 37 "Rate" and the actual charge in field 38 "Covered Charges."

3630. SKILLED NURSING FACILITIES

The requirements for processing hospital bills (inpatient Part A, inpatient Part B, and outpatient) (see SS3600-3628) apply to bills from SNFs. In addition, the following requirements are applicable.

Occurrence code 70 is used to indicate qualifying stay dates involving Part A claims for SNF level of care only. This code indicates that the dates shown are for a hospital stay of at least 3 days which qualifies the patient for payment of the SNF level of care services billed.

Verify that you have received a hospital bill that permits SNF coverage. If you have not received a bill, process the claim on the assumption that the SNF bill is correct. Diary for development if a hospital bill is not received within 90 days.

The requirement for a hospital stay of at least 3 days is applicable only to SNF admissions prior to January 1, 1989. For admissions on or after that date, there is no hospital prior stay requirement and occurrence code 70 is not required.

3630.1 Processing Beneficiary Demand Bills for Noncovered Admissions.—If a beneficiary requests the SNF to bill Medicare for services that the SNF thinks are noncovered, the SNF must do so.

If the bill relates to a noncovered admission, the SNF must submit the bill in the next billing cycle. It shows the charges as noncovered and reports condition code 20 to indicate the beneficiary thinks the services are covered. Process the bill, including medical review, as described in S3900.1B. Provide the appropriate notice to the beneficiary and SNF (allowance or denial with appeal rights as appropriate) on every demand bill received.

If the SNF reports condition code 21, the bill is not a demand bill. The bill is submitted to obtain a denial notice for Medicaid or another insurer. Process these bills in accordance with S3900.1D. Provide the appropriate letter to the beneficiary and SNF.

3630.2 Processing Beneficiary Demand Bills for Continued Stay Denials.—Where the SNF believes that a covered level of care has ended but the beneficiary disagrees, the SNF reports occurrence code 21 (UR Notice Received) or 22 (active care ended) as applicable. Condition code 20 indicates the beneficiary believes the services are covered beyond that date. The SNF reports the days and charges after the Item 21 or 22 date as noncovered.

Process the bill, including medical review, as described in S3900.1B. Provide the appropriate notice to the beneficiary and SNF (allowance or denial with appeal rights) on every demand bill received.

See S3723 if you decide coverage is appropriate for the period the beneficiary disputes.

3630.3 Processing Beneficiary Complaints and Inquiries Regarding Demand Bills.—Search your files to determine if a bill has been submitted when you receive an inquiry or complaint regarding a demand bill. Advise the beneficiary of the status or disposition of the bill if located. If the bill has not been received:

- o Advise the beneficiary (or person acting on his/her behalf) that the SNF will be requested to submit a bill and that they will receive either a copy of the bill or notice that it has been submitted from the SNF. Notify the beneficiary of the Medicare decision after the bill has been reviewed. The beneficiary is not required to pay for services which could be covered by Medicare until a Medicare decision is made. The SNF must refund monies collected if the beneficiary has paid the bill and if Medicare determines the care is covered. (See §3723 for reversal letter.)

- o Request the SNF to submit the bill, medical evidence, and a copy of the beneficiary denial notice within 5 working days of your request. (See §3723.1 for request letter.)

- o Followup by telephone if necessary until the bill and information are received.

- o Refer SNFs to the State Survey Agency through the RO if there are repeated complaints from beneficiaries about noncompliance with requests to submit bills to Medicare.

- o Refer to §3900.1 (Exhibit 1) for reporting requirements.

3630.4 Review of SNF Denial Notices for Demand Bill Requests.—To ensure that all SNFs institute the denial letter and demand bill procedures properly, SNFs must submit for two consecutive quarters, copies of all notices to beneficiaries where the URC or SNF believes that the care required by the beneficiary will not be covered by Medicare and the beneficiary has requested that a claim be submitted for a Medicare decision. Consent forms for admissions or tranfers to noncertified beds must be attached. Review these notices as follows:

- o Ensure that notices are received from each SNF. Followup if notices are not received.

- o Count the number of demand bill notices and compare with the number of demand bills you received from the SNF. Followup any discrepancies.

- o Discontinue review of a SNF after two consecutive quarters unless there are major discrepancies or noncompliance by the SNF. (Notify the SNF accordingly.)

- o Record for each SNF; the number of notices received; the number of demand bills not submitted (i.e., followup required) and the number of notices in error for noncompliance with procedures (other than demand bills not submitted).

- o Attach this report to the MR activity report in §3900.1 and forward it at the end of each quarter.

3634. SWING-BED SERVICES

Swing-bed services require the provider to bill inpatient hospital services and SNF services separately. The 3 day hospital stay requirement and the timely transfer requirement outlined in §§3131ff. must be met. Swing-bed hospitals use their regular provider numbers when billing for hospital services and an alpha letter "U" in the third position of the provider number to identify swing-bed SNF bills.

A. Inpatient Hospital Services in a Swing-Bed.--Where there is no change to a SNF level of care, services are billed in accordance with hospital billing instructions. (See §3604.) Where the beneficiary's level of care changes from hospital to SNF level, the provider shows patient status code 03 on the hospital bill in item 20 to indicate transfer to a SNF level of care. (This constitutes a discharge for purposes of Medicare payment for inpatient hospital services under the PPS.) Indicate on Item 22 the last day of care at the hospital level.

B. SNF Services in a Swing-Bed.--Services are billed in accordance with §3604, with the following exceptions:

o The swing-bed SNF bill has a hospital provider number in lieu of a provider number in the usual SNF provider number series. This is a unique SNF bill identified by an alpha letter "U" in the third position.

o The date of admission on the swing-bed SNF bill is the date the patient began to receive a SNF level of care service.

o State level agreements may call for varying type of bill coding in Item 4. HCFA does not perform edits on type of bill coding on bills with 8 in the 2nd digit (bill classification), in field 6 (location 54) of the UNIBILL inpatient record if the record is identified in field 1 as hospital or SNF. Therefore, accept with subsequent conversion, any bill type agreed to at the State level to identify swing-bed billing, e.g., 18X, 28X, 11X, 21. Be sure the record identification of UNIBILL field 1 is consistent with the provider number shown.

o If the hospital has 50-99 beds, additional processing rules apply:

— The hospital may not be paid for more than the number of capped days for swing bed stays. See subsection C for determining the limitation.

— Payment may not be made for services furnished after the end of the 5 day period (excluding weekends and holidays) beginning when the hospital is notified that a bed is available in a SNF, unless the patient's physician certifies within that 5-day period that transfer to a SNF is not medically appropriate.

The PRO is responsible for review to assure that the provider has considered availability of a SNF bed and obtained appropriate certification. Assume that payment is appropriate on initial bills, subject to the cap limitation. The PRO may later deny the bill and notify you.

See §3130.1 for additional coverage policy information.

C. Determination of Capped Amount (50-99) Bed Provider.--Maintain a record for each swing bed provider of 50-99 beds. This record must contain:

- The capped amount for the period;
- The SNF days paid for the period (or the days remaining if you prefer); and
- The date the cap is met (not the date you record it).

Notify the hospital if a beneficiary's extended care stay cannot be covered because the cap has been reached. In such a case, the law prohibits payment under Part A. However, payment may be made under Part B for certain medical and other health services. (See §3110.)

On each bill from a provider with 50-99 beds, determine whether the provider had already been paid for its limit of capped days before the date of admission to the SNF level of care. If an admission occurs prior to the date the capped days are exhausted, the entire stay is reimbursed (if otherwise covered) even though the cap is met during the stay.

Determine the number of capped days by multiplying .15 times the product of the number of days in the cost reporting period and the average number of licensed beds at the hospital for the period. From your State licensing agency, determine the number of licensed beds at the beginning of the current cost reporting period or from the date of the swing bed approval, if later.

In States that do not license beds, hospitals use the average number of hospital beds reported on their most recent Certificate of Need (CON) (excluding bassinets). If during the cost reporting period, there is an increase or decrease in the number of licensed beds, multiply the number of licensed beds for each part of the period by the number of days for which that number of licensed beds was available. After totalling the results, compute 15 percent of the total available licensed bed days to determine the payment limitation.

3638. BILLING BY HOME HEALTH AGENCIES

HHAs use the HCFA-1450 when billing for services rendered under a plan of treatment and for medical and other health services. Beneficiaries are entitled to unlimited home health visits when they meet the requirement of intermittent care and are homebound.

Start of care Notices are not required when billing for services, therefore, maintain a Medicare elgibility history file to determine when a beneficiary is entitled to Medicare Part A or Part B. When entitlement is questionable, submit a status query. (See §3507.3.)

3638.1 When Bills are Submitted.—The HCFA-1450 is submitted on a periodic basis, e.g., monthly.

- For services furnished under a home health plan of treatment when a bill includes at least one visit.
- For medical and other health services under Part B. (See §3127.)
- The patient (or his representative) refuses to request payment on his behalf.
- When the beneficiary is a HMO enrollee and you have jurisidiction for processing.
- The provider is responsible for not filing a timely claim for payment. (See § 3309.1.)

The agency must submit a separate bill for each beneficiary for services provided in different accounting years.

3638.2 Billing for Nonvisit Charges.—For benefits furnished under a Part A home health plan the HHA will normally prepare and submit a HCFA-1450 only when the bill includes charges for at least one visit. If only nonvisit charges (e.g., nonroutine medical supplies, DME) were incurred during the billing period and it is expected that another visit will be made under the existing plan of treatment, the HHA will not immediately submit a bill but include such nonvisit charges on the next billing which does reflect a visit.

When a nonvisit charge is incurred after the last home health visit, but before the plan is terminated, the HHA does not bill for the nonvisit charge until termination of the plan. It then submits a HCFA-1450 showing only the nonvisit charge as a separate line item, with an annotation "Final Covered Charge" in Item 94, Remarks.

Do not forward a bill record showing only the final covered nonvisit charge to HCFA. Instead, pay the covered charge and notify the beneficiary of payment made on his behalf.

Nonvisit charges incurred after termination of the plan are reimbursable under Part B medical and other health services.

3638.3 Payment System for HHA Claims.—Maintain the payment of claims for home health services in three categories to ensure proper accumulation of data for the PS&R and the cost report.

- o Services under a plan of treatment, beneficiary is entitled to Part A.
- o Services under a plan of treatment, beneficiary is entitled to Part B only (Part B Trust Funds).
- o Medical and other health services.

3638.4 DME Furnished as a Home Health Benefit.—Effective July 18, 1984, medical applicances furnished as a covered home health service are redefined as DME in accordance with the definition in §3113.1 and are subject to 20 percent coinsurance. Items which prior to July 18, 1984, could qualify as medical appliances under the home health benefit, but which do not meet the definition of DME, may be covered if the requirements in §3113.1B3, which pertain to such items, are met. Medicare reimbursement cannot exceed 80 percent of the reasonable cost of the DME. DME furnished free, or at a nominal charge by a public HHA, or by another HHA which requsts and receives approval to have payments made to it as a public HHA because a significant portion of its patients are low income, receive interim reimbursement equal to the number of covered visits times the estimated reasonable cost per visit. Coinsurance is applicable for DME furnished at a nominal charge. All DME billed under these instructions must be identifiable for cost report and final cost settlement purposes.

Where a beneficiary meets the criteria for coverage of home health services and the HHA is providing the care under Part A, any DME provided is under Part A (Bill Type 33). Where the patient meets the criteria for coverage of home health services and the HHA is providing the care under Part B because the patient is not eligible for Part A, the DME provided by the HHA may, at the beneficiary's option, be billed under Bill Type 33 or as a medical and other health service (Bill Type 34).

For DME billed under the home health benefit, generate a notice to the beneficiary to be used for payment of coinsurance by Medicaid and other supplementary insurance carriers. An EOMB or other notice may be used, but include the following language:

"Effective July 18, 1984, an individual receiving home health services is required to pay 20 percent coinsruance for the use of DME, e.g., hospital bed, wheelchair, respirator, walker. For your portion of the charge for use of durable medical equipment furnished to you from ________________ to ________________ the provider of services shown above may bill you for $ __________ coinsurance. If you have other health insurance that pays for some or all services not paid by Medicare, you may use this notice to claim the other insurance benefits. Since the insurance company may keep this notice, make a copy before sending it."

3638.5 More Than One Agency Furnished Home Health Services.—When a physician deems it necessary to use two participating HHAs, the physician designates the agency which renders the major services and assumes the major responsibility for the patient's care. The primary agency bills for all services rendered by both agencies and keeps all records pertaining to the care. The secondary agency is reimbursed through the primary agency under mutually agreed upon arrangements.

Where agencies do not agree on a prearranged agreement for billing and reimbursement, each agency:

- o Establishes a home health plan of treatment and required certification.
- o Advises the other agency of services provided to avoid duplication of services.
- o Secures independently the necessary physician signature.

3638.6 Home Health Services Are Suspended or Terminated Then Reinstated.—A physician may suspend visits for a time to determine whether the patient is recovered sufficently to do without further home health services. When the suspension is temporary (not more than 60 days) and the physician later determines that the services must be resumed, the resumed services are paid under the same program (Part A or Part B) and plan of treatment as before. The date care started and the date plan established remain the same as on the initial bill. A no-payment bill should not be submitted for the period in which there were no visits.

For Medicare reimbursement, a suspension of home health visits for more than 60 days terminates the plan of treatment unless the physician has reviewed the plan and made an appropriate recertification (see §3326) within 60 days, indicating that the lapse of visits is a part of the planned regimen for the patient. If there has been no recertification, no discharge bill is prepared by the agency.

There may be instances in which a physician determines that home health services furnished under Part A are no longer necessary and discharges the patient. The physician may later determine that the home health services are again necessary and may establish a plan for services related to the same condition. However, since the previous plan of treatment was terminated, the subsequent services must be established under a new plan of treatment.

3638.7 Preparation of a Home Health Billing Form in No-Payment Situations.—

A. No Utilization Chargeable.—HCFA does not maintain open items on start of care. Therefore, do not forward a bill record on bills where no payment is made.

B. Utilization is Chargeable.—Even though no payment is made, a fully completed home health form must *always* be submitted when:

- o The patient or his representative refuses to request payment on his behalf. The agency should enter "Refused Payment" in the open area under

Item 94. Send the beneficiary a denial notice as indicated in §3722.4, MISC-1, which explains the reason for Medicare nonpayment.

- **You deny the bill because the provider fails to submit the requested information.**
- **The provider is responsible for not filing a timely claim for payment. (See §3309.1.)**
- **A waiver of liability decision results in the beneficiary being found without fault and the provider being at fault. Process the bill as a nonpayment case, even though the beneficiary may be reimbursed through the indemnification procedure.**

If the bill reviewer determines that additional information is needed for any item on the bill in order to make a final decision, and the provider fails to submit the requested information, deny the entire bill. Denying the entire bill:

- Permits easier bill processing procedures;
- Protects the beneficiary because he cannot be billed by the provider for any services furnished for the billing period;
- Motivates the provider to submit the needed information; and
- Provides for simpler procedures if the bill is later reopened.

3638.8 Intermediary Denies HHA Bill But Plan of Treatment Still in Effect.—After previous bills have been paid for a beneficiary under a plan of treatment which is still in effect, a bill submitted to you may be noncovered, e.g., for services that are precluded from payment or for items or services not related to the plan of treatment. Process the denial and notify the beneficiary. Do not batch the nonpayment bill. Retain the bill and records until 60 days have elapsed after the last covered services were provided, since at that time the plan of treatment may be considered terminated.

When you determine that noncovered services were furnished from the start of care date to discharge, notify the provider and beneficiary but do not submit a bill to HCFA.

3638.9 Billing for Part B Medical and Other Health Services.—Form HCFA-1450 is submitted for certain Part B medical and other health services for which a HHA may receive reimbursement. (See §3127.)

A. Patient Not Under a Home Health Plan of Treatment or Visits Exhausted.—The HHA uses a HCFA-1450 (Bill Type 34x) to bill for certain Part B "medical and other health services" when there is no home health plan of treatment. Specifically the HHA may bill for the following services. (There must be a physician's certification on file.):

o Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations.

o Rental or purchase of DME.

o Ambulance service operated by the HHA.

o Prosthetic devices. (See §3660.6 for billing enteral and parenteral supplies and equipment.)

o Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.

o Outpatient physical therapy services. (See §§3147ff.)

o Outpatient speech pathology services. (See §§3147ff.)

o Outpatient occupational therapy services. (See §§3147ff.)

B. The Patient is Under a Home Health Plan of Treatment.—If a patient is receiving home health services under a plan of treatment the agency may bill for the following services on form HCFA-1450 (Bill Type 34x). All other services are home health services and should be billed for on form HCFA-1450 with Plan of Treatment Bill Types (33x for Part A or 32x for Part B.)

o Ambulance service operated by the HHA.

o Prosthetic devices not covered as medical supplies. (See §3660.6 for billing for enteral and parenteral supplies and equipment.)

o Rental or purchase of DME.

o Outpatient rental or purchase of DME.

NOTE: Do not bill rental or purchase of DME or outpatient physical therapy, speech pathology and occupational therapy services as a medical and other health service unless the patient is entitled to Part B only and elects to have these services billed under this benefit.

C. Billing Spanning Two Calendar Years.—The agency should not submit a Part B medical and other health services bill for an inclusive period beginning in one calendar year and extending into the next. If the agency does not bill on a calendar month basis, it prepares two bills. The first covers the period ending December 31 of the old year; the second, the period beginning January 1 of the new year. This permits you to apply the appropriate deductible for both years.

3642. RURAL HEALTH CLINICS

A. Full-Time Physician Employees.—Physicians who are full-time employees of a RHC may furnish services to clinic patients at the clinic facility or in other locations, such as in a patient's home or in a hospital. These services are RHC services and are reimbursable only to the clinic. Thus, a physician who is a full-time employee of a RHC may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic patients regardless of place of service. It is possible, however, that such physicians may provide services to beneficiaries who are not clinic patients and payment may be made on a reasonable charge basis for these services. In these situations, such physicians would bill the Medicare program through the carrier for services furnished to Medicare beneficiaries for these nonclinic services.

NOTE: The status of whether a physician is full time or part time is determined by his agreement with the RHC.

B. Part Time Physician Employees-RHC Services.--A physician who is a part time employee of the clinic may provide medical services to clinic patients under an agreement with the clinic. In that event, any services furnished by the physician to patients at the clinic facility are RHC services, and, as such, are reimbursable only to the clinic. The physician must seek compensation for the services from the clinic; the services may not be billed to the Medicare program on a reasonable charge basis. The amount paid by the clinic for the services is an allowable clinic cost to the extent it is reasonable.

C. Part Time Physician Employees-Non-RHC Services.--The services furnished to clinic patients in locations other than at the clinic facility by physicians who are not full-time employees of a clinic may or may not be RHC services, depending upon the agreement between the clinic and the physician. If the agreement provides that the clinic will compensate the part-time physician for these services, the clinic includes this compensation in its allowable costs and is reimbursed as part of its per visit rate. The physician may not bill the Medicare program on a reasonable charge basis.

If the clinic's agreement with the part-time physician does not provide for the clinic to compensate the physician for services furnished to clinic patients in locations other than at the clinic facility, Medicare payment for covered services furnished to beneficiaries at other sites is on a reasonable charge basis through the area carrier.

D. Other Services.--Certain items and services furnished by clinics may be covered under the Medicare program but are not included in the definition of RHC services. Among these are ambulance sevices and DME. Clinics may bill the carrier on a reasonable charge basis for these services.

3642.1 Coordination Between RHC Intermediaries and Carriers.--Because of the reimbursement practices when physicians associated with an RHC are eligible to receive payment from either you or the area carrier, close coordination among the RHC, you, and the carrier is required to prevent duplicate payment.

A. Release of Information From the RHC to You.--Within 30 days of receipt of certification of the RHC, secure the following information:

- o The names of all physicians associated with the clinic and their relationship with the clinic (e.g., owner, full or part-time supervisor or other) and the address of any place other than the clinic where the physician renders services.
- o A copy of any written compensation agreement between the physician and the clinic.

You should receive a list of any accretions or deletions to the above list of personnel within 30 days of the occurrence.

B. Transfer of Information Between You and the Area Carrier.-- Within 60 days of certification of the RHC, send to the carrier servicing the area in which the RHC is located the following:

- o The names of all physicians associated with the clinic, their relationships with the clinic, and the address of any place other than the clinic where they render services;
- o A copy of any written compensation agreement between the physician and the clinic; and
- o The names of all RHC physicians who must also provide coverage at the emergency room of hospitals at which they have staff privileges.

NOTE: Travelers acts as the Part B carrier for Railroad Retirement beneficiaries. These beneficiaries can be distinguished from other beneficiaries by their unique claim numbers. These numbers contain an alpha prefix instead of an alpha suffix. The RHC intermediary must also send the above information to Travelers within the time frames specified and carry out the following duplicate check procedures.

Provide the area carrier and Travelers with anv accretions or deletions to the above information within 15 days of receipt.

C. Comparison of Your and Carrier Records for Providers Associated with RHCs.--During the first week of each calendar quarter (January, April, July, October) provide the appropriate carrier with a magnetic tape in HICN sequence containing only the claims of the RHCs involved with a given carrier that were processed and paid within the previous 3 months. A tape will be created for each carrier servicing any medical personnel who are affiliated with a RHC.

The format of the tape is:

Tape Header

Standard IBM

LINE ITEM

HIC/Beneficiary Name/Date of Service/Provider Identification/Control Number

Tape Characteristics

9 Track
1600 BPI
Standard 1200' or 2400' reel

External Label

Intermediary Name, Address, Record Identification Rural Health Clinic Dup Control (date), Record Length, Block Size

Record Description

Field	Size	Type	Location
1. HICN (See §3502ff. for an explanation of the HICN). The number is shown left-justified with unused columns blank.	12	A/N	1-12
2. Beneficiary Surname - First Initial-Middle Initial - Should be left justified. Remaining spaces blank. Do not use punctuation. Show two-word surnames as one word.	8	A	13-20
3. Date of Service - MMDDYY	6	N	21-26
4. Provider Identification - Provider ID Number assigned to the RHC.	6	N	27-32
5. Control Number - May be the DCN, Batch Number, or any data you desire. Data entered here will be returned by the carrier for all matching records.	15	A/N	33-47

In those cases where medical personnel associated with an RHC may be served by more than one carrier, provide the 3-month history to all carriers. This condition may be determined by reviewing the information received from the RHC as explained in §3642C and flagging the records of personnel served by other carriers.

Each quarter:

- Within 15 days of receipt of the intermediary's tape, the carrier will match this tape against its history file. A match is based on:
  - Beneficiary HICN.
  - Date of service on your record being the same or within dates of service on the carrier's file.
- For all records determined to be a potential duplicate, the carrier sends a copy of its history file and supporting documentation to interpret the history, including the control number of the matching record for investigation. (Documentation will only be provided with the initial submittal.) The carrier provides a history printout unless tape is specifically requested.
- Investigate matches by comparing the RHC's bill to the record received from the carrier and determining which, if any, is a duplicate charge. Depending on initial findings, determine whether all matches require development or whether a sample review is sufficient.
- If you determine that the RHC was in error, make necessary adjustments and institute recovery procedures against the RHC. (See SS3707ff.)
- If you determine that the carrier-filed HCFA-1490 was in error, send all pertinent information to the affected carrier for necessary action.

3644. DIALYSIS FOR ESRD - GENERAL

A. Methods of Payment for Home Dialysis Patients.--Medicare beneficiaries dialyzing at home can choose between two methods for Medicare program payment for care (exclusive of physician services). The choice is indicated on Form HCFA-382, Beneficiary Selection Form. A change in method may be made annually effective January 1 of the following year. The ESRD facility is responsible for obtaining the selection form and forwarding it to you.

In addition, HCFA includes the method the beneficiary has selected in the query reply "S" trailer which is appended to query replies or to the Code 39 automatic notice. See §3535.1).

Method I

If the dialysis facility with which the Medicare home patient is associated assumes responsibility for providing all home dialysis equipment and supplies, the beneficiary may decide to have the facility provide these items. For this service, the facility receives the same Medicare dialysis payment rate as it would receive for an infacility patient under the composite rate system. The beneficiary is responsible for paying any unmet Part B deductible and the 20-percent coinsurance on the Medicare rate to the facility.

Under Method I items and services included in the composite rate must be furnished by the facility, either directly or under arrangement. If it fails to provide (either directly or under arrangements) any part of the items and services covered under the rate, the facility cannot be paid any amount for the items and services that it does furnish. These items and services include:

- Medically necessary dialysis equipment and dialysis support equipment;
- Home dialysis support services including the delivery, installation, maintenance, repair, and testing of home dialysis equipment, and home support equipment;
- Purchase and delivery of all necessary dialysis supplies;
- Routine ESRD related laboratory tests; and
- All dialysis services furnished by the facility's staff.

Some examples (but not on all-inclusive list) of items and services that are included in the composite rate and may not be billed separately when furnished by a dialysis facility are:

- Staff time used to administer blood;
- Declotting of shunts and any supplies used to declot shunts;
- Oxygen and the administration of oxygen; and
- Staff time used to administer nonroutine parenteral items.

See Chapter 27 of the Provider Reimbursement Manual, Part I, for more information on establishing the composite rate.

Method II

The beneficiary retains the right to deal directly with the Medicare program and make arrangements for securing the necessary supplies and equipment to dialyze at home. Under this arrangement, the beneficiary is responsible for dealing with the facility or the various suppliers and the Medicare program to arrange for payment. The beneficiary is also responsible to the facility or suppliers for any unmet Part B deductible and the 20-percent Medicare coinsurance requirements. The dialysis facility may not bill for or receive the composite rate for treatments furnished.

The facility furnishes and bills for all home dialysis support services. The facility may be paid for home dialysis support services; the beneficiary may not. However, the beneficiary may obtain the remaining supplies and equipment from the facility that are not obtained from a supplier. If the beneficiary chooses the facility to act as a supplier, the facility may bill you for any supplies and/or equipment it provides. Hospital-based facilities are reimbursed the reasonable cost of support services and any items not furnished by an outside supplier, subject to the lesser of cost or charges provisions of section 1833(a)(2)(A) of the Social Security Act. Independent facilities are reimbursed on a reasonable charge basis for any home dialysis support services they furnish; and on a reasonable cost basis for any supplies or equipment they furnish.

B. Processing Home Dialysis Claims.--

o Use the method of election information provided in the 'S' query reply trailer to verify the beneficiary's election. See §3535.1.

o Check the claim to determine if there is EGHP insurance. See §§3490ff. where the beneficiary is covered under the EGHP insurance.

o If the beneficiary has elected Method I, process the claim per §3644.1.

o If the beneficiary has elected Method II, do not pay the composite rate. Follow §3644.3.

o The effective date of the election chosen by the home dialysis beneficiary on the HCFA-382 is the date the patient signed the form. Prior to that date all home dialysis items and services are billed and reimbursed in accordance with Method II. Therefore, the facility may not be paid the composite rate for any home dialysis treatments furnished prior to the date that the patient signed the HCFA-382. The effective date for changes is the January 1 that follows the date of election.

o All home dialysis patients must have chosen either Method I or Method II. If you receive a claim on behalf of a beneficiary for whom you have not received a copy of the HCFA-382, hold the claim. Contact the facility immediately for a copy of the HCFA-382. Process the claim accordingly.

C. Reduction in Medicare Program Reimbursement Due to P.L. 99-509.—

1. General.—On October 21, 1986, the Omnibus Budget Reconciliation Act of 1986 (OBRA) (P.L. 99-509) was enacted. Section 9335(j) of OBRA requires the Secretary to reduce the amount of each composite rate payment for each treatment by 50 cents and to allocate these amounts to ESRD network activities. This section of OBRA applies to all dialysis treatment furnished on or after January 1, 1987. All Medicare hospital-based and independent ESRD facilities reimbursed the composite rate are affected.

2. Changes Required in Bill Payment Procedures.—Revise your program for calculating payment. Deduct 50 cents per treatment on each claim from the amount paid to ESRD facilities for all treatments furnished on or after January 1, 1987. For example, if a facility's composite rate payment is $120, Medicare will pay the renal facility $95.50 per treatment, ($120 x 80% - $.50). The 50 cents reduction is also applicable to modes of dialysis other than hemodialysis (including training treatments). Reduce the facility's weekly composite rate payment by $1.50 for CAPD or continuous CCPD. Where there is less than a week of CCPD or CAPD treatment, prorate the $1.50. For peritoneal dialysis furnished in sessions of greater than 20 or 30 hours per treatment, multiply the 50 cents reduction times 1.5 or 3 depending upon the length of the treatment.

Report the reduction amount in your PS&R and UNIBILL using value code 71 in field 30 of UNIBILL to identify monies withheld to fund ESRD networks. Enter the dollar amount in field 31 of UNIBILL.

Indicate for the individual claims on your remittance record to the facility the Medicare payment reduction allocated toward funding the ESRD networks.

3. Application of ESRD Network Funding to MSP Claims.—Apply the ESRD offset for network funding on MSP claims as follows:

o Where another payer, primary to Medicare, pays the claim in full, no ESRD offset is applicable;

o Where another payer, primary to Medicare, makes a partial payment, deduct the ESRD offset for each treatment as described in subsection C2 from the Medicare secondary payment amount;

o Where the ESRD offset amount is greater than the secondary payment amount, apply the entire Medicare secondary payment amount towards the ESRD network funding. No Medicare secondary payment would be made to the facility in this situation and no further ESRD offset is applicable. Do not make an additional ESRD offset for treatments on this claim against other payments to the facility on the same remittance or on future payments for the same beneficiary.

See §§3490.8 and 3490.9 for determining what constitutes a full or partial payment by a primary payer.

3644.1 Special Consideration When Processing ESRD Bills Under Method I.—Laboratory reimbursement for certain laboratory tests, whether performed by the facility or through an independent laboratory, is included in the composite rate and may not be billed separately. These tests are listed in SS3172ff.

Hospitals may not show charges anywhere on the bill for these laboratory tests if they are performed in the hospital's laboratory. Hospitals must maintain a log of these charges in their records for cost apportionment purposes. Charges for any laboratory tests performed in the dialysis unit must be included in the hospital's dialysis charge.

Pharmacy

Parenteral items routinely used in the dialysis procedure are covered under the facility's composite rate. Following is a list of the routine items that may not be billed separately:

heparin
protamine
mannitol
saline
glucose
dextrose
antiarrythmics

Also, included in routine pharmacy would be topical anesthetics (e.g., xylocaine).

There are other parenteral items that are not routinely furnished as a part of the dialysis procedure but may be medically necessary for some patients receiving dialysis. When furnished to infacility dialysis patients these may be billed separately provided they are justified for medical necessity. They include:

antibiotic
hematinics
anabolics
analgesics
sedatives
tranquilizers
muscle relaxants

These other parenteral items (i.e., those not included as routine) may only be billed by a ESRD facility if they are administered in the facility by its staff.

CCPD and CAPD Sessions - CCPD and CAPD is billed and reimbursed on the basis of an equivalence rate. Because CCPD and CAPD are continuous therapies, and not furnished in discrete treatments, they are reimbursed at three times the facility's per treatment composite rate per week. The facility must show the number of patient weeks (including any fraction of a patient week) in place of the number of treatments. If the patient is hospitalized, is dialyzed in a facility, or the facility bills on a monthly basis and there are 31 days in the month, the odd days are accounted for by prorating the weekly rate by 1/7 for each day.

Example

Facility A has a CAPD patient who dialyzes on CAPD for the full month of January. Facility A bils on a monthly basis and its per treatment composite rate is $130.

For the 3 additional days:
CAPD daily rate = 1/7 x $390 = $55.71
2 x $55.71 = $167.13

The proper total amount billed for January is:

$1,560 + $167.13 = $1727.13

Part B
Assume the patient's deductible amount is met. Your payment is 80% x $1,727.13 = $1,381.70.

Require facilities to bill only full weeks (e.g., every 4 weeks) to avoid the above computation.

Training Sessions'

Hemodialysis, Peritoneal Dialysis, and CCPD

Training sessions for these types of dialysis are billed at their approved frequencies and reimbursed the composite rate plus $20.

CAPD Training Sessions

CAPD training sessions are reimbursed the composite rate plus $12. A maximum of 15 CAPD training sessions are covered routinely for each patient. The training session(s) billed must be enumerated on the bill (either in the unlabeled column to the right of item 50 or in Remarks), e.g., "CAPD training sessions nos. 6-10." Claims for additional training sessions beyond 15 may be paid if they are documented for medical necessity. Extra training sessions raise questions about either the adequacy of CAPD for the patient or the patient's capacity to learn to perform the CAPD technique. The patient's physician should address these questions in his explanation of the need for extra training sessions. Report any facilities that consistently bill for excessive CAPD training sessions to the ARA, HSQ RO to determine whether there are any problems with the facility's training program that require improvement.

If it is necessary to supplement the patient's CAPD during training with either hemodialysis or peritoneal dialysis sessions, these sessions are billed and reimbursed as any other session furnished by the facility.

The facility must indicate on the bill the number of the session and that this session is supplemental to CAPD training; e.g., "CAPD training supplemental dialysis session no. 2." Normally, not more than three supplemental dialysis sessions during the training course are necessary.

Infacility Back-Up Dialysis

A back-up dialysis is an infacility dialysis furnished to a home dialysis patient.

Condition code 76 must appear as one entry in items 35 through 39.

Equipment and Equipment Related Services Provided to Home Dialysis Patients

Home dialysis equipment may not be billed separately. It is included in the composite rate.

Delivery, installation, repair, maintenance, and removal services may only be billed separately under a 100-percent reimbursement agreement for home dialysis equipment. The composite rate adjusted (composite rate reduced by $12) is used to reimbursement the remaining items and services covered under the composite rate.

best copy available

3644.2 Review of ESRD Bills Under Method I.—All items on the HCFA-1450 are completed in accordance with §3604 except for the following.

Item 4. Type of Bill

Required. This three-digit numeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (only codes used to bill Medicare are shown).

First Digit - Type of Facility

Hospital-based renal dialysis facilities enter code "1" Hospital.

Independent renal dialysis facilities enter code "7" Clinic.

Second Digit - Classification

Hospital-based renal dialysis facilities enter code "3" Outpatient.

Independent renal dialysis facilities enter code "2" Free-Standing Renal Dialysis Center.

Third Digit - Frequency

Hospital-based and independent renal facilities enter the appropriate code as defined below.

1 - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of outpatient treatment for which the provider expects reimbursement from the payer.
2 - Interim - First Claim	This code is used for the first of an expected series of payment bills for the same course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for the same course of treatment has been submitted and further bills are expected to be submitted later.
4 - Interim - Last Claim	This code is used for a payment bill which is the last of a series for this

	course of treatment. The "Through" date of this bill (Item 22) is the discharge date for this course of treatment.
5 - Late Charge Only	This code is used only for outpatient claims. Late charge bills are not accepted for Medicare inpatient claims.
7 - Replacement of Prior Claim	This code is used when the provider wants to correct (other than late charges) a previously submitted bill. This is the code applied to the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is also submitted to show the corrected information.

Item 15. Admission Date
Not required.

Item 17. Type of Admission
Not required.

Item 18. Source of Admission
Not required.

Item 21. Patient Status
Not required.

Item 22. Statement Covers Period (From-Through)
Required. Hospital-based and independent renal dialysis facilities:

Show the dates during which the patient's care was under the supervision of the facility. Exclude dates when the patient's care was under the supervision of another entity (e.g., hospital, another ESRD facility, SNF.)

Item 23. Covered Days
Not required.

Item 24. Noncovered Days
Not required.

Item 25. Coinsurance days
Not required.

Item 26. Lifetime Reserve Days
Not required.

Item 33. Occurrence Span Code and Dates
Not required.

Item 34. Untitled
Not required.

Item 35, 36, 37, 38, and 39. Condition Codes
Required. Hospital-based and independent renal facilites complete this item. Note that one of the codes 71-76 will be applicable for every bill.

Code Structure (only codes effecting Medicare payment/processing are shown).

CODE	TITLE	DEFINITION
02	Condition is Employment Related	Providers enter this code if the patient alleges that the medical condition causing this episode of care is due to environment/events resulting from employment.
04	Patient is HMO Enrollee	Providers enter this code to indicate the patient is a member of an HMO.
71	Full Care in Unit	Providers enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	Providers enter this code to indicate the billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care in Training	Providers enter this code to indicate the billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.
74	Home	Providers enter this code to indicate the billing is for a patient who received dialysis services at home but code 75 below did not apply.

CODE	TITLE	DEFINITION
75	Home 100 Percent Reimbursement	Providers enter this code to indicate the billing is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100 percent program.
76	Back-up Infacility Dialysis	Providers enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.

Item 40. Pints of Blood Furnished
Required. Hospital-based and independent renal facilities must complete this item. Providers enter the total number of pints of blood or units of packed red cells furnished, whether or not replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1 1/4 pints is shown as 2 pints. This entry serves a basis for counting pints towards the blood deductible.

Item 41. Pints of Blood Furnished
Required. Hospital-based and independent renal facilities must complete this item. Providers enter the total number of pints of blood donated on the patient's behalf. Where one pint is donated, one pint is replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration, i.e., it does not charge a "replacement deposit fee" for unreplaced pints, the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 39x revenue code series (blood administration).

Item 42. Pints of Blood Not Replaced
Required. Hospital-based and independent renal facilities must complete this item. Providers enter the difference between the number of pints of blood furnished and the number of pints replaced.

Item 43. Blood Deductible Pints
Required. Hospital-based and independent renal facilities must complete this item. Providers enter the number of unreplaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.

Item 44. Special Program Indicator
Not required.

Items 46, 47, 48, and 49. Value Codes and Amounts

Required. Providers enter a code(s) and related amount(s) to identify data of a monetary nature necessary for the claim's processing. The codes are two numeric digits, and each value allows up to eight numeric digits (000000.00). Negative amounts are never shown. If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are two lines of data, line "a" and line "b." Items 46a through 49a are used before Items 46b through 49b (i.e., the first line is used up before using the second).

Code Structure (Only codes used to bill Medicare are shown.)

Code	Title	Definition
06	Medicare Blood Deductible	Part B Code indicates the amount that the patient paid for unreplaced deductible blood.
07	Medicare Cash Deductible	Part B Providers enter this code to indicate that the amount shown is the Part B cash deductible the patient paid in cases where the Part B blood deductible was also paid. In all other cases, the entry in item 60 reflects the Part B deductible paid by this patient and no entry is needed in this item.
12	Working Aged Beneficiary/Spouse With EGHP	Providers enter this code to indicate the amount shown is for a higher priority employer group health insurance payment made on behalf of an aged beneficiary that the provider is applying to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage.
13	ESRD Beneficiary in the 12-Month Coordination Period With An EGHP	Providers enter this code to indicate that the amount shown is that portion of a higher priority EGHP payment on behalf of an ESRD beneficiary that

Code	Title	Definition
		applies to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field, it is claiming a conditional payment because the EGHP has denied coverage or there has been a substantial delay in its payment.
14	Automobile, No-Fault, or Any Liability Insurance	Providers enter this code to indicate the amount shown is that portion of a higher priority automobile, no-fault, or liability insurance payment made on behalf of a Medicare beneficiary that they are applying to covered Medicare charges on this bill. If they enter six zeros (0000.00) in the amount field, they are claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment.
15	WC/BL	Providers enter this code to indicate the amount shown is that portion of a higher priority WC insurance payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. If the provider enters six zeros (0000.00) in the amount field it is claiming a conditional payment because there has been a substantial delay in the other payer's payment.
16	VA, PHS, Other Federal Agency	Providers enter this code to indicate the amount shown is that portion of a higher priority VA, PHS, or other Federal Agency's payment made on behalf of a Medicare beneficiary that they are applying to covered Medicare charges on this bill.
71	Funding of ESRD Networks	PROVIDERS DO NOT ENTER THIS CODE. FOR PAYER INTERNAL USE ONLY. Indicates the amount of Medicare payment reduction to help fund the ESRD networks.

Item 50. Revenue Description
Required. Refer to §3170 for detailed information on when providers may bill for these revenue centers. A complete list of revenue codes and descriptions is in Addendum C.

Unlabeled Column Required with Peritoneal Dialysis

When a revenue code in the 83x series (peritoneal dialysis) is placed in Item 51, an entry must also appear in the untitled column to the left of Item 51. This entry identifies the duration (number of hours) of the peritoneal treatments.

Peritoneal dialysis is usually done in sessions of 10-12 hours durations 3 times per week, and each session is billed and reimbursed as one treatment. Providers enter the number of hours for each session in this column. They also enter the number of sessions (treatments) in Item 52.

Some peritoneal dialysis is done only once or twice a week for a longer duration per treatment. Therefore, peritoneal dialysis sessions of between 20-29 hours duration will be reimbursed as 1 1/2 treatments. However, for purposes of billing, since fractions or decimals are not acceptable, the number of treatments is rounded upwards e.g., 1 1/2 treatments are equal to 2. The total number of treatments is placed in Item 52. In the unlabeled column, the number of hours for each treatment is entered so that proper reimbursement can be made.

Extended peritoneal dialysis sessions of 30 hours or more, given once a week, in place of 2 or 3 sessions of shorter duration are billed and reimbursed as three treatments. Providers enter the number of hours for each session in this column. They also enter the number of treatments in Item 52.

Item 52. Units of Service
Required. Hospital-based and independent renal facilities must complete this Item. The entries quantify services by revenue category, e.g., number of dialysis treatments. Units are defined as follows:

82X (Hemodialysis) - Sessions
83X (Peritoneal) - Sessions
84X (CAPD) - Days covered by the bill
85X (CCPD) - Days covered by the bill

Item 53. Total Charges
Required. Hospital-based and independent renal facilities must complete this item. Providers must show their customary charge in this item to correspond to the appropriate revenue code in Item 51. They must not enter their composite rate as their charge. The last revenue code entered in column 51 is "001" representing the total of all charges billed.

3644.3 Special Consideration When Processing ESRD Bills Under Method II.—These instructions apply only to home dialysis items and services billed and reimbursed under Method II. Under Method II, all home dialysis items and services must be billed and reimbursed on an itemized basis.

Under Method II, the home dialysis patient may choose to obtain home dialysis equipment and/or supplies directly from a supplier that is not a facility. In this case the patient (or supplier) bills the carrier. However, if the home dialysis patient chooses to obtain home dialysis equipment and/or supplies from the facility, the facility bills its intermediary on an itemized basis using basis using a HCFA-1450.

A. Laboratory.—Independent facilities may not bill for laboratory tests.

Hospital-based laboratories providing laboratory service to hospital dialysis patients of the hospital's dialysis facility will be paid in accordance with the outpatient lab provisions. However, where the hospital lab does tests for an independent dialysis facility or for another hospital's facility, the nonpatient billing provisions apply.

Specimen collection fee up to $3 will be allowed only in the following circumstances:

- Drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with a syringe or vacutainer to draw the specimen).
- Collecting a urine sample by catheterization. Both independent and hospital-based facilities bill this fee.

B. Pharmacy.—All routine ESRD parenteral items are billed in this item. Routine parenteral items may be covered without documentation for medical necessity and may be billed by an ESRD facility regardless of where they are furnished. All other parenteral items may only be billed by a hospital-based ESRD facility if they are administered in the hospital facility by its staff. They must be documented for medical necessity, either through information on the claims form, or as requested by you. Hospital-based facilities are reimbursed on a reasonable cost basis. Independent facilities are reimbursed on a reasonable charge basis. Obtain the reasonable charge from the carrier.

C. Home Dialysis Equipment.—Equipment that is owned by a facility may not be furnished by the facility on a rental basis. It must be sold. It is billed and reimbursed on either a lump sum or periodic purchase payment basis.

A facility may only furnish home dialysis equipment on a rental basis, if the facility itself rents the equipment from a supplier or manufacturer. In this case, no markup is allowed to the facility above its rental charge.

Determine the allowable cost of equipment furnished by or through a facility at the time you process the claim. You may also be able to compare this cost against the equipment costs reported by the facility on its Renal Dialysis Cost Report. Check with your audit department to determine whether the facility reported home dialysis equipments costs for patients not under the composite rate in a way that can be used for this purpose. Equipment distributed directly to a home patient by a manufacturer, but billed to the facility, is considered as furnished through the facility on the date the equipment is delivered.

Those services furnished with respect to dialysis equipment purchase before August 1, 1983, under the 100-percent reimbursement agreement, continue to be reimbursed at 100 percent of their costs.

D. Support Services.—All home dialysis support services must be furnished by a renal dialysis facility. A facility must bill for these services, and only a facility may be reimbursed. Hospital-based facilities are reimbursed on a reasonable cost basis. Independent facilities are reimbursed on a reasonable charge basis. An appropriate chrge for a service furnished by an independent facility must be reasonably related to the cost of furnishing the service. For example, the facility should indicate the length of time, type of personnel, and travel used in furnishing the service so that you may estimate the cost of furnishing that service. Do not allow a charge that is unreasonably related to the cost (e.g., a charge of twice the cost).

E. Support Services Furnished to Home CAPD Patients.—The support services specifically applicable to home CAPD patients must be furnished and billed by the sponsoring CAPD certified facility. These include, but are not limited to:

- Changing the connecting tube (also referred to as an "adminsitration set").
- Watching the patient perform CAPD and assuring that it is done correctly, and reviewing for the patient any aspects of the technique he may have forogtten, or informing the patient of modifications in apparatus or technique.
- Documenting whether the patient has or had had peritonities that requires physician intervention or hospitalization, (unless there is evidence of peritionities, a culture for peritonities is not necesary).
- Inspection of the catheter site.

These services are furnished in accordance with the written plan required for home dialysis patients. Each of the CAPD support services may be covered and reimbursed routinely at a frequency of once per month. Any support services furnished in excess of this frequency must be documented for medical necessity. For example, the patient may contract peritonities and require an unscheduled visit. (See §3170.3.)

Support services are reimbursed on a reasonable charge basis to independent facilities and a reasonable cost basis to hospital-based facilities. A reasonable cost determination must be made for each individual support service furnished to home CAPD patients. Use $75 as a guideline for the total of the reasonable costs for all support serivces furnished to each home CAPD patient in a month except changing the connecting tub (also referred to as the "administration set"). Lab services and supplies are not included. The connecting tub change may be reimbursed at an additional amount which generally should not exceed $15. (This amount includes both the supplies and the personnel service required. Although the guidelines provided appear to be high for the services, they are also intended to reflect the fact that staff time is often spent helping the patient in ways that cannot be directly billed, e.g., consulting with the patient over the phone.

F. Revenue Codes.—Only the following revenue codes may be billed.

25X **Pharmacy**

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of a licensed pharmacist. This includes blood plasma, other components of blood, and IV solutions.

This category should be used only for nonroutine drugs and biologicals since routine drugs and biologicals are included in the composite rate under METHOD I and are part of home dialysis supplies under METHOD II. They must be documented for medical necessity. The administration of drugs and biologicals (both staff time and supplies are covered and billed as revenue code 259).

Subcategory	Standard Abbreviation
0 - General Classification	PHARMACY
1 - Generic Drugs	DRUGS/GENERIC
2 - Non-generic Durgs	DRUGS/NONGENERIC
4 - Blood Plasma	BLOOD/PLASMA
5 - Blood-Other Components	BLOOD/OTHER
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRUGS/OTHER

27X **Medical/Surgical Supplies**

Charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

30X **Laboratory**

Charges for the performance of diagnostic laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	LABORATORY or (LAB)
1 - Chemistry	LAB/CHEMISTRY
2 - Immunology	LAB/IMMUNOLOGY
3 - Renal Patient (Home)	LAB/RENAL HOME
4 - Non-Routine Dialysis	LAB/NR DIALYSIS
5 - Hematology	LAB/HEMATOLOGY
6 - Bacteriology & Microbiology	LAB/BACT-MICRO
7 - Urology	LAB/UROLOGY
9 - Other Laboratory	LAB/OTHER

OTE: Under METHOD I, all hospital-based laboratories providing services to patients associated with hospital-based dialysis facilities are reimbursed according to the 62 percent fee screen. These bills are sent to you for payment. However, if the hospital is acting as an independent laboratory, it must bill you but will be reimbursed at the 60 percent level.

31X Laboratory Pathological

Charges for diagnostic laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that providers may wish to identify is provided.

Subcategory	Standard Abbreviation
0 - General Classification	PATHOLOGY LAB or (PATH LAB)
1 - Cytology	PATHOL/CYTOLOGY
2 - Histology	PATHOL/HYSTOL
4 - Biopsy	PATHOL/BIOPSY
9 - Other	PATHOL/OTHER

32X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided of the major areas and procedures that individual providers or third party payers may wish to identify.

Subcategory	Standard Abbreviation
0 - General Classification	DX X-RAY
4 - Chest X-Ray	DX X-RAY/CHEST
9 - Other	DX X-RAY/OTHER

38X Blood

Rationale: Charges for blood must be separately identified for private payer purposes.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD
1 - Packed Red Cells	BLOOD/PKD RED

Subcategory	Standard Abbreviation
2 - Whole Blood	BLOOD/WHOLE
3 - Blood Plasma	BLOOD/PLASMA
4 - Blood Platelets	BLOOD/PLATELETS
5 - Blood Leucocytes	BLOOD/LEUCOCYTES
6 - Blood - Other Components	BLOOD/OTHER COMP
7 - Blood - Other Derivatives (Cryoprecipitates)	BLOOD/ OTHER DER
9 - Other Blood (Describe)	BLOOD /OTHER

39X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD/STOR-PROC
1 - Blood Administration	BLOOD/ADMIN.
9 - Other Blood Storage & Processing	BLOOD/OTHER STOR

73X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in action of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Subcategory	Standard Abbreviation
0 - General Classifications	EKG/ECG
1 - Holter Monitor	Holter Mont
9 - Other EKG/ECG	Other EKG-ECG

82X Hemodialysis - Outpatient or Home Dialysis

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required; therefore, do not sum services at the zero level.

Subcategory	Standard Abbreviation
0-General Classification	HEMO/OP OR HOME
1-Hemodialysis/Composite	HEMO/OP/COMPOSITE

2-Home Supplies	HEMO/HOME/SUPPL
3-Home Equipment	HEMO/HOME/EQUIP
4-Maintenance/100%	HEMO/HOME/100%
5-Support Services	HEMO/HOME/SUPSERV
9-Other Hemodialysis Outpatient	HEMO/HOME/OTHER

NOTE: This revenue code should not be used to indicate sessions under METHOD II. However, backup dialysis furnished to home patients in the facility may be billed. (See condition code 76.)

83X Peritoneal Dialysis - Outpatient or Home

A waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	Standard Abbreviation
0-General Classification	PERITONEAL/OP OR HOME
1-Peritoneal/Composite	PERTNL/OP/COMPOSITE
2-Home Supplies	PERTNL/HOME/SUPPL
3-Home Equipment	PERTNL/HOME/EQUIP
4-Maintenance/100%	PERTNL/HOME/100%
5-Support Services	PERTNL/HOME/SUPSERV
9-Other Peritoneal Dialysis	PERTNL/HOME/OTHER

NOTE: This revenue code should not be used to indicate sessions under METHOD II. However, backup dialysis furnished to home patients in the facility may be billed. (See condition code 76.)

84X Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient

A continuous dialysis process performed in an outpatient or home setting, using the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0-General Classification	CAPD/OP OR HOME
1-CAPD/Composite	CAPD/OP/COMPOSITE
2-Home Supplies	CAPD/HOME/SUPPL
5-Support Services	CAPD/HOME/SUPSERV
9-Other CAPD Dialysis	CAPD/HOME/OTHER

NOTE: This revenue code should not be used to indicate sessions under METHOD II. However, backup dialysis furnished to home patients in the facility may be billed. (See condition code 76.)

85X Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home

A continuous dialysis process performed in an outpatient or home setting which uses a machine to make automatic exchanges at night.

Subcategory	Standard Abbreviation
0-General Classification	CCPD/OP OR HOME
1-CCPD/Composite or Other Rate	CCPD/COMPOSITE
2-Home Supplies	CCPD/HOME/SUPPL
3-Home Equipment	CCPD/HOME/EQUIP
4-Maintenance 100%	CCPD/HOME/100%
5-Support Services	CCPD/HOME/SUPSERV
9-Other Outpatient CCPD	CCPD/HOME/OTHER

86X Reserved

87X Reserved

88X Miscellaneous Dialysis

0 - General
1 - Ultrafiltration

3648. REVIEW OF HOSPICE BILLS

Form HCFA-1450 was developed by representatives of the hospital and health insurance industries to be suitable for billing most third party payers (both Government and private). Because it serves the needs of many payers, some data elements may not be needed by a particular payer. Detailed information is given only for items required for Medicare hospice claims. Items not listed need not be reviewed although providers may complete them when billing multiple payers.

Item 1. (Untitled) - Provider Name, Address, and Telephone Number
Required. The minimum entry is the provider's name, city, State, and ZIP code. The post office box number or street name and number may also be included. The State may be abbreviated using standard post office abbreviations. Five or nine digit zip codes are acceptable. Use the information to reconcile provider number discrepancies.

Item 4. Type of Bill
Required. This three-digit numeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as a "frequency" code.

Code Structure (only codes used to bill for hospice care are shown).

1st Digit - Type of Facility

8 - Special (Hospice)

2nd Digit - Classification (Special Facility)

1 - Hospice (Nonhospital Based)
2 - Hospice (Hospital Based)

3rd Digit - Frequency	Definition
A - Admission Notice	The hospice notifes you of the beneficiary's election of hospice benefits by fowarding form HCFA-1450. For admission purposes items 1, 4, 7, 10, 11, 12, 13, 15, 65, 68, 77, 92, and 93 are completed. (Also item 34 when the admission is for a patient who has changed an election from one hospice to another.)
1 - Admit Through Discharge Claim	This code is used for a bill encompassing an entire course of hospice treatment for which the provider expects reimbursement from the payer, i.e., no further bills will be submitted for this patient.
2 - Interim - First Claim	This code is used for the first of an expected series of payment bills for a hospice course of treatment.
3 - Interim - Continuing Claim	This code is used when a payment bill for a hospice course of treatment has already been submitted and further bills are expected to be submitted.
4 - Interim - Last Claim	This code is used for a payment bill which is the last of a series for a hospice course of treatment. The "Through" date of this bill (Item 22) is the discharge date or date of death.
7 - Replacement of Prior Claim	This code is used by the provider when it wants to correct (other than late charges) a previously submitted bill.

	This is the code applied to the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	This code indicates this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is also being submitted by the provider showing the corrected information.

Item 7. Medicare Provider Number
Required. This is the six-digit number assigned by HCFA.

Item 10. Patient's Name
Required. The patient's name is shown with the surname first, first name, and middle initial, if any.

Item 11. Patient's Address
Required. This item shows the patient's full mailing address including street number and name, post office box number or RFD, city, State, and ZIP code.

Item 12. Patient's Birthdate
Required. (If available.) The month, day, and year of birth is shown numerically as MM-DD-YY. If the date of birth was not obtained after reasonable efforts by the hospice, the field will be blank.

Item 13. Patient's Sex
Required. An "M" for male or an "F" for female must be present.

Item 15. Admission Date
Required. The admission date to the hospice is used to report the effective date of the hospice election. If a patient changes the election to another hospice, the admission date to the second hospice is shown. It represents the effective date of the hospice election change. The date of admission may not precede the physician's certification by more than 2 calendar days. The month, day, and year are shown numerically as MM-DD-YY.

EXAMPLE: The hospice election (admission) is January 1, 1986. The physician's certification is dated January 10, 1986. The hospice admission date for coverage and billing is January 8, 1986. The first hospice benefit period ends 90 days from January 8, 1986.

Item 21. Patient Status
Required. This code indicates the patient's status as of the "Through" date of the billing period (Item 22).

Code Structure
01 - Discharged (left care of this hospice)
30 - Still patient (remains a patient of this hospice)

40 - Died at home
41 - Died in a medical facility, such as a hospital, SNF, ICF or Free Standing Hospice
42 - Place of death unknown

Item 22. Statement Covers Period (From-Through)
Required. The beginning and ending dates of the period covered by this bill are shown in numeric fields (MM-DD-YY). Days before the patient's entitlement are not shown. The "From" date is used to determine timely filing. (See §§3307ff.) Since the 12 month hospice "CAP period" (see Hospice Manual §§405 and 407) ends each year on October 31, hospice services for October and November cannot be submitted on the same bill.

Items 28, 29, 30, 31, and 32. Occurrence Codes and Dates
Required. Code(s) and associated date(s) defining specific event(s) relating to this billing period are shown. Event codes are two numeric digits and dates are shown as six numeric digits (MM-DD-YY). If there are more occurrences than there are spaces on the form, Item 33 (occurrence span) or Item 94 (remarks) is used to record additional occurrences and dates.

NOTE: There are occurrences on which other payers require reporting that are not shown below. See §3419, §3490, and §3491 to determine when Medicare is the secondary payer.

Code	Title	Definition
42	Termination of Hospice Care	The date the patients hospice care ends. Hospice care may be terminated by a change in the hospice election to another hospice, a revocation of the hospice election, or death. Termination code 42 should be shown in item 28.

NOTE: See §3604 for additional occurrence codes and payment information where other payers are involved.

Item 34. Transferring Hospice I.D.
When a receiving (second) hospice submits an admission notice involving a patient who changed the hospice election and moved from one hospice to another, this item reflects the transferring hospice's complete name, address, and provider number. This information is an alert that the hospice admission continues a hospice benefit period rather than beginning a new one.

Items 46, 47, 48, and 49. Value Codes and Amounts
The only value codes that apply to hospice benefits are those that indicate Medicare payment is secondary to another payer. Deduct the amount of payment shown in the value field from the payment to the hospice. If the primary payment is greater than the payment due the hospice, adjust against past or future payments due the hospice for the beneficiary involved. See §3604 for a complete description of codes used for reporting primary payers.

Item 50. Revenue Description
Required. A narrative description or standard abbreviation for each revenue code shown in column 51 is shown on the adjacent line in column 50. The information assists clerical bill review. Descriptions or abbreviations correspond to the revenue codes shown in Addendum C. "Other" code categories descriptions are locally defined and individually described on each bill.

Item 51. Revenue Code
Required. For each reimbursement rate, a revenue code is assigned. The appropriate three-digit numeric revenue code is entered on the adjacent line in column 51 to explain each charge in column 53.

NOTE: Revenue code 657 identifies provider charges for physician services furnished to hospice patients by physicians employed by the hospice or receiving compensation from the hospice for services rendered. In conjunction with revenue code 657, the provider enters a physician procedure code. Request the carrier to provide area prevailing charge data for physician services provided to hospice patients. Make reasonable charge determinations for revenue code 657 by reimbursing the hospice for the lower of the area prevailing or billed charge. You are responsible for forwarding the physician procedure codes to the provider to facilitate hospice billing.

These are the revenue codes used by hospices to bill Medicare.

Code	Description	Standard Abbreviation
651	Routine Home Care	RTN Home
652	Continuous Home Care	CTNS Home (a minimum of 8 hours, not necessarily consecutive, in a 24 hour period is required. Less than 8 hours is routine home care for reimbursement purposes. A portion of an hour is 1 hour).
655	Inpatient Respite Care	IP Respite
656	General Inpatient Care	GNL IP
657	Physician Services	PHY SER (must be accompanied by a physician procedure code)

Item 52. Units of Service
The hospice enters the number of units for each type of service on the line adjacent to the revenue code and description. Units are measured in days for codes 651, 655, and 656, in hours for code 652, and in procedures for code 657.

Item 53. Total Charges
The hospice enters the total charges for the billing period by revenue code (column 51) on the adjacent line in column 53. The last revenue code entered in column 51 is "001" which represents the grand total of all charges billed. The total will be in column 53 on the adjacent line. Each line allows up to eight numeric digits (000000.00).

Items 57A, B, C. Payer Identification
If Medicare is the primary payer, "Medicare" is on line A.

If Medicare is not the primary payer, the primary payer is identified on line A and Medicare on line B or C, if appropriate. See §§3419, 3490, and 3491 to determine when Medicare benefits are secondary.

Where the primary payer has made payment to the hospice at the time of billing to Medicare, the hospice indicates the type and the amount of payment in Item 46 (value code).

If the primary payer has denied payment, the denial is indicated with zeros in the value amount. The date of the denial and occurrence code 24 is entered in the appropriate occurrence field. Items 65-75 are completed to the extent applicable, and the information is available, for your development with the primary payer. See §3604 for a detailed description of the value codes and Items 65-75.

Items 65A, B, C. Insured's Name
The hospice enters the beneficiary's name on line A if Medicare is the primary payer. The name is shown as on the beneficiary's HI card. If Medicare is the secondary payer the beneficiary's name is entered on line B or C as applicable, and the insured's name on the applicable primary policy is entered on line A.

Items 68A, B, C. Certificate/Social Security Number Health Insurance Claim/Identification Number
On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information was shown in Items 57-63, the hospice enters the patient's Medicare HICN; i.e., if Medicare is the primary payer, this information is entered in Item 68A. The number is shown as it appears on the patient's Health Insurance Card, Social Security Award Certificate, Utilization Notice, EOMB, Temporary Eligibility Notice, etc., or as reported by the SSO.

Item 77. Principal Diagnosis Code
The full ICD-9-CM diagnosis code is shown. The principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospice for care.

Item 92. Attending Physician I.D. Required
The name, number and address of the licensed physician normally expected to certify and recertify the medical necessity of the services rendered and/or, who has primary responsibility for the patient's medical care and treatment is here. The hospice uses Item 94 "Remarks" for additional space for recording this information.

Item 93. Other Physician I.D. Required
The word "employee" or "nonemployee" is entered here to describe the relationship the patient's attending physician has with the hospice.

Item 94. Remarks
The hospice enters any information not shown elsewhere on the bill but is necessary for proper payment.

Provider Representative Signature and Date
A hospice representative makes sure that the required physician's certification and a signed hospice election statement is in the records before signing the HCFA-1450. A stamped signature is acceptable.

3648.1 Billing for Covered Medicare Services Unrelated to Hospice Care.—Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, which are provided during a hospice election period, are billed to you for nonhospice Medicare reimbursement. These services are billed by the provider in accordance with existing procedures as a new admission with appropriate query and billing actions.

3648.2 Billing for Covered Medicare Services After Hospice Benefits Are Exhausted.—Covered Medicare services rendered to hospice patients after the maximum 210 day hospice benefit expires, are billed to you for nonhospice Medicare reimbursement. Where hospice benefits are exhausted, billing procedures are the same as those prior to the hospice election. Covered services are billed by the provider in accordance with existing admission, query, and billing instructions.

3650. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFs)

A. General.—Certain services provided by the CORF are considered administrative services. Do not included these charges on the HCFA-1450. Their costs are included in the cost report and are considered in the calculation of the interim rate you pay for billable services.

Examples of administrative services are CORF physicians' services, team conferences, case reviews, plan of treatment review, and routine nursing services. (See §3183.1.)

Use the guidelines in §3903 for the MR of CORF services.

NOTE: Physicians' diagnostic and therapeutic services furnished to a CORF patient are not CORF physician's services. The physician must bill the Part B carrier for these services.

B. Patient Evaluation and Reevaluation.—

- When an initial evaluation is performed and there is no need for additional services, the evaluation is billed as a visit.

- When an initial evaluation and treatment are rendered on the same day, two visits cannot be billed. The usual charge for one visit can be increased to reflect the extra services.

- A reevaluation performed during a regular treatment visit must not be billed separately. The charge for one visit can be increased to reflect the additional services.

NOTE: Generally, CORFs will bill using the zero level revenue code. You may require the specific code for evaluation/reevaluation if you use them for bill review.

C. Services Billed on the HCFA-1450.—Services that can be billed by a CORF are:

- Physical therapy, occupational therapy, speech pathology services and respiratory therapy. Includes patient evaluation, testing, treatment, and other services defined as covered therapy services. (See §§3183.2-3183.5.)

NOTE: Certain services such as patient education and monthly reevaluation of a patient undergoing speech therapy are included in the course of treatment and are not billed separately.

- Social and psychological services. (See §§3183.7 and 3183.8.)

- Nursing services that are identifiable rehabilitation services which a nurse is qualified to perform and do not duplicate services performed by the therapist or other skilled nursing services specified in the plan of treatment. (See §3183.9.)

o Prosthetic and orthotic devices, including testing, fitting, or training in their use. (See S3183.6.)

o Drugs and biologicals which cannot be self administered. (See S3183.10.)

o Supplies, appliances, and equipment including the purchase or rental of DME from the CORF. (See S3183.11.)

NOTE: Equipment and appliances used at the CORF are reimbursed as overhead costs.

o Home environment evaluation, a single home visit to evaluate the potential impact of the home environment on the rehabilitation goals. Billed under line item or revenue code of professional who made the visit. (See S3183.12.)

o Certain diagnostic tests to be evaluated by a physician, such as pulmonary function, spirometry, and blood gas analysis are included under specific revenue codes. (See S3101.5.)

D. Offsite CORF Services.—Effective with services furnished on and after December 22, 1987, CORFs may provide physical, speech and occupational therapy off the CORF's premises in addition to the home evaluation. (See S3182.) Services provided offsite are billed separately and identified as "offsite" on the UB-82, in Item 94, Remarks. The charges for offsite visits includes any additional charge for providing the services at a place other than the CORF premises. There is no change in the interim reimbursement method for offsite services. Perform appropriate edits to prevent duplicate payments.

E. Psychiatric Services Limitation.—The amount of a beneficiary's incurred psychiatric expenses that can be recognized in any calendar year is the lesser of 62 1/2 percent of expenses or the amount shown in the following table:

Year of Service	Limit Recognized	Payment Limit
Through 12/31/87	$ 312.50	$ 250.00
1/1/88 - 12/31/88	562.50	450.00
1/1/89 and after	1,375.00	1,100.00

Apply these limits to revenue code 910 on CORF claims.

F. Revenue Codes.—Revenue codes to bill Medicare for CORF services are as follows:

Description	Code
Drugs and Biologicals	250
Supplies	270
Prosthetic Devices	274
Orthotic Devices	279
Rental of DME	291

9

Purchase of New DME	292
Purchase of Used DME	293
Respiratory Therapy Services	410
Home Evaluation Visit	419
Physical Therapy Services	420
Home Evaluation Visit	429
Occupational Therapy Services	430
Home Evaluation Visit	439
Speech Pathology Services	440
Home Evaluation Visit	449
Pulmonary Function	460
Audiology	470
Stress Test	482
Nursing Services	550
Home Evaluation Visit	559
Social Services	560
Home Evaluation Visit	569
EKG, ECG	730
Psychological Services	910
Diagnostic Testing	918
Home Evaluation Visit	919
EMG	922
Other Diagnostic Services (Specify)	929

Use these revenue codes when billing for the following outpatient therapies:

Physical Therapy	420
Occupational Therapy	430
Speech Pathology	440

3654. COORDINATION WITH HEALTH MAINTENANCE ORGANIZATIONS

3654.1 Provider Billing for Services Provided to HMO Beneficiaries.—When a HMO qualifies for participation under the Medicare program, HCFA annotates its records to indicate which Medicare beneficiaries are HMO enrollees.

Depending on the contractual arrangements between the HMO and HCFA, Medicare bills for HMO enrollees may be paid either by an intermediary or HMO. (See §§3555ff. for description of how to determine who processes the bill.) Where these guidelines indicate the HMO has processing jurisdiction, inform the provider to bill the HMO. Process the bill showing HMO payment.

When services are provided to a HMO enrollee for which the HMO has payment jurisdiction it either sends a HCFA-1450 to you via EMC, if possible, for processing as a "paid" HMO bill or arranges for the provider to send a HCFA-1450 directly to you.

Send the UNIBILL to HCFA, showing HMO paid code in field 67 position 1840. In field 53 positions 1707-1715 show zeros as Medicare Reimbursement Amount, and charges as covered.

Do not make a duplicate payment for the same services the HMO has paid. When you pay a HMO enrollee's bill follow regular bill processing procedures, including proper coding in location 1840 of UNIBILL to indicate whether you, or the HMO, paid the bill.

3654.2 Patient is a Member of HMO for Only Part of Billing Period.—Where a patient either enrolls or disenrolls in a HMO during a period of services, two factors determine whether the HMO is liable for the payment.

- o Whether the facility is included in PPS, and
- o The date of enrollment.

If the patient changes HMO status during an inpatient hospitalization in a PPS hospital, his status at admission determines liability. If he was enrolled in the HMO before admission, the HMO is responsible regardless of whether the patient disenrolled before discharge. If the patient was not a HMO enrollee upon admission, later enrolls before discharge, the HMO is not responsible for payment.

Where the facility is a non-PPS hospital or unit, SNFs, HHAs, etc., the HMO is responsible for payment for services on and after the day of enrollment up through the day disenrollment is effective.

3656. COMPUTER PROGRAMS SUPPLIED BY HCFA

3656.1 Medicare Code Editor (MCE).–

A. Implementation Requirements.–The MCE edits claims to detect incorrect billing data. In determining the appropriate DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the Grouper program. The logic of the Grouper software assumes that this information is accurate. The Grouper does not edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a DRG. Therefore, use the MCE to improve the quality of information given to Grouper.

Process all inpatient Part A discharge/transfer bills for both PPS and non-PPS facilities (including waiver States, long-term care hospitals, and excluded units) through the MCE. Process claims that have been reviewed by the PRO prior to billing through the MCE only for edit types #1, 2, 3, 4, 7, and 12. Bills not to process through the MCE include:

o Where no Medicare payment is due (amounts reported by value codes 12, 13, 14, 15, or 16 equal or exceed charges).

o Where no Medicare payment is being made. Where partial payment is made, editing is required.

o Reviewed by the PRO before billing (code 1 or 3 in Item 87). You may process these exceptions through the program and ignore development codes or bypass the program.

The MCE software contains multiple versions. The version of the MCE accessed by the program depends upon the patient dischage date entered on the claim. The following chart lists the patient discharge periods and the MCE version associated with each.

For Patients Discharged From	MCE Version Used
03/01/84 - 09/30/86	MCE 2.0
10/01/86 - 09/30/87	MCE 3.0
10/01/87 - 09/30/88	MCE 4.0

B. Bill System/MCE Interface.–Install MCE online if possible, so that prepayment edit requirements identified in subsection C can be directed to hospitals without clerical handling.

The MCE needs the following data elements to analyze the bill:

o Age
o Sex

- Discharge status
- Diagnosis (5)
- Procedures (3)
- Discharge date

MCE provides you an analysis of "errors" on the bill as described in subsection C. Develop your own interface program to provide data to MCE and receive data from it.

The MCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

C. Processing Requirements.--Follow these procedures for each error code. Where bills are returned to the hospital, consider the bill improperly completed for control and processing time purposes. (See §3600.1C.)

1. Invalid Diagnosis or Procedure Code.—The MCE checks each diagnosis code, including the admitting diagnosis, and each procedure code against a table of valid ICD-9-CM codes. If the recorded code is not in this table, the code is invalid.

For a list of all valid ICD-9-CM codes see Internation Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases) and Volume 3 (Procedures). Return the claim and request a corrected bill with a valid diagnosis or procedure.

2. Invalid Fourth or Fifth Digit.—The MCE identifies any diagnosis code, including the admitting diagnosis or any procedure that requires a fourth or fifth digit, which is either missing or not valid for the code in question.

For a list of all valid fourth and fifth digit ICD-9-CM codes see International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume 1 (Diseases) and Volume 3 (Procedures). Return the claim and request a corrected bill with a valid diagnosis or procedure.

3. E-Code as Principal Diagnosis.—E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore are not principal diagnoses. E-codes are all ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume 1 (Diseases). Return the claim and request a proper principal diagnosis on a corrected bill.

4. Duplicate of PDX.—Any secondary diagnosis that is the same code as the principal diagnosis is identified as a duplicate of the principal diagnoses, because the secondary diagnosis may cause assignment to a complication/comorbidity DRG in error. Delete the secondary diagnosis from your bill record. Continue processing without it.

5. Age Conflict.—The MCE detects inconsistencies between a patient's age and the diagnosis. Examples of conflicts are:

- A 5 year old patient with benign prostatic hypertrophy.
- A 78 year old delivery.

In the above cases, the diagnosis is clinically impossible for a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories follow.

- A subset of diganoses are intended only for newborns and neonates. These are identified as "Newborn" diagnoses. For "Newborn" diagnoses the patient's age must be 0 years.
- Certain diagnoses are only considered reasonable for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are only coded for patients between the ages of 12 and 55 years.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are identified as "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

Addendum E, pages E-2-17, contains listings for each category. The listings include both the ICD-9-CM diagnosis codes and the corresponding English descriptions.

If you edit online, return the bill and request a proper diagnosis or correction of age as applicable. If you edit in batch operations after receipt of the admission query response, use the age based on HCFA records and return bills that fail this edit. Request a proper diagnosis.

6. Sex Conflict.—The MCE detects inconsistencies between a patient's sex and the diagnosis or procedure on the patient's record. Examples of a conflict are:

- Male patient with cervical cancer (diagnosis).
- Male patient with a hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect.

Addendum E, pages E-18-38 contain listings of male and female related ICD-9-CM diagnosis and procedure codes and the corresponding English descriptions. Return the bill. Request a corrected bill with the proper sex, diagnosis, and procedure.

7. Manifestation Code As Principal Diagnosis.—These describe the manifestation of an underlying disease, not the disease itself, and therefore, cannot be a principal diagnosis. Addendum E, pages E-39-41, contains listings of ICD-9-CM diagnoses identified as manifestation codes. Return the bill. Request a corrected bill with the diagnosis for the underlying condition.

8. Nonspecific Principal Diagnosis.—A set of diagnosis codes, particularly those described as "not otherwise specified," are identified by the MCE as nonspecific diagnoses. While these codes are valid according to the ICD-9-CM coding scheme, more precise codes can be used for the principal diagnosis.

A diagnosis is considered a nonspecific principal diagnosis only if the patient was discharged alive. Deceased patients often do not receive a complete diagnostic workup, thus, the specification of precise principal diagnosis may not be possible.

Addendum E, pages E-42-50, contains listings of ICD-9-CM diagnosis codes identified as "nonspecific" when used as principal diagnosis.

Do not develop before payment. Count bills monthly by provider and analyze them to determine whether educational contacts are needed. If the number of bills containing nonspecific coding exceeds 10 percent, contact the provider to discuss proper coding.

9. Questionable Admission.—There are some diagnoses which are not usually sufficient justification for admission to an acute care hospital. For example, if a patient is given a principal diagnosis of:

4011 Benign Hypertension

then this patient has a questionable admission, since benign hypertension is not normally sufficient justification for admission.

Addendum E, page E-51, contains a listing of ICD-9-CM diagnosis codes identified as "Questionable Admission" when used as principal diagnosis.

PROs review on a post-payment basis all questionable admission cases. Where the PRO determines the denial rate is sufficiently high to warrent, it uses the PRS to accomplish prepayment review.

Do not interrupt processing based upon MCE identification of questionable admission.

10. Unacceptable Principal Diagnosis.—There are selected codes that describe a circumstance which influences an individual's health status but is not a current illness or injury; therefore, these codes are unacceptable as a principal diagnosis. For example, V173 (Family History of Ischemic Heart Disease) is an unacceptable principal diagnosis.

In a few cases, there are codes that are not unacceptable if a secondary diagnosis is coded. If no secondary diagnosis is present for them, the message "requires secondary dx" appears. Codes that follow this rule are indicated with an asterisk (*) in Addendum E, pages E-52-57.

The PRO reviews claims with diagnosis V571, V572, V573, V5789 and V579 and a secondary diagnosis.

If these codes are identified without a secondary diagnosis, return the bill. Request a secondary diagnosis that describes the origin of the impairment. Return bills containing other "unacceptable principal diagnosis" codes. Request a principal diagnosis that describes the illness or injury.

11. Nonspecific O.R. Procedures.—A set of O.R. procedure codes, particularly those described as "not otherwise specified" are identified by the MCE as nonspecific. While these codes are valid according to the ICD-9-CM coding scheme, more precise codes must be used. For example, 8020 (Arthroscopy NOS) is identified as a nonspecific O.R. procedure because the site is not specified by the code. Codes 8021-8029 specify the precise site.

MCE reports the nonspecific O.R. procedure condition only if all the O.R. procedures performed have been coded as nonspecific.

Addendum E, page E-58, contains a listing of ICD-9-CM procedure codes identified as "Nonspecific O.R. Procedure."

Do not develop before payment. Count bills monthly by provider for this exception. Analyze to determine whether educational contacts are needed. If the number of bills containing nonspecific coding exceeds 10 percent, contact the provider to discuss proper coding.

12. Noncovered O.R. Procedures.—There are some O.R. procedures for which Medicare does not reimburse.

Addendum E, page E-59, contains a listing of ICD-9-CM procedure codes identified as "Noncovered O.R. Procedure."

Return the bill. Request the following appropriate action:

- A no pay bill,
- A correction in the procedure code, or
- A bill indicating the covered and noncovered procedures. (See §3101.14.)

If the hospital indicates that there are covered and noncovered procedures, refer the bill to the PRO for prepayment review. Upon receipt of the PROs response, either delete the noncovered procedures and charges or require the hospital to delete them. Do not process the noncovered procedures through Grouper (see §3656.2) or the noncovered charges through Pricer. (See §3656.3.)

Do not return procedure code 375 without first checking to determine if the bill is from an approved heart transplant center. (See §3613 where the bill is from an approved heart transplant center.)

13. Open Biopsy Check.—Biopsies can be peformed as open (i.e., a body cavity is entered surgically), or closed (percutaneously or endoscopically). The DRG definitions assign different DRGs depending upon whether or not the biopsy was open. In general, for most organ systems, open biopsies are performed infrequently.

Effective October 1, 1987 there are revised biopsy codes that distinguish between open and closed biopsies. It is no longer necessary to request O.R. reports for all open biopsy procedures identified in the MCE. However, to make sure that hospitals are using the new ICD-9-CM codes correctly, request O.R. reports on a sample of 10 percent of claims with open biopsy procedures (see Addendum E) for review on a postpayment basis.

If the O.R. report reveals that the biopsy was closed (performed percutaneounsly, endoscopically, etc.) change the procedure code on the bill to the closed biopsy code and process an adjustment bill. Some biopsy codes (3328 and 5634) have two related closed biopsy codes, one for closed endoscopic and for closed percutaneous biopsies. Assign the appropriate closed biopsy code after reviewing the medical information. If the hospital's biopsy coding error rate exceeds 10 percent, place the hospital on prepayment review for these claims until its error rate is below 10 percent.

14. Medicare as Secondary Payer - MSP Alert.—Addendum E, pages E-61-68, identifies situations that may involve automobile medical, no-fault or liability insurance. See §§3419.5 and 3489.4B for processing instructions and tolerances.

15. Bilateral Procedure.—There are certain codes that do not accurately reflect performed procedures in one admission on two or more different bilateral joints of the lower extremeties. A combination of these codes show a bilateral procedure when, in fact, they could be single joint procedures (i.e., duplicate procedures).

If two more more of these procedures are coded, and the principal diagnosis is in MDC 8, they are flagged for post-pay development. Process the bill as coded but request an O.R. report. If the report substantiates bilateral surgery, no further action is necessary. If the report does not substantiate bilateral surgery, prepare and process an adjustment bill. Code it appropriately.

If the error rate for any provider is sufficiently high, you may develop claims prior to payment on a provider-specific basis.

16. Invalid Age.—A patient's age is usually necessary for an appropriate DRG determination. If the age reported is not between 0 years and 124 years, the MCE assumes the age is in error.

Reenter the bill with the proper age. If the beneficiary's age is established at over 124, reenter it with 123.

17. Invalid Sex.—A patient's sex is sometimes necessary for appropriate DRG determination. The sex code reported must be either 1 (male) or 2 (female).

18. Invalid Discharge Status.—A patient's discharge status is sometimes necessary for appropriate DRG determination. Discharge status must be coded according to the UB-82 conventions.

The following UB-82 discharge status codes are considered valid by the MCE.

01	Home, self-care (routine)
02	Short term hospital
03	SNF
04	ICF
05	Other facility
06	Home health service
07	Left against medical advice
20	Died (or did not recover if CSCs are involved)
30	Still a patient

19. Invalid Discharge Date.—An invalid discharge date is a discharge date that does not fall into the acceptable range of numbers to represent either the month, day or year (e.g., 13/03/87, 12/32/87). If no discharge date is entered, it is also invalid. When an invalid discharge date is entered, version 4.0 of the MCE is automatically edits the claim.

3656.2 DRG Grouper Program.—Pay for inpatient hospital services on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. Each DRG represents the average resources required to care for a case in that particular DRG relative to the national average of resources consumed per case. The DRG weights used to calculate payment are in the Pricer DRGX file.

Use the Grouper program to assign the DRG number. Grouper is the software that determines the DRG from data elements reported by the hospital. This applies to all inpatient discharge/transfer bills received from both PPS and non-PPS facilities, including those from waiver States, long-term care hospitals, and excluded units.

The Pricer (PPSMAIN) driver program calls the correct Grouper based upon the discharge date. If you write your own driver program, you need to access the following Grouper programs:

- 5.0 for discharges from October 1, 1987
- 4.0 for discharges from October 1, 1986 through September 30, 1987
- 3.0 for discharges from May 1, 1986 through September 30, 1986
- 2.0 for discharges from before May 1, 1986

Grouper does not determine the DRG price. Grouper input/output are specified below. Determine the best place in your total system to place the Grouper program.

Input	Output
1. Principal and up to four other diagnoses.	1. Major diagnostic category
	2. DRG number
2. Principal and up to two additional procedures.	3. Grouper return code (one position code indicating the action taken by the program)
3. Age (at last birthday on admission date, verified by the 0 trailer).	4. Procedure code used in determining the DRG
4. Sex (1=male, 2=female)	5. Diagnosis code use in determining the DRG
5. Discharge destination	6. Secondary diagnosis used, if applicable, in determining DRG.

EMC/UB-82 (HCFA-1450) sex coding is M for male, F for female, and U for unknown, while Grouper is 1 for male and 2 for female. Discharge destination codes are similar except codes 20-29 are summarized as 20. Calculate age at admission as Grouper needs age rather than date of birth.

3656.3 PPS Pricer Program.—

A. General Description.—HCFA provides a PRICER program to determine the price upon which to base reimbursement under prospective payment. A separate PRICER installation guide has been provided. Use the appropriate Pricer for discharges occurring during the periods below:

- o 7.2 for discharges after April 1, 1988;
- o 7.1 for discharges from November 21, 1987 through March 31, 1988; and
- o 7.0 for discharges from October 1, 1987 through November 20, 1987.

The Pricer program relies upon your system to call the appropriate Grouper depending upon the discharge date. After the DRG is determined by Grouper, your system calls the Pricer program. Pricer determines the price to pay and prepares a report.

Four data files are included. HCFA maintains three:

o DRGX file — contains DRG weights, average length of stay and outlier cutoff points.

o MSAX file — contains urban and rural wage indexes used in calculating payment.

- RATE file — contains census division values and updating amounts used in calculating payment.

You maintain the last, the Provider Specific File, (PROV file). This contains information about the facts specific to the provider that affects computations, e.g., effective dates for PPS, type of provider (for application of special computation rules), census division, MSA, adjusted cost per discharge, disproportionate share adjustment percentage.

Pricer also calculates the disproportionate share adjustment and adds it to the DRG payment. Correct calculation depends upon the accuracy of related information you include in the Pricer PROV file.

The Pricer program applies the DRG relative weights, hospital urban or rural and census division location, provider specific data, and beneficiary hospital data from the bill to determine the amount payable for each PPS discharge bill.

Pricer uses the Intern-to-Bed ratio in calculating the indirect teaching adjustment for you to accumulate and use in related payments. Insure that this ratio is available for Pricer to compute the reimbursement for teaching hospitals. Include the ratio in your PROV file to insure that cost outliers are not overpaid to your teaching hospitals.

Pricer does not calculate utilization days required for UNIBILL or the cost report. It does not determine the amount to pay after deduction for deductible, coinsurance, or the primary payment where Medicare is secondary. Calculate the price and make adjustments to the price furnished before making payment.

B. Data Requirements for Bill Processing.—The Pricer subroutine (PPSSUB) that determines the DRG price refers to the four files described in subsection A and to the following data from the bill.

- Provider number,
- Review code (see §3656.3D.2),
- DRG,
- Approved length of stay (see §3656.3D.1), or
- Covered days (see §3656.3D.1).

- Lifetime reserve days,
- Discharge date, and
- Charges (excluding kidney acquisition costs).

C. Bill Processing Report from Pricer.—Pricer may be operated to provide the following levels of information in response to bill processing.

Option 1

- Return Codes - After processing, the program provides the following "return codes" to report disposition. Codes 00-49 describe how the bill was priced. Codes 50-99 describe why the bill was not priced.

  00=Priced standard DRG payment
  01=Priced as a day outlier
  02=Priced as a cost outlier
  03=Priced on per diem basis (received review code 03)
  04=Priced standard DRG payment only. Day or cost outlier status was ignored.
  05=Priced as per diem days plus cost outlier
  06=Priced as per diem days only

  51=No provider specific information found
  52=Invalid MSA # in provider file
  53=Waiver State - not calculated by PPS
  54=DRG not 001-468 or 471
  55=Discharge date is earlier than provider's PPS start date
  56=Invalid length of stay (e.g., nonnumeric or zero with review code not = 03)
  57=Review code not 00-06
  58=Total charges not numeric
  60=Review code was 02 and length of stay indicates day outlier. Bill is thus not eligible as cost outlier.
  61=Lifetime reserve days not numeric
  62=Invalid number of covered days (e.g., covered days greater than length of stay, or nonnumeric, or lifetime reserve days greater than covered days.

- Wage index
- Outlier days
- Average length of stay
- Outlier cutoff days

- Indirect teaching adjustment -, price calculated on per-bill basis
- Total payment (indirect teaching excluded)
- Hospital specific portion
- Federal specific portion (DSH excluded)
- Outlier portion
- Regular covered days used in pricing
- Lifetime reserve days used in pricing
- Disproportionate share amount
- PRICER version number

Option 2

Information in option 1 plus the following will be provided.

- Hospital specific portion of the payment
- Federal portion of the payment
- National percentage of Federal Blend
- Regional percentage of Federal Blend
- Case mix index adjusted for computation (cost per discharge)
- PPS update factor/special update factor
- DRG relative weight
- National labor share
- National nonlabor share
- Regional labor share
- Regional nonlabor share
- Cost of living adjustment

- Intern-to-bed ratio
- Cost outlier portion of the payment
- Bill cost data
- PPS dollar threshhold
- PPS provider record
- FY table

Within option 1 and option 2 there are variables with respect to format and operating procedures. These are described in the Pricer Implementation Guide. You must determine which data elements are useful in processing or in your history records and construct the interface system to obtain them.

D. Developing PRICER Input Parameters

1. Approved length of stay.—Approved length of stay is necessary for PRICER to determine whether day outlier status is applicable in nontransfer cases, and in transfer cases to determine the number of days for which to pay the per diem rate. Normally, Pricer covered days and approved length of stay will be the same. However, when benefits are exhausted, or when entitlement begins during the stay, PRICER length of stay days may exceed Pricer covered days in the nonoutlier portion of the stay.

As a result, the days that PRICER returns reflect only the days used to calculate the rate and may not accurately reflect the utilization days required for UNIBILL or your cost report. The program uses the relationship between the covered days and the day outlier trim point of the assigned DRG to calculate the rate. Where the covered days are more than the approved length of stay, PRICER may not return the correct utilization days. The host system determines and/or validates the correct utilization days to charge the beneficiary in accordance with §3637.1.

Example

Covered Days sent to PRICER	26
Outlier Days	0
Lifetime Reserve Days	0
Approved Length of Stay	20
Day Outlier Cutoff	22
PRICER Length of Stay Days	22

If the hospital has not notified the beneficiary, charge utilization to the beneficiary for actual days. Pricer will calculate your payment from the approved length of stay. The hospital may not charge the beneficiary for the difference.

If the hospital has notified the beneficiary, charge utilization to the beneficiary for medically approved days, and base your payment on them. The hospital may charge the beneficiary for the difference.

To develop approved length of stay used by PRICER:

- For discharge destination (value) codes 01, 03, 04, 05, 06, 07, or 20 in HCFA-1450 locator 21. Enter the number of days from the later of entitlement or admission to the earlier of discharge or death.

  Subtract any days before the ending date that the medical review entity disapproved, except for days approved for payment under waiver. PRICER uses approved length of stay and covered days shown on the bill (including LTR where applicable) to determine how many outlier days can be paid.

- For discharge destination code 02 - Enter as above except do not use benefits exhausted (HCFA-1450 locator 28, code 23) in your calculation. If benefits are exhausted after admission, but before transfer, payment is made for any days prior to transfer regardless of whether benefits are exhausted.

- Discharge destination 02 does not identify a cost outlier on transfers made on, or after, October 1, 1984. To pay these cost outliers adjust the approved length of stay to be less than the trim point of the DRG.

2. PRICER Review Code.—The review code instructs the program as to the disposition of the bill. Select the proper review code as described below.

00 = Pay standard DRG and any days or cost outlier. Use for nontransfer cases which do not contain condition code 66 (Locator 35-39 on the HCFA-1450).

01 = Pay standard DRG and days outlier. Use when condition code 66 is present. Pricer will calculate the standard DRG payment. It will also calculate the day outlier portion of the payment if the covered days exceed the outlier cutoff for the DRG.

02 = Pay standard DRG and cost outlier. Pricer will calculate the standard DRG payment. It will also calculate the cost outlier portion of the payment if the adjusted charges exceed the cost theshold. If the approved length of stay exceeds day outlier cutoff, no price will be computed and it will return code 60.

03 = Pay per diem and any cost outlier. Use for transfer cases which do not contain condition code 66. Pricer will calculate a per diem payment based upon the standard DRG payment if the covered days are fewer than the average length of stay for the DRG. If the covered days are equal to, or exceed, the average length of stay, the standard DRG payment is calculated. If transfer is after 9/30/84 and the charges claimed exceed the threshold, the cost outlier is also calculated and a code 05 is returned.

04 = Pay only standard DRG. Pricer will not edit for day or cost outliers.

05 = Pay per diem and cost outlier. Use for transfer cases where prior approval is required in your system. Pricer will calculate a per diem payment based upon the standard DRG payment if the approved length of stay is less than the average length of stay for the DRG. If the approved length of stay is equal to, or exceeds, the average length of stay, the standard DRG payment is calculated. It also calculates the cost outlier portion of the payment if the adjusted charges of the bill exceed the cost threshold.

06 = Pay per diem days only. Use for transfer cases which contain code 66. Pricer will not edit for cost outlier.

D. Provider Specific File.—The PROV file contains needed information about each provider to calculate the payment amount. Maintain the accuracy of the data in accordance with the following criteria.

Whenever the status of any element changes, prepare an additional record showing the effective date. For example: when a hospital's FY end changes as a result of a change in ownership or other "good cause," make an additional record showing the effective date of the change. As Pricer was designed to accommodate FY ends, it automatically applies the appropriate update factor and hospital-specific portion/Federal portion blend. The only exception is when the effective date of the change in ownership begins in a transition period different from that under the old ownership. In these cases, force the hospital into a specific (PPS) year using file position "17." Pricer will compare the discharge date on the bill record with the effective date in file to determine the proper data to use in calculating the payment.

The format and data shown below are required by the Pricer program and by the quarterly Provider Specific File you submit to HCFA. (See §3850.)

File Position	Format	Title	Description
1-6	X(6)	Provider Number	Alpha-numeric 6 character provider number.
7-12	9(6)	Effective Date	Numeric YYMMDD. This date is the effective date of the provider's first PPS period or the first record for each provider. This date should be 1 day later than the end of the provider's original FY. For subsequent records, for the same provider, this date is the effective date of the change.
13	X	Waiver Indicator	"N" means not waived (under PPS) and "Y" means waived (not under PPS).

File Position	Format	Title	Description
14-15	XX	Provider Type	This identifies providers that require special handling. Enter the appropriate code: Must be blank or 00-12 00 or blanks = Short Term Facility 01 Sole community provider 02 Long Term 03 Psychiatric 04 Rehabilitation Facility 05 Pediatric 06 Hospital distinct parts 07 Rural referral center 08 Indian Health Service 09 Redesignated Rural - year 1 10 Redesignated Rural - year 2 11 Sole community/referral center provider 12 Alcohol Facility
16	9	Current Census Division	Enter the appropriate code for the current census division: 1 New England 2 Middle Atlantic 3 South Atlantic 4 East North Central 5 East South Central 6 West North Central 7 West South Central 8 Mountain 9 Pacific
17	9	Provider PPS Period	Present when forcing provider into a specific PPS period, blank or 0-6. NOTE: Once a provider is forced into a specific PPS period, use an additional record each successive period through PPS period 5. If not, the provider stays in the PPS period of the last record indefinitely.
18-21	9(4)	Metropolitan Statistical Area	Enter the appropriate code for the metropolitan statistical area 0040-9340 or 9999 for rural.

File Position	Format	Title	Description
22-27	9(6)	Fiscal Year End	Enter the appropriate numeric MMDDYY. On the first record for each provider this is the FY end of its last year before PPS. (PPS bills will be accepted for dates after this date.) For subsequent provider records, this only changes if the provider changes its FY end, e.g., a change of ownership.
28-34	9(5)V99	Case Mix Adjusted Cost per Discharge	Enter the PPS base year cost per discharge divided by the case mix index. Enter zero for new providers.
35-38	9V999	Cost of Living Adjustment	Enter the appropriate cost of living adjustment as listed below:

Area	FY 84	FY 85 (10/1/84-4/30/86)	FY 86 (5/1/86-9/30/86)	FY 87-89 (10/1/86-9/30/89)
Alaska	1.250	1.250	1.250	1.250
Oahu	1.200	1.225	1.225	1.225
Kauai	1.175	1.150	1.150	1.175
Maui	1.200	1.200	1.200	1.200
Molakai	1.200	1.200	1.200	1.200
Lanai	1.200	1.200	1.200	1.200
Hawaii	1.100	1.125	1.125	1.150
All other	1.000	1.000	1.000	1.000

39-43	9V9(4)	Intern/Beds Ratio	Enter the provider's intern/resident to bed ratio. Calculate this by dividing the provider's full-time equivalent interns and residents by the number of available beds (as calculated in positions 50-54). Do not include interns and residents in anesthesiology who are employed to replace anesthetists or those assigned to excluded units. Base the count upon the number of interns and residents assigned to the hospital on September 1. Correct cases where there is reason to believe that the count is substantially in error for a particular facility. You are responsible for reviewing hospital records and making any necessary changes in the count at the end of the cost reporting period. Enter zero for nonteaching hospitals.

File Position	Format	Title	Description
44-49	9V9(5)	Special Provider Update Factor (PRUP)	Use this field only for hospitals that have special update factors because their base period ended prior to September 30, 1982. Enter that factor here. Each time a new regular update factor is published in the Federal Register, compute a new special update factor. Place it and its effective date in the provider file. For example, provider 010010 has a special update factor of 1.17268 effective 840203. If its current cost reporting period under PPS ends 12/31/84, the regular update factor would be 1.06003 and the new special update factor effective 850101 would be: 1.17268 * 1.06003 = 1.24308 Zero fill for non-PRUP hospitals.
50-54	9(5)	Hospital Beds	Number of hospital beds. Indicate the number of adult and pediatric beds available for lodging inpatients. (See §2405.3G Provider Reimbursement Manual.) If there is a change during the year, make an adjustment if it would make a significant difference in the amount of payments.

NOTE: The effective date for PRUP changes computed this way is based upon cost reporting periods beginning on or after 10/1/84; i.e., a cost reporting period ending 9/30/84 has a PRUP effective 10/1/84; a cost reporting period ending 10/31/84 has its PRUP effective 11/01/84, etc.

File Position	Format	Title	Description
55-58	V9(4)	DSH	Disproportionate share adjustment percentage. For discharges occurring on or after May 1, 1986 and before October 1, 1990, make an additional payment for each PPS hospital that meets the criteria for serving a disproportionate share of low income patients. Place this factor in this field if the hospital qualifies for this additional payment. Edit to assure that the DSH adjustment factor does not exceed .9999. Pricer multiplies this percentage (expressed as a decimal) by the Federal portion and outlier payment to determine the DSH adjustment. Enter "zero" for hospitals that do not qualify.
59-62	9V999	Cost to Charge Ratio	Derived from the latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare operating costs by the Medicare covered charges. Obtain Medicare operating costs from the Medicare cost report Form HCFA-2552-85 Supplemental Worksheet D-1, Part II, Line 54. Obtain Medicare covered charges from your billing file, i.e., PS&R record. Hospitals for which you are unable to compute a reasonable cost-to-charge ratio, use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by HCFA. Use these average ratios to calculate cost outlier payments for those hospitals where you compute cost-to-charge ratios lower than 0.36 or greater than 1.24. (The list of state wide cost-to-change averages follows this section).

File Position	Format	Title	Description
63-67	9V9(4)	Case Mix Index	The case mix index used to complete positions 28-34. In most cases this is the case mix index that has been calculated and published by HCFA for each hospital (based on 1981 cost and billing data) reflecting the relative costliness of that hospital's mix of cases compared to the national average mix.
68	X	Filler	Blank
69-74	9(6)	Report Date	Date file created. Must be MMDDYY.
75	X	Filler	Blank
76-80	X(5)	Intermediary Number	Intermediary #
81-86	9(6)	Fiscal Year Beginning Date	Must be numeric (MMDDYY) Month: 01-12 Day: 01-31 Year: Greater than 81 but not greater than current year.
87-92	9(4)V99	Pass Thru Amount Capital	Per diem amount based on the interim payments to the hospital. (See §2405.2, Provider Reimbursement Manual.)
93-98	9(4)V99	Pass Thru Amount for direct medical education	Per diem amount based on the interim payments to the hospital. (See §2405.2, Provider Reimbursement Manual.)
99-104	9(4)V99	Pass thru amount for Organ Acquisition	Per diem amount based on the interim payments to the hospital. (See §2405.2, Provider Reimbursement Manual.)
105-110	9(4)V99	Total pass thru amount, including miscellaneous	Per diem amount based on the interim payments to the hospital. (See §2405.2, Provider Reimbursement Manual.)
111-114	V9(4)	Supplemental Security Income Ratio	SSI ratio used to determine if the hospital qualifies for the disproportionate share adjustment in positions 55 - 58.
115-118	V9(4)	Medicaid Ratio	Medicaid ratio used to determine if the hospital qualifies for the disproportionate share adjustment in positions 55 - 58.
119-160	9(42)	Filler	Blank

Statewide Average Cost-to-Charge Ratios for Urban and Rural Hospitals (Case Weighted)

NOTE: This data should be rounded up to the nearest three digit decimal for claims processing and payment purposes.

State	Urban	Rural
Alabama	0.5194	0.5815
Alaska	0.6731	0.8809
Arizona	0.6117	0.6523
Arkansas	0.6076	0.5922
California	0.6095	0.6023
Colorado	0.6747	0.7349
Connecticut	0.7262	0.8198
Delaware	0.6008	0.6079
District of Columbia	0.6429	—
Florida	0.5455	0.5496
Georgia	0.6174	0.5996
Hawaii	0.6498	0.7848
Idaho	0.7100	0.7257
Illinois	0.6055	0.6643
Indiana	0.7174	0.7392
Iowa	0.7118	0.7290
Kansas	0.6590	0.7555
Kentucky	0.6030	0.5904
Louisiana	0.6001	0.6339
Maine	0.6815	0.6640
Maryland	0.7315	0.7333
Massachusetts	0.6993	0.7797
Michigan	0.6214	0.7019
Minnesota	0.7073	0.7762
Mississippi	0.6301	0.6376
Missouri	0.5989	0.6416
Montana	0.6694	0.7304
Nebraska	0.6232	0.7383
Nevada	0.5141	0.6392
New Hampshire	0.7298	0.7469
New Jersey	0.6823	—
New Mexico	0.5939	0.6106
New York	0.6270	0.7102
North Carolina	0.6560	0.5987
North Dakota	0.7175	0.7089
Ohio	0.7129	0.7016
Oklahoma	0.6111	0.6355
Oregon	0.6747	0.6872
Pennsylvania	0.5684	0.6402
Puerto Rico	0.5959	0.7761
Rhode Island	0.7797	—
South Carolina	0.5975	0.5795
South Dakota	0.6142	0.6991
Tennessee	0.5642	0.5681

State	Urban	Rural
Texas	0.6134	0.7097
Utah	0.6636	0.6854
Vermont	0.7698	0.7129
Virginia	0.6019	0.6018
Washington	0.6933	0.7362
West Virgina	0.6474	0.6071
Wisconsin	0.7769	0.7733
Wyoming	0.7400	0.7458

3656.4 Ambulatory Surgical Center (ASC) Pricer Program.—

A. General Description.—The ASC Pricing Program, when interfaced with your calling program, performs calculations necessary to permit your accumulation of ASC limits for use at the hospital's cost settlement. It produces records formatted for the PS&R system for making adjustments to interim payment rates and at cost settlement. Process all bill records that the OCE system indicates as bill type 83x in this program.

Four data files are included:

o HCPCS codes subject to ASC limitation - this file contains a listing of five character HCPCS codes that includes all ASC covered procedures. A sixth character designates the associated payment category (1-4). (See Addendum F for listings of codes.) It also contains a listing of HCPCS procedure codes that are considered out-of-scope. (See §3626.4.) Most non-ASC procedures on the same bill with an ASC procedure will result in the bill not being subject to the cost limitation (i.e., not priced by the ASC Pricing program). Procedures in the out-of-scope table will not result in excluding the bill from the ASC limitation.

o Revenue codes subject to ASC limitation - this file contains a listing of revenue center codes subject to the ASC payment limitation. (See §3626.4C(1)(a).)

o Payment categories - this file contains dollar amounts for the four ASC payment groups for as many as 3 payment years. (See §3626.4.)

o Wage index - this file has the capacity to retain wage indices for multiple time periods. Use the November 26, 1984 BLS index.

The files are maintained by HCFA. Maintain a related provider file to use with the wage index table containing the provider number and MSA code. The program uses the MSA code to obtain the wage index. In addition, design and maintain an interface system between the ASC Pricer program and your system. Specific requirements are in subsection B.

Run the program before the PS&R system. If possible, place it immediately before the PS&R to avoid having to expand processing systems to include additional data elements such as ASC price and split transactions before that point. The PS&R system reports provide any reporting to the provider on ASC limits that apply to the claims.

B. Interface System Requirements.—Your interface system (driver program) must pass the following record to the pricing program:

Location	Data Description
1-4	MSA Number - to access the wage index. See Addendum G for MSA designations. This data is not identical to your inpatient PROV file. The ASC payment limit is based upon a different wage index than the PPS wage index.

Location	Data Description
5-10	Date of Service - the "from" date in Item 22 of Form HCFA-1450 (YYMMDD).
11-12	Number of HCPCS Codes - the number of HCPCS codes included in the record (01-28). Do not count HCPCS codes associated with revenue codes 29x (DME) or 300-319 (lab).
13-152	HCPCS Codes - these are in Item 50 of HCFA-1450. Up to 28 codes are accepted. Do not submit HCPCS codes associated with revenue code 29x (DME) or 300-319 (lab). Include these HCPCS codes with the related revenue codes returned from the ASC PRICER Program on bill type 13X.
153-154	Number of Revenue Codes - the number of revenue codes included in the record (01-28). Do not include or count revenue code 001 (total charges) in the record.
155-238	Revenue Center Codes - these are in Item 51 of HCFA-1450. Up to 28 codes are accepted. Do not pass revenue code 001 (total charges). Submit all 29x (DME) and 300-319 (Lab) revenue codes to the ASC Pricer Program in order to have the ASC Pricer Program return data for a 13x record.

NOTE: Revenue charges are not used by the pricing program but must be maintained in the calling program for association when records are returned.

Your interface program receives the following data from the ASC Pricer.

Location	Data Description
1-4	Return Code - a four digit code describing action taken or required. See subsection C for processing requirements.

Location	Data Description
5-9	Wage index used.
10-13	MSA code used.
14-21	Total of all HCPCS prices on the bill.
22-23	Number of HCPCS codes priced.
24-947	For each code (28 times).
(5)	HCPCS code;
(1)	Percent 150 = 3 100 = 2 50 = 1 0 = 0
(1)	Group number;
(3)	Group rate;
(8)	Adjusted labor portion;
(8)	Nonlabor portion; and
(7)	Payment rate for code.
948-949	Number of revenue codes subject to limitation.
950-1033	Each included revenue code up to 28.
1034-1035	Number of excluded HCPCS codes.
1036-1175	Each excluded HCPCS code up to 28.
1176-1177	Number of revenue codes not subject to limitation.
1178-1261	Each excluded revenue code up to 28.
1262-1269	Version number.

C. Return Codes and Related Intermediary Processing.--Return codes 1000-1499 indicate that pricing has been performed for the return data.

Code	Action
1000	All HCPCS and revenue codes are subject to the payment limitation. Out-of-scope procedures are considered

Code	Action
	subject to the limitation, but are priced at zero. Prepare one transaction for the PS&R. Use bill type 83x. Include the following from the ASC Pricer return record in the PS&R. Place the return code in location 3372-3375 of the PS&R. Place the total price in location 3376-3382 of the PS&R (PIC 9(5) V99). Place the revenue codes, individual HCPCS codes, and individual payment rates starting in position 527 of the PS&R in accordance with PS&R instructions. The additional data in the output record is for your use in internal control or in resolving inquiries.
1010	The bill contains included and excluded revenue codes. Prepare two transactions for the PS&R. The first is all procedures and revenue codes subject to the limitation (included), prepared as described in code 1000 above. Include any out-of-scope procedures. The second is excluded revenue codes. Use bill type 13x. Include the return code in location 3372-3375 of both records to indicate a companion record is applicable. ASC prices are not applicable to the 13x record. Include all lab and DME HCPCS codes that were not submitted to ASC Pricer as described in subsection B.

	Record any applicable deductible on the 83x record. Allocate coinsurance, reimbursement amount, interest amount, and MSP value code amounts based on the ratio of total charges (revenue codes) remaining on each record after substracting charges for clinical diagnostic lab services paid under the fee schedule and deductible that you allocate to the 83x record. Repeat all other coding (occurrence codes, condition codes, beneficiary and provider identification, from/through dates, etc.), on each transaction.
1020	Valid HCPCS codes but all revenue codes excluded. This situation indicates that revenue codes were omitted, coded incorrectly, or that HCPCS codes were coded incorrectly. Pricing data is returned, but development is required to obtain the missing codes or determine the correct codes.

Return codes 1500-1999 indicate that pricing has not been performed for the return data.

1500	Some or all of the HCPCS codes are surgery codes not subject to the payment limitation. The claim is not subject to the ASC payment limit. Prepare a 13x record for the PS&R.
1510	MSA code not on the MSA wage index file. Check for correct MSA code.
1520	Date of service is prior to October 1, 1987. No pricing is performed for any services prior to October 1. Prepare a 13x record for the PS&R.
1530	Invalid HCPCS count. The count did not fall within the range of 01-28. Resubmit with the proper number.
1540	Invalid HCPCS codes. Resubmit with valid code.
1550	Invalid revenue count. The count did not fall within the range of 01-28. Resubmit with the proper number.

1560	Invalid revenue code (e.g., nonnumeric). Resubmit with the proper revenue code.
1570	All HCPC codes are out-of-scope. Prepare a 13x record for the PS&R.
1580	Input coding indicates operations on more than two eyes. Resubmit with proper codes.

D. ASC Pricer Program Function.—The program uses the data you provide and internal files to determine the ASC limitation for each procedure on the bill record and provides you with data for your processes described in subsection B.

Internally, the program:

o Checks the HCPCS code from the bill against a table of ASC and out-of-scope codes and selects the group number.

o Uses the from date parameter to locate the correct group table.

o Uses the group number obtained from the procedure code check to obtain the correct payment amount from the payment category table.

o Uses the from date to locate the correct wage index table.

o Uses the MSA number to obtain the correct wage index from the wage index table.

o Performs one wage index calculation for each procedure. (Payment amount x 1/3) x wage index + (payment amount x 2/3.)

o For procedures flagged to pay at 100 percent, passes the calculated amount to the calling program; otherwise divides the amount by two and passes the result.

o If procedure code 66983 or 66984 is involved, pays at 150 percent of the group 4 rate, and considers it the first procedure.

3656.5 OCE Editor.—

A. Implementation Requirements.—The OCE edits outpatient hospital claims to detect incorrect billing data and determines if the ASC limit applies to each bill. It reviews each HCPCS and ICD-9-CM code for validity and coverage.

Process all outpatient Part B bills (bill types 13x and 83x) through the OCE.

B. Bill System/OCE Interface.—Install OCE online if possible, so that prepayment edit requirements in subsection C can be directed to hospitals without clerical handling.

The OCE needs the following data elements to analyze the bill:

- ICD-9-CM diagnosis codes (up to 15);
- HCPCS procedure codes (up to 15);
- Age;
- Sex; and
- From date (Item 22 on Form HCFA-1450).

OCE provides you an analysis of "errors" on the bill as described in subsection C. Develop your own interface program to provide data to OCE and receive data from it.

OCE reports to your claims processing system the status of each procedure code and indicates whether the bill is subject to the ASC limit and which edit conditions apply.

The OCE Installation Manual describes the installation and operation of the program, including data base formats and locations.

C. Processing Requirements.—Follow the procedure described below for each error code. Where bills are returned to the hospital, consider them improperly completed for control and processing time purposes. (See §3600.1.)

1. Invalid Diagnosis or Procedure Code.—The OCE checks each diagnosis code against a table of valid ICD-9-CM diagnosis codes and each procedure code against a table of valid 1987 HCPCS codes. If the reported code is not in these tables, the code is considered invalid. Return the bill to the hospital and request a corrected bill with a valid diagnosis or procedure. If you use DME or local HCPCS codes for clinical diagnostic lab services, review the excepted HCPCS procedure code against a file of valid local codes before deciding whether to reject the bill. You may use a supplement table that you develop or you may add local codes to the HCPCS tables.

For a list of all valid ICD-9CM codes see International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases) and the September 1986 "Addendum/Errata" issued by Program Memorandum A-86-18. For a list of valid 1987 HCPCS codes see Physicians' Current Procedural Terminology, 4th Edition, CPT 1987 and HCFA Common Procedure Coding System (HCPCS) 1987, Non-CPT-4 Portion.

2. Invalid Fourth or Fifth Digit for Diagnosis Codes.—The OCE identifies any diagnosis code that requires a fourth or fifth digit, which is either missing or not valid for the code in question.

For a list of all valid fourth and fifth digit ICD-9-CM codes see International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases) and the September 1986 "Addendum/Errata" issued by Program Memorandum A-86-18. Return the claim to the hospital and request a corrected bill with a valid diagnosis.

3. E-Code as Principal Diagnosis.—E-codes describe the circumstances that caused an injury, not the nature of the injury, and therefore, are not used as a principal diagnosis. E-codes are all ICD-9-CM diagnosis codes that begin with the letter E. For a list of all E-codes, see International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM), January 1979, Volume I (Diseases). Return the claim to the hospital and request a proper principal diagnosis on a corrected bill.

4. Age Conflict.—The OCE detects inconsistencies between a patient's age and any diagnosis on the patient's record. Examples of such conflicts are:

- A 5 year old patient with benign prostatic hypertrophy.
- A 78 year old delivery.

In the above cases, the diagnosis is clinically impossible in a patient of the stated age. Therefore, either the diagnosis or age is presumed to be incorrect. Four age code categories are described below.

- A subset of diagnoses are intended only for newborns and neonates. These are identified as "Newborn" diagnoses. For "Newborn" diagnoses the patient's age must be 0 years.
- Certain diagnoses are only considered reasonable for children between the ages of 0 and 17. These are "Pediatric" diagnoses.
- Diagnoses identified as "Maternity" are only coded for patients between the ages of 12 and 55.
- A subset of diagnoses is considered valid only for patients over the age of 14. These are identified as "Adult" diagnoses. For "Adult" diagnoses the age range is 15 through 124.

Addendum E, page E-2-17 contain listings for each of the age categories described above. The listing includes both the ICD-9-CM diagnosis codes and the corresponding English descriptions.

If you edit online, return the bill to the provider and request a proper diagnosis or correction of age as applicable. If you edit in batch operations after receipt of the admission query response, use the age based on HCFA records and return bills that fail this edit, requesting a proper diagnosis.

5. Sex Conflict.—The OCE detects inconsistencies between a patient's sex and any diagnosis or procedure on the patient's bill. Examples of a sex conflict are:

- o Male patient with cervical cancer (diagnosis).
- o Male patient with hysterectomy (procedure).

In both instances, the indicated diagnosis or the procedure conflicts with the stated sex of the patient. Therefore, either the patient's diagnosis, procedure or sex is incorrect. Return the bill to the hospital and request a corrected bill with the proper sex, diagnosis, and procedure.

Addendum E, pages E-18-31 and E-35-36 contain listings of female and male related ICD-9-CM diagnosis codes and the corresponding English descriptions. For listings of female and male related HCPCS procedure codes see Addendum F.

6. Questionable Covered Procedures.—These are procedures that may be covered under the Medicare program, depending upon the medical circumstances. For example, HCPCS code 19360 "Breast reconstruction with muscle or myocutaneous flap" is a condition that is not covered by the program when performed for cosmetic purposes. However, if this procedure is performed as a follow up to a radical mastectomy, it would be covered.

Addendum F contain listings of questionable covered procedure codes. Perform medical review prior to a payment.

7. Noncovered Procedures.—These are procedures that are not reimbursable under the Medicare program. Deny the bill.

Addendum F contain listings of noncovered procedure codes.

8. Medicare as Secondary Payer - MSP Alert.—Addendum E, pages E-61-68 identify situations that may involve automobile medical, no-fault or liability insurance. See §§3341 9.5 and 3489.4B for processing instructions and tolerances.

9. Invalid Age.—If the age reported is not between 0 years and 124 years, the OCE assumes the age is in error.

Reenter the bill with the proper age. If the beneficiary's age is established at over 124, reenter with 123.

10. Invalid Sex.—The sex code reported must be either 1 (male) or 2 (female).

11. Date Range.—The OCE checks the from date in Item 22 on Form HCFA-1450. Billing dates not in the acceptable range of 7/1/87 through 9/30/88 are not edited. Continue processing the bill in your system.

12. Valid Date.—The OCE checks the month, day, and year from Item 22 (from date). If the date is impossible, return the bill to the hospital and request a corrected bill with a valid date.

13. Unlisted Procedures.—These are codes for surgical procedures (i.e., codes generally ending in 99). For listings of these codes and development instructions, see §3626.4.

NOTE: The OCE will produce a summary of "errors," including counts of the number of occurrances of each. Use this information to identify provider coding problems.

3660. SPECIAL BILLING SITUATIONS

3660.1 Ambulance Services.—Process claims for ambulance service furnished by, or under arrangements, made by a provider. Whether or not the patient is admitted as an inpatient, the provider bills ambulance services as an outpatient service. For an exception to this ruling see §3618A. In addition to the information ordinarily supplied, the provider furnishes the following data: (You may develop a form for use by your providers in furnishing the required information.)

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether or not the patient was admitted as an inpatient. If applicable, it shows the name and address of facility;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- Point of pickup (identify place and complete address);
- Destination (identify place and complete address);
- Number of miles
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services, explain. (§3114A.3.)

NOTE: This information is not required for transportation services identified in §3618A, since such transportation is not an ambulance service. Hospitals include such charges on an inpatient bill.

A. Coverage Guidelines for Ambulance Service Claims.--Reimbursement may be made for provider costs incurred in furnishing ambulance service provided conditions in the left-hand column below have been met. The right-hand column indicates the documentation needed to establish that the condition has been met.

Conditions	Review Action
1. The provider has obtained the required physician certification. (§3322)	1. Condition met if the HCFA-1450 is properly signed.

2. Patient was transported by an approved amublance service. (See §3114A.)	2. The provider is listed in your list of those having approved ambulance service. Where the service has been furnished by a supplier under arrangements with the provider, check your list based upon verification with carriers, that the ambulance company is approved.

NOTE: If the ambulance service is not on either list, undertake full development in accordance with §3114A to determine the status of the ambulance company.

3. The patient was suffering from an illness or injury which contraindicated transportation by other means. (See §3114B.)	3. Presume the requirement is met if the file shows the patient: o Was transported in an emergency situation, e.g., as a result of accident, injury, or acute illness; o Needed to be restrained; o Was unconscious or in shock; o Required oxygen or other emergency treatment on the way to his destination; o Had to remain immobile because of a fracture that had not been set or the possibility of a fracture; o Sustained an acute stroke or myocardial infarction; o Was experiencing severe hemorrhage; o Was bed confined before and after the ambulance trip; or

	o Could be moved only by stretcher. In the absence of any of the above conditions obtain additional documentation to establish medical need where the evidence indicates existence of any of the following circumstances: o Patient's condition would not ordinarily require movement by stretcher; o The individual was not admitted as a hospital inpatient, (except in accident cases); o The ambulance was used solely because other means of transportation were unavailable; or o The individual merely needed assistance in getting from his room or home to a vehicle. Where the information indicates a situation not listed above, refer the case to your supervisor.
4. The patient was transported from, and to, points listed below: (See §3114C.)	4. Claims show points of pickup and destination. The patient was transported from, and to, points listed below:
(a) From patient's residence (or other place where need arose) to hospital or SNF.	(a) Condition met if trip began within the institution's service area as shown in your locality guide. Condition met where the trip began outside the institution's service area if the institution was the nearest one with appropriate facilities. Refer to supervisor for determination.

NOTE: A patient's residence is the place where he makes his home and dwells permanently or for an extended period of time. A SNF is an institution which meets section 1861(j)(1) of the law.

(b) SNF to a hospital or hospital to a SNF.	(b) Condition met if pickup point was in the service area of the destination as shown in your locality guide. Condition met where the pickup point is outside the service area of the destination if the destination institution was the nearest one with appropriate facilities. Refer to supervisor for determination.
(c) Hospital to hospital or SNF to SNF.	(c) Condition met if the discharging institution was not an appropriate facility and the admitting facility was one with appropriate facilities.
(d) From a hospital or SNF to patient's residence.	(d) Condition met if patient's residence is within the institution's service area as shown in your locality guide. Condition met where the patient's residence is outside the institution's service area if the institution was the nearest one with appropriate facilities. Refer to supervisor for determination.

NOTE: Ambulance service to a physician's office or a physician-directed clinic is not covered. (See §3114C.5 where a stop is made at a physician's office enroute to a hospital.)

B. Partial Payment.--Partial reimbursement may be made for otherwise covered ambulance service which exceed the criteria in 4 above. Base payment upon the amount that would have been payable had the patient been transported from the pickup point to the nearest appropriate facility. However, when the beneficiary was transported from a distant hospital or a SNF to his residence, base payment upon the amount that would have been payable had the beneficiary been transported to his residence from the nearest institution with appropriate facilities.

3660.2 Hepatitis B Vaccine.—Effective September 1, 1984, Part B of Medicare covers the reasonable cost of provider services for hepatitis B vaccine and its administration to a patient if it is ordered by a doctor of medicine or osteopathy. Deductible and coinsurance amounts apply.

Where the vaccine is administered in connection with other outpatient services, it may be included on the same outpatient bill (bill type 13). Where the vaccine is given to an inpatient, a separate Part B bill will be prepared because of a differing deductible and coinsurance requirement from inpatient services.

Applicable revenue code (e.g., 250) will be used. No special annotations are needed.

See §3157 for discussion of who is eligible for such vaccine.

6

3660.3 Rental or Puchase of DME.—

A. General Requirements.—The provider bills on HCFA-1450 for DME rented or sold to a beneficiary for use in his home or in an institution used as his home. A beneficiary may elect to rent an item of equipment rather than purchase it even though it may appear that purchase would be more economical for the program. Except for used equipment (see below), payment is made to the provider (subject to final settlement) at 80 percent of reasonable cost, less any unmet Part B deductible. Make full payment for the purchase of used DME which meets the criteria for waiver of the beneficiary's 20 percent coinsurance, less any unmet Part B deductible. (See §§3113ff. for coverage of equipment, §3113.7 for processing and payments, including lump-sum payments for inexpensive equipment, and §3525.7 for query procedures and diarying for continuing payments.)

Where the purchase price for equipment is $50 or less and a lump-sum payment made, the usual outpatient billing procedures apply. Where a lump-sum cannot be paid for purchased equipment, make payment in installments equal to those that would have been made had the beneficiary rented the equipment.

1. Processing Periodic Payments.--Where the provider rents the equipment to the patient, it submits a HCFA-1450 for each month's rental charge.

Where the provider sells the equipment to the patient, it submits one HCFA-1450 showing the purchase price. The provider may bill the patient once for his deductible and coinsurance liability or submit a bill each month.

To determine the number of periodic payments, divide the total charge (plus allowable State and local taxes and allowable interest or carrying charges) by the reasonable monthly rental charge. Where these do not divide evenly, make an additional periodic payment based upon the remainder if it is one-half or more of the reasonable monthly rental charge. Where the remainder is less, add the remaining reimbursement to the last full periodic payment.

2. Safeguards to Stop Payments When Medical Necessity Ends.--Establish appropriate safeguards to insure that payments are not made beyond the last month of medical necessity or beyond the month in which reimbursement will be completed, whichever comes first. For example, if medical necessity for a given item of equipment is estimated by the physician to be 8 months and periodic payments would extend over a period of 10 months, take appropriate steps to insure that the periodic payments are stopped at the end of the 8-month period.

Send notices to beneficiaries well in advance of the date that payments to providers are scheduled to stop so that payment would not be unnecessarily terminated where there is a continuing medical necessity for the equipment. Advise him of the reason that payments will be stopped, and that payments can continue if the continues to be medically necessary.

B. Special Bill Entries.—The following special entries are applicable.

Item 50. Description

Contains a description of the equipment. Compare this with the diagnosis (Item 77) and Remarks to determine necessity.

Item 51. Revenue Code

The following codes indicate the type.

291 - rental
292 - purchase new
293 - purchase used

Revenue code 293 represents used equipment for which the 20 percent coinsurance is waived. If you reduce the purchase price shown to a lower figure, report the lower figure in UNIBILL.

Item 94. Remarks

The rental rate, cost and anticipated months of use is shown. Compare these to determine whether the billed price is consistent with the length of time needed.

C. Coverage Revew.—Reimbursement may be made for expenses incurred by a patient for the rental or purchase of DME for use in his home provided that the conditions in Column A are met. Column B indicates the action to take to establish that the conditions have been met.

The patient may elect to rent even though purchase is more economical. However, make reimbursement on the basis of which is less expensive to the program.

Column A	Column B
Conditions	Review Action
1. Make payment for the following:	1.
Items of DME (§3113.1B) that are medically necessary. (See §3113.2).	Appendix shows coverage status of items of equipment. If item is not listed in appendix, refer to supervisor, who will determine whether item is covered in accordance with §§3113ff.
Separate charges for repairs, maintenance, and delivery. (See §3113.3.)	Repairs--only if DME is being purchased or is already owned by patient and repair is necessary to make the equipment serviceable. If expense for repairs exceeds the estimated expense to purchase or rent another item for the remaining period of medical need, deny the excess.

	Maintenance--only if the equipment is being purchased or is already owned by the patient and if the maintenance is extensive amounting to repairs, i.e., requiring the services of skilled technicians. (Deny claims for routine maintenance and periodic servicing, e.g., testing, cleaning, checking oiling.)
	Delivery--of rented or purchased equipment only if the supplier customarily makes a separate charge for delivery, and this is a common practice of the local suppliers.
Separate charges for disposable supplies, e.g., oxygen, if essential to the effective use of medically necessary DME. Separate charges for replacement of essential accessories such as hoses, tubes, mouthpieces, etc., only if the beneficiary owns or is purchasing durable medical equipment (§3113.4). (Medications used in connection with durable medical equipment are covered under certain conditions, see §3313.4.)	Claim must indicate that the patient has the DME for which the item is intended; the DME continues to be medically necessary; and the items are readily identifiable as the type customarily used with such equipment.

NOTE: If the quantity of accessories and/or supplies included in a claim seems excessive or if claims for such items are received from the same claimant with undue frequency, refer to a supervisor for handling in accordance with §3113.5.

2. DME must be for use in patient's residence other than a health care institution (§§3113.6 and 3120.5).	2. Payment cannot be made for equipment for use in an institution whose provider number in the current edition of the Directory of Medical Facilities classifies it as:

(a) a participating hospital;
(b) an emergency hospital;
(c) meets 1861(e)(1);
(d) a participating SNF; or
(e) meets 1861(j)(1)

If one of the above institutions has a distinct part which does not meet either 1861(e)(1) or (j)(1), the patient may be considered in his residence if he was physically located in such distinct part during the use period.

3. Physician's prescription

3. (a) Prescription and other required information must be reviewed to determine medical necessity and establish the duration of medical need. If DME is currently necessary, accept the physician's estimate of duration when it does not exceed 6 months. When the physician's estimate exceeds 6 months, is indefinite, or is lacking, refer to your supervisor. (See § 3113.7C.)

(b) The prescription should include the patient's diagnosis and prognosis, the reason the equipment is required and an estimate (in months) of the duration of need; if the prescription lacks this information, refer to your supervisor. (See §3113.7C.)

(c) Prescriptions for home dialysis delivery systems do not require an estimate of the duration of need, or estimate may be shown as indefinite.

(d) Prescriptions or other documentation for home oxygen systems must also include specification of the oxygen flow rate and an estimate of the frequency and duration of use of the oxygen system in addition to the information specified in (b) above. Prescriptions also may include specification of the type of oxygen delivery system to be used. If the type of system is specified, the medical reasons for selecting that system over alternative systems must also be specified. (See HCFA Pub. 6, §60-4.)

NOTE: When medical necessity has been established, approval of the claim should not be delayed because of a question involving the period of need. (See § 3113.7C.)

3660.4 All-Inclusive Rate Providers.—

A. Providers Using All-Inclusive Rates for Inpatient Part A Charges.—Providers have the option with your approval to bill on a flat fee charge incurred on either a daily basis or total stay basis for services rendered. This is an "All Inclusive Rate." These charges may cover room and board including ancillary services or room and board only. The following explain the essential data entries that must be made on the HCFA-1450 by providers that use all-inclusive rates as charges. All-inclusive rate providers are identified by one of the following charge structures:

- One total all-inclusive charge rate for both accommodations and ancillary services, including the cost of blood in the rate,
- One total all-inclusive charge rate for both accommodations and ancillary services, not including the cost of blood in the rate,
- One all-inclusive charge rate for accommodations and another for ancillary services including the cost of blood in the all-inclusive rate, or
- One all-inclusive charge rate for accommodations and another for ancillary services, not including the cost of blood in the all-inclusive rate.

Providers follow these special instructions for completing Items 50-56 of the billing form.

1. Accommodations

Revenue Codes - Codes which identify the accommodations furnished, ancillary services provided or billing calculation are entered in field 51. The code indicates whether the rate includes charges for ancillary services or only room and board.

If the patient was furnished more than one type of accommodation, the lines for each type of accommodation are completed. This is necessary whether or not the provider charges an all-inclusive rate according to accommodations.

Where the all-inclusive rate varies with the type of accommodation, Item 94 (Remarks) is annotated for a five-or-more bed accommodation showing the reason for the accommodation.

Unit of Service - A quantative measure for services rendered by revenue category to or for the patient which includes items such as the number of accommodation days, pints of blood, renal dialysis treatments, etc., is entered in column 52.

Total Charges - The total charges pertaining to the related revenue code for the current billing period is enter in column 53.

Unlabeled Charge Columns - These columns (54-56) are used to identify and allocate charge information pertaining to the related revenue code. They indicate whether the charges are for covered or noncovered services.

2. Ancillary Services

One All-Inclusive Charge Rate - Hospitals with one all-inclusive charge rate, including ancillary services, are reflected in the revenue code in item 51. The total charge in item 53 should reflect the charge for both accommodations and ancillary services.

Separate Ancillary All-Inclusve Rate - Some providers segregate charges for ancillary services for billing purposes. Where a separate flat rate charge for ancillary services is incurred either on a daily or total stay basis, the provider enters separate codes in items 5-52 for the services. These codes indicate whether the total charge includes only ancillary cost or includes other costs (i.e., blood).

If applicable, the following additional billing instructions are applied:

- Blood

  Whenever whole blood is furnished the patient, items 40-43 are completed. If the all-inclusive rate does not include the charge for whole blood or packed cells, items 50-52 are completed in the same way a provider not using all-inclusive rates would complete them. When the provider discounts its customary charges for unreplaced blood to which the deductible is applicable, it shows the charges before the discount.

  If the all-inclusive rate covers the cost of providing blood whenever a patient needs it, the number of pints furnished, replaced, not replaced, and the estimated cost per pint is entered in items 40-43. No amount can be shown in the Total Charges Column since the rate includes the cost of blood. The cost of any of the first three pints which are not replaced is shown in item 42. It is not necessary to show the cost for any replaced blood.

- All-Inclusive Charges Acccording to Disease, Injury, or Type of Treatment

  Providers that have a charge system based on the patient's illness or injury or type of treatment complete the line(s) for type of accommodation furnished showing number of days, rate, and total charges. The rate amount and total amounts should be the same. Blood entries are indicated as above.

- Physician's Component

  As with providers having a schedule of charges for individual services, the amount of any physician's component included in the all-inclusive charge is removed from the total covered charges before applying the inpatient deductible or coinsurance.

- Combined Billing

  Do not encourage the all-inclusive rate provider to combine bill. However, if it does, it must develop the capability and indicate in Item 94, Remarks, the number and type of each service it is combined billing. To identify such cases, the remark "Combined Billing" must be written in item 94, Remarks.

B. Providers Using All-Inclusive Rates for Part B Charges.—The following explains entries on the HCFA-1450 by providers that use all-inclusive rates as charges for Medicare Part B services. (See §3604 for instructions to complete the rest of the bill.)

1. Part B Services Rendered to Outpatients by Providers Which Charge One Outpatient Rate.--All-inclusive rate providers that charge one outpatient rate no matter what services are rendered to the outpatient indicate their charge in Item 50, as one total charge amount. These charges are identified as "All-inclusive Rate in Item 51. The total charge on Item 53 is the same as the covered charge in Item 51. The rest of the bill is completed according to §3604.

- Combined Billing

  This type of all-inclusive rate provider should not be encouraged to combine bill. However, if such a provider does combine bill, it must develop the capacity and indicate in Item 94 "Remarks" the number and type of each service it is combined billing. To identify such cases, the remark, "Combined Billing" is written in "Remarks".

2. Part B Services Rendered to Inpatients.--For billing purposes, the determination of charges for Part B ancillary services furnished to hospital or SNF inpatients when Part A benefits are not payable is dependent upon the cost reimbursement method used by the provider to apportion allowable costs between Medicare beneficiaries and other patients. (See Provider Reimbursement Manual, Part 1, §2208.3, regarding the various cost reimbursement methods used by all-inclusive rate providers in determining Part B inpatient ancillary costs.) These inpatient ancillary services may be payable under Part B when the level of care becomes noncovered under Part A or when Part A benefits become exhausted or are otherwise not payable.

Part B inpatient ancillary services include radiology, pathology, electrocardiology, electroencephalography, physical therapy, speech pathology, renal dialysis, and prosthetic devices, braces, and splints covered under the heading of medical supplies.

Participating hospitals use form HCFA-1450 to bill a limited number of services furnished inpatients whose benefit days are exhausted or who are otherwise not entitled to have payent made under Part A.

3. Part B Services Rendered to Inpatients by Providers That Have A Separate All-Inclusive Rate for Ancillary Services.--All-inclusive rate providers that have a separate all-inclusive charge rate for ancillary services bill for the limited number of covered services on the HCFA-1450. In all cases, item 4, "Type of Bill" indicates that the bill is for "Inpatient (Medicare Part B Only)." The all-inclusive ancillary rate or charge is in Item 50, as one charge amount. This ancillary charge rate is coded as "All-inclusive Rate" in Item 51, and the total charge (obtained by multiplying this rate per day x number of days after Part A benefits were exhausted) is entered in Item 53, Total Charges. The rest of the bill is completed according to §3604.

o Combined Billing

Providers that have a separate all-inclusive charge rate for ancillary services and use combined billing complete Item 18, Professional Component (hospital inpatients), when radiology or pathology services are provided.

4. Part B Services Rendered to Inpatients by Providers That Have One Total All-Inclusive Rate for Both Accommodations and Ancillary Services.-- All-inclusive rate providers that have one all-inclusive rate for both accommodations and ancillary services should follow the appropriate cost reimbursement method of billing instructions listed below. Regardless of the cost reimbursement method used by the hospital or SNF to obtain the rate, all charges allocated to the inpatient ancillary services are entered in Items 50-53 as one charge amount and identified as "Inclusive Rate." The rate is multiplied by the number of days the patient was in the facility (receiving covered services) after Part A benefits were exhausted to obtain the total charge for Part B inpatient services, entered on Item 53, TOTAL.

5. Cost Reimbursement Methods of Billing

a. Hospitals and SNFs Using Method A (Use of Statistical Data).--For billing purposes, using the costs report for the immediately preceding cost reporting period, the ratio of total allowable costs of the Part B inpatient ancillary services to total allowable costs of all inpatient services (including routine) applied to the provider's current all-inclusive billing rate represent the inclusive billing rate applicable to the ancillary services covered for Part B inpatients when Part A benefits are not available. They enter the charge amount obtained by this computation in Item 51.

b. Hospitals using Method B (Sliding Scale to Account for Difference between Average Length of Stay for Medicare Patients and that for All Patients).--Not applicable to SNFs. For billing purposes, an inclusive charge for the Part B inpatient ancillary services is determined by applying the same fixed percentage employed in the cost apportionment formula to the hospital's average inpatient ancillary charge. The average ancillary charge is determined from the hospital's prior year costs report by applying a percentage to its all-inclusive rate based on its total inpatient ancillary costs divided by total costs for all inpatient services (including routine).

Based on the best available data, the following percentages represent the average ratio of inpatient ancillary service costs which would be reimbursable under Part B, when Part A benefits are not available, to total inpatient ancillary service costs:

All hospitals Except Psychiatric	45%
Psychiatric	48%

The amount derived by mutiplying the appropriate percentage figure by the hospital's average inpatient ancillary service charge is entered in Item 51.

c. Hospitals using Method C (Hospitals with Established Descending Rates of Charges).--(Not applicable to SNFs.)

An inclusive charge for the Part B ancillary services is determined by applying the same fixed percentage (see below) employed in the cost apportionment formula to the hospital's all-inclusive rate, after application of the descending rates.

The following percentages, based on the best available data, represent the average ratio of inpatient ancillary service costs reimbursable under Part B, when Part A benefits are not available, to total costs of all inpatient services (ancillary and routine).

All Hospitals Except Psychiatric	16%
Psychiatric	6%

The amount derived by multiplying the hospital's total charge for inpatient services (ancillary and routine) by the appropriate percentage figure is entered in Item 51.

d. Hospitals and SNFs Using Method D (Use of Comparable Hospital or SNF Data).--For billing purposes, an inclusive billing rate applicable to the ancillary services covered for Part B inpatients, when Part A benefits are not available, is determined in the same manner and employing the same fixed percentages as those used by Method b hospitals (using 65 percent for SNFs).

The amount derived by multiplying the provider's average inpatient ancillary service charge by the appropriate percentage figure is entered in Item 51.

e. Hospitals and SNFs Using Method E (Percentage of Per Diem).--For billing purposes, the inclusive charge for Part B inpatient ancillary services is computed by applying the same fixed percentages as those used by Method C hospitals or by using 2.5 percent for SNFs. The amount derived by multplying the provider's total charge for inpatient services (ancillary and routine) by the appropriate percentage figure is in Item 51.

Any payments made by Medicare beneficiaries to providers for Part B inpatient ancillary services which are billable to, and reimbursable by, Medicare under these guidelines must be refunded to the beneficiaries.

3660.5 Hospitals That Do Not Chare.—Participating hospitals that do not charge individuals and also meet the exceptions to the law that normally exclude payment for expenses paid for directly or indirectly by a governmental entity, may be reimbursed the reasonable cost of furnishing covered services to Medicare beneficiaries. The following special procedures apply to their bills.

- Part A Services

Computing Medicare Billing Rate.--The Medicare billing rate per day is determined by the following equation:

$$\frac{\text{Total allowable inpatient cost}}{\text{Total inpatient days}} = \text{cost per day per patient}$$

Thus, the billing rate that appears is the average inpatient cost per day per inpatient as calculated from entries on the latest cost settlement report approved by Medicare. Where this is the provider's first year in the program, determine this rate based on the provider's books and record the appropriate billing rate for services rendered to Medicare beneficiaries.

Computing Medicare Billing Rate (Inpatient).--The Medicare billing rate is determined in the following manner:

$$\frac{\text{Total available inpatient cost}}{\text{Total inpatient days}} = \text{Cost per day per patient}$$

Multiply the cost per day per patient by 93 percent for short-term hospitals and by 98 percent for long-term hospitals. (See §2208.1E of the Provider Reimbursement Manual, Part I, for definitions of "short-term" and "long-term" hospitals.) Then apply the following fixed percentages. The result is the Medicare billing rate.

Computing Medicare Billing Rate (Outpatient).--The Medicare billing rate is determined by the following equation:

$$\frac{\text{Total allowable outpatient costs}}{\text{Total vists (occasions of service)}} = \text{average cost per visit}$$

Thus, the billing rate is the average cost per outpatient visit as calculated from entries on the latest cost settlement report approved by Medicare. Where this is the provider's first year in the program, determine this rate based on the provider's books and record the appropriate billing rate for services rendered to Medicare beneficiaries.

A. Explanation of Medicare Benefits (EOMB).--Where the hospital does not charge for outpatient services, do not send the individual to EOMB. This avoids confusion and the appearance that the beneficiary is liable for services received.

3660.6 Billing for Enteral and Parenteral Nutritional Therapy.--Providers can bill for necessary medical supplies, equipment, and nutrients for enteral and parenteral nutritional therapy (EPT) when the therapy meets the coverage guidelines (Coverage Issues Manual 65-10 - 65-10.3) as a prosthetic device. HHAs, SNFs, and hospitals which supply medical supplies, equipment and nutrients for enteral and parenteral nutritional therapy as a prosthetic device under Part B Medical and other health benefits, will bill the two Part B specialty carriers. When the EPT therapy meets the coverage guidelines, they are billed on the HCFA-1500.

Return claims containing EPT charges for services where the bill type is 12, 13, 22, 23, 33 or 34.

Manual instructions to the providers direct them to submit the EPT charges on Form HCFA-1500 to the carrier according to the locale of the provider (or home office if billing is centralized):

West of the Mississippi and the State of Minnesota

Transamerica Occidental Life Insurance Co.
Medicare Pen Mail
P.O. Box 60848 Terminal Annex
Los Angeles, CA 90054

East of the Mississippi

Blue Cross and Blue Shield of South Carolina
Parenteral/Enteral Claims Processing
Drawer F
Columbia, SC 29260-9987

They are also instructed to resubmit a new bill for services where the bill contained a combination of services.

3660.7 Pneumococcal Vaccinations.--Part B pays 100 percent of the reasonable charges for pneumoccal vaccinations and its administration to a patient if it is ordered by a physician who is a doctor or medicine or osteopathy. (See §3157A.) Neither deductible nor coinsurance apply.

The provider bills for these services on a HCFA-1450 with bill type 12X (hospital inpatient Part B) or 13 X (hospital outpatient), as appropriate with the following entries:

- o Revenue code 250 in Item 51;
- o Narrative description in Item 50; and
- o Code 06 in Item 44.

The provider completes the remaining items in accordance with regular billing instructions.

3660.8 Immunosuppressive Drugs Furnished to Transplant Patients.--Part B of Medicare covers the reasonable cost of FDA-approved immunosuppressive drugs. Payment is made for those immunosuppressive drugs that have been specifically labeled as such and approved for marketing by the FDA, as well as those prescription drugs, such as prednisone, that are used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs. Therefore, antibiotics, hypertensives, and other drugs that are not directly related to rejection are not covered. Deductible and coinsurance apply. This benefit is limited to a 1-year period after the date of the transplant procedure if the patient received a Medicare covered organ (e.g., kidney or heart) transplant. Coverage of immunosuppressive drugs received as a result of a transplant is contingent upon the transplant being covered by Medicare. (See §3613.) Medicare pays for immunosuppressive drugs which are provided outside the 1-year period if they are covered under some other provision of the law (e.g., when the drugs are covered as inpatient hospital services or are furnished incident to a physician's service).

The "1-year period after the date of the transplant procedure" is defined as 365 days from the day on which an inpatient is discharged from the hospital stay during which the transplant was performed. During a covered stay, include payment for these drugs in your payment to the hospital. If the same patient receives a subsequent transplant operation within 365 days, the 1-year period begins anew.

The FDA has identified and approved for marketing only the following specifically labeled immunosuppressive drugs:

- Sandimmune (cyclosporine), Sandoz Pharmaceutical (oral or parenteral form);
- Imuran (azathioprine), Burroughs-Wellcome (oral);
- Atgam (antithymocyte/globuline), Upjohn (parenteral); and
- Orthoclone (OKT3 (muromonab-CD3), Ortho Pharmaceutical (parenteral).

In addition to the above listed drugs, prescription drugs used in conjunction with immunosuppressive drugs as part of a therapeutic regimen reflected in FDA-approved labeling for immunosuppressive drugs are also covered.

You are expected to keep informed of FDA additions to the list of the immunosuppressive drugs. Prescriptions generally should be nonrefillable and limited to a 30 day supply. The 30 day guideline is necessary because dosage frequently diminishes over a period of time, and further, it is not uncommon for the physician to change the prescription. Also, these drugs are expensive and the coinsurance liability on unused drugs could be a financial burden to the beneficiary. Unless there are special circumstances, do not consider a supply of drugs in excess of 30 days to be reasonable and necessary. Deny payment accordingly.

A. Billing Requirements.--The hospital bills on HCFA-1450 with bill type 12x (hospital inpatient Part B) or 13x (hospital outpatient) as appropriate with the following entries:

- Occurrence code 36 and date in Items 28-32;
- Revenue code 250 in Item 51; and

- Narrative description in Item 50.

The hospital completes the remaining items in accordance with regular billing instrutions.

B. EOMB Messages.--If the claim for an immunosuppressive drug is denied because it was not approved by the FDA, state on the EOMB:

- "Medicare does not pay for immunosuppressive drugs that are not specifically labeled and approved for marketing by the FDA."

If the claim for an immunosuppressive drug is denied because the 1 year time limit has expired, use the following message;

- "Medicare cannot pay for this drug since coverage is limited to 1 year following your discharge from the hospital after your transplant."

If the claim for an immunosuppressive drug is partially denied because of the 30 day limitation, use the following message;

- "Medicare will only pay for a 30 day nonrefillable supply of immunosuppressive drugs at one time."

If the claim for an immunosuppressive drug is denied because a transplant was not covered, use the following message;

- "Medicare does not pay for immunosuppressive drugs furnished in conjunction with a transplant unless the transplant itself was covered by Medicare."

3664. ADJUSTMENT BILLS

A. General.—Adjustment bills are the most common mechanism for changing a previously accepted bill. They are required to reflect the results of PRO medical review. (See §3674.5.) You may process a PRO adjustment and count it processed before receiving the batch acceptance record. (See §3674.5.) Adjustments may also be requested by HCFA if HCFA discovers that bills have been accepted and posted in error to a particular record. (See §3816.2.) Providers report adjustments as described in §3664.1.

Where reimbursement is handled through cost reporting and settlement processes, the provider accumulates a log for those items not requiring an adjustment bill. For cost settlement, pay on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

Providers in Maryland, which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment bills, enter the payment amounts from the summary log into the PPS waiver simulation and annually pay the items on the log after the cost report is filed.

An original bill does not have to be accepted by HCFA prior to making related adjustments to the provider. However, for all adjustments other than PRO adjustments (e.g., provider submitted, and/or those you initiate) submit an adjustment bill to HCFA following HCFA's acceptance of the initial bill. To verify HCFA's acceptance, take one or both of the following actions:

1. Submit a Status Query.—The reply to a status query provides the thru or discharge date of the last bill posted as well as all open items. When the admission for the bill in question is absent from the query reply and the thru or discharge date of the last bill posted is on, or after, the discharge date of the bill in question, presume that the original bill has been posted.

2. Review Your Batch Record.—The first interim batch record shows the status of each bill. The final batch record shows which were accepted and which were deleted. If a final batch record has not been prepared, review all interim batch records for the batch in which the original bill (the bill to be adjusted) was submitted. If the bill was deleted, it should appear on an interim batch record. If the bill is shown as pending on the first interim batch record but does not appear as a deleted item or on an interim batch record and no final batch record has been received, the bill may have been accepted by HCFA. A status query will verify acceptance.

The status query is the fastest way to determine whether an original bill has been accepted. However, if the status query reply shows that the bill has not been posted, review the batch notices to determine if it is still pending within HCFA's system or has been rejected. If rejected, see subsection B. If pending, do not send an adjustment until the bill is accepted. For PRO initiated adjustments, these requirements are waived.

You may submit PRO adjustments to HCFA absent HCFA's acceptance of the initial bill, if you choose to do so. You should, however, be aware that should the initial bill RTI, the adjustment will also RTI.

B. General Rules for Submitting Adjustment Bills.--Adjustment bills which are "credits" must match the original on the following fields:

- o Surname;
- o HICN;
- o Admission date;
- o From/thru dates;
- o When present, discharge date;
- o Utilization days (i.e., full, coinsurance);
- o Deductible and blood (pints furnished, pints replaced, and deductible); and
- o Intermediary control number.

Cancel only adjustments are not acceptable, except in cases of incorrect provider identification or HICNs.

If billing data was submitted in a format which HCFA no longer accepts, use the new format.

If you furnished the Part B carrier a copy of the original bill which is being adjusted, furnish them a copy of the adjusted bill.

If adjustment bills returned by HCFA for additional corrections need to be resubmitted, send them in the applicable batch category (e.g., you must include inpatient adjustment bills in an inpatient bill batch). Even if the adjustment action is requested by letter from HCFA, submit the adjustment bill in your UNIBILL record. If a rejected adjustment bill is determined to be unnecessary, stop the adjustment action upon receipt of correction.

Where an adjustment changes subsequent utilization, note this and process adjustments to subsequent bills if you service the provider. In New Jersey there may be additional changes in utilization because it is a waiver State. If you do not service the provider, HCFA will contact the intermediaries which submitted bills with subsequent billing dates that are affected by the adjustments via an SSA-L389 or SSA-L1001 (see §3816.2) upon receipt of the adjusted bills via magnetic tape. (An indicator is set by HCFA on its records upon advising an intermediary of the appropriate adjustment actions.)

C. Action When Original Bill is or Can be Expected to be Rejected by HCFA.—If you determine that the original bill has been rejected, you may process the adjustment and the RTI correction in the same action, if your system permits. If you do this, include the "P" in the third position of bill type on all PRO requested adjustments.

Enter on the resubmittal items which you or the provider wish to adjust. This eliminates the need for an adjustment bill. If review of the batch records shows that the original bill is still pending within HCFA, but the error on the bill will cause HCFA to delete it, for a provider's or your own adjustments, wait until it is rejected and returned before submitting the adjustment. However, do not wait until you have received the deleted bill from HCFA before instructing the provider to refund any overcollection in accordance with §3401.

When you doubt whether the original bill will be deleted by HCFA, do not send any adjustment (except a PRO initiated one, as described in §3674.5.B.) until you receive the batch record indicating final disposition (accepted or deleted).

NOTE: Resubmit any original bill which is deleted for correction even if you or the provider have already submitted an adjustment. The submission of an adjustment bill does not replace the need for the corrected original bill, and HCFA will delete any adjustment for which the original bill has not been processsed. In addition, the open item remains open and under RTI control until the corrected original is received.

D. Adjustment Bills Involving Time Limitation for Filing Claims.--If a provider fails to include a particular item or service on its initial bill, an adjustment bill(s) to include such an item(s) or service(s) is not permitted after the expiration of the time limitation for filing a claim. However, to the extent that an adjustment bill otherwise corrects or supplements information previously submitted on a timely claim about specified services or items furnished to a specified individual, it is subject to the rules governing administrative finality rather than the time limitation for filing. (See §3799.2.)

Providers in Maryland which are not paid under PPS or cost reports, submit an adjustment bill for inpatient care of $500 or more, and submit a log for the lesser amounts.

3664.1 Tolerance Guides for Submitting Adjustment Bills.—

A. Inpatient Adjustment Bills.—When a bill has been submitted and you discover an error, the provider submits an adjustment bill if the error is:

o A change in the number of inpatient days (including a change in the length of stay or a different allocation of covered/noncovered days);

- A change in blood deductible;
- A change in the inpatient cash deductible of more than $1;
- A change in the servicing provider;
- A change in discharge status in a PPS hospital;
- A change in the DRG code; or
- A change in outlier payment amount.

When you receive any of the above, submit UNIBILL to HCFA. An adjustment from the PRO for any of the above also requires submission to HCFA.

Providers in Maryland submit a log for inpatient items under $500 along with their cost reports.

After cost reports are filed, make a lump sum payment to cover charges shown on the summary log. Additionally, if PPS is involved and the DRG has been changed as a result of medical review after an original bill has been forwarded to HCFA, adjustment debit/credit bills are required. The corrected bill must be an exact duplicate of the original, except for any changed fields including diagnostic and procedure codes.

Do not perform a separate audit for the summary log. Audit the log during the regular provider audit.

B. Outpatient Adjustment Bills.—When an initial bill for outpatient services has been submitted and the provider or you discover an error, the provider submits debit/credit adjustment bills to you. You submit debit/credit adjustment bills to HCFA if there is a change:

- In the Part B deductible of more than $1;
- In covered charges of more than $1 on bills for surgery or other outpatient procedures;
- In the servicing provider;
- In the blood deductible;
- In the coinsurance amount greater than $1.99; or
- In procedure codes.

Providers submit a log for use in the cost settlement for outpatient services not requiring an adjustment bill.

Physician Services

3668. PHYSICIAN SERVICES

3668.1 Billing for Physicians Services.—The services of provider-based physicians which are directly related to the medical care of the individual patient are not includable as covered provider costs. (See §§3145 and 3902.) However, the services of interns and residents, even though they are licensed physicians, are covered as a provider cost, except for "moonlighting" interns and residents who are reimbursed on a reasonable charge basis. (See §3115B.) The cost for interns and residents under an approved teaching program is included as routine services (accommodations charge, see §3101.6), or as part of the hospital component charge for outpatient department services. (See §3617 on billing for interns or residents who are in a program which has not been approved.)

Part B benefits for the professional components of physician and other nonprovider services are reimbursable on a reasonable charge basis. There are two methods of claiming them: The patient (or his representative) may request payment on the basis of an itemized bill (receipted or unpaid), or he may assign his claim to his source of medical treatment or services. By accepting assignment, the physician (or hospital authorized to bill and receive payment for physician services (see §§3688-3688.5)) can claim the payment. The physician or hospital accepting the assignment agrees to consider the reasonable charge as determined by the carrier to be the full charge for the service.

Ways in which physician services may be billed:

- HCFA-1500 Health Insurance Claim Form.—It is the prescribed form for claims prepared by physicians or suppliers whether or not the claims are assigned. Hospitals may use the HCFA-1500 to bill the carrier for the professional component of physicians' services where applicable.

- The combined billing method (form HCFA-1450 may be used only by all inclusive rate hospitals. (See §3604.1-3604.5.)

- HCFA-1490S Patient's Request for Medicare Payment.—This form is used only by beneficiaries (or their representatives) who complete and file their own claims.

3668.2 Combined Billing by All-Inclusive Rate and Teaching Hospitals.—

A. Hospital Requirements.—The combined billing method is available only to all inclusive rate and teaching hospitals. It combines the billing of the provider and professional components and eliminates the need for separate billings for physician's services. For interim reimbursement purposes, pay the hospital on the basis of a single billing. Obtain a realistic allocation of the physician compensation in accordance with §§3912ff. and make an adjustment between the Part A and Part B Trust Funds at the end of the provider's fiscal year.

The hospital must be entitled to receive SMI payment for a physician's services as an employer under §3488 or as a facility under §3488.1. Where a physician charges a fee for service, the combined billing method cannot be used. Combined billing is used only where the physician is compensated by salary or receives a percentage of charge.

When combined billing is used for either radiology or pathology, it must be used for both inpatient and outpatient services. All radiologists or all pathologists must agree. The combined billing method does not apply to any inpatient services except those furnished by radiologists or pathologists. Inpatient services (professional component) of hospital-based physicians other than radiologists or pathologists is billed to the carrier.

Combined billing may be used by other hospital-based physicians (except those treating mental disease) for outpatient services. However, before outpatient services furnished for an individual medical specialty can be billed, all physicians in that medical specialty department must agree. The use of the combined billing method by the individual medical specialty department is not dependent upon the approval of physicians in other medical specialty departments.

EXAMPLE All radiologists in a hospital agree to combined billing. The pathologists do not. Combined billing can be used for both inpatient and outpatient radiology services. It cannot be used for pathology services for either inpatient or outpatient services. Combined billing could not be used for pathology services even if the physicians reached a limited agreement to allow it for inpatient services, since the agreement to use combined billing must cover both inpatient and outpatient services.

Prior to the Omnibus Reconciliation Act of 1980, the Medicare Part B program paid 100 percent of the reasonable charges (no deductible or coinsurance) for physician's radiological and pathological services covered under Part B furnished to an inpatient of a qualified hospital by a physician in the field of radiology or pathology. Under the Omnibus Reconciliation Act, the Medicare Part B program pays 100 percent of the reasonable charges for such services only if the physician has in effect an agreement to accept assignment for all such services he furnishes to hospital inpatients. If he does not have such an agreement in effect, the program pays 80 percent of the reasonable charges after the application of any unmet deductible, whether the particular claim is submitted on an assigned or unassigned basis.

Ultrasonic diagnostic procedures are not considered radiological services, i.e., the physician's charge for his professional service is subject to the applicable Part B deductible and coinsurance. Accordingly, where a provider uses combined billing in the radiology department, it may not include the cost of ultrasonic procedures in that department. The cost of these procedures is included in another cost center appropriate for such services. If combined charges are used for ultrasonic procedures, their cost must be included in a cost center which uses combined charges. Conversely, if the provider does not use combined charges for these procedures, the cost of the procedures must be included in a cost center that does not use combined charges.

B. Physician's Authorization for Combined Billing.--Where the hospital uses the combined billing method. A one time authorization is necessary. The authorization is retained in the hospital's files. The signature of the hospital's representative on the billing form serves as a request for payment on behalf of the physician and as a certification that proper authorizations are on file. The following is a sample of an authorization which satisfies this requirement:

> "I hereby authorize the (name of hospital or any of its duly authorized administrators) to accept on my behalf any assignment made by any individual who receives medical treatment from me at the (name of institution) of the amount payable to such individual under Part B of Title XVIII of the Social Security Act, and to receive on my behalf any payments which may be made pursuant to such assignment. It is understood and agreed that the reasonable charge which will serve as the basis for payment in accordance with the terms of such assignment shall be the full charge for the services."

An additional statement includes the individual arrangements agreed upon by the provider and the physician(s) governing the conditions of withdrawing the authorization.

C. Intermediary Controls.—You may not authorize the use of, or discontinuation of, the use of the combined billing method until the carrier has been advised of:

- The name of the hospital where the combined billing method will be used or discontinued;
- The specific departments involved, and whether the combined billing agreement covers both outpatient and inpatient services;
- The names of the physicians in each department; and
- The effective date or the change to (or from) the combined billing procedure.

The hospital is expected to be consistent in its billing practices and to notify the carrier and you of any changes in the manner of billing or in any item shown above.

When changes occur, promptly confirm from your copy of the notice or from the provider that the Part B carrier has been notified, and insure that the notification shows whether the change covers outpatient services as well as inpatient radiology and/or pathology. If any departments are excluded from the combined billing arrangements, identify them.

D. Bill Preparation.—

1. General.—To use combined billing, the hospital in consultation with you must calculate an apportionment for physician patient care services on a per diem basis. This apportionment is divided between inpatient and outpatient services on the basis of the time spent on each. The inpatient per diem figure is obtained by dividing the total annual inpatient charge for these services by the estimated annual number of inpatient days for all patients. Base outpatient professional component on per visit (i.e., visits divided into total outpatient charges). Exclude the cost on Reasonable Compensation Equivalent (RCE) for hospital-based physician individual patient care services from the hospital's all-inclusive rate. Include it separately on the hospital bill.

2. Part A Inpatient Combined Billing All-Inclusive Rate Hospital.—Providers indicate the psychiatric professional revenue code as 961 and all other professional components either with code 960, or an appropriate detail level 96X, 97X, or 98X, depending on circumstances.

Create and process a Part B bill as if a separate HCFA-1450 was received.

For patients enrolled under Part B, reimburse the provider for 80 percent of the physician per diem charges in excess of the Part B deductible, prepare an EOMB for the beneficiary, and report the bill to HCFA using an UNIBILL outpatient record. (See §§3825.1, 3871, and 3880.2.) Where psychiatric services are involved, the $500 annual limitation applies to outpatient professional components only. (See §§3525ff.)

Patients not enrolled under Part B are liable for the entire physician charge. The provider maintains a record of the inpatient days of these individuals so that this cost may be excluded from the amount of program obligation at the time of retroactive cost adjustment.

3. Part B Inpatient and Part B Outpatient Combined Billing, All Inclusive Rate Hospital.—The instructions in §3622 and subsection 2 above apply except:

- Only one bill need be processed.
- The $500 annual psychiatric limitation applies to outpatient services only.

4. Acceptable Alternative Methods.—An alternative to consider where the bill volume is low, is to request the all-inclusive rate or teaching hospital to prepare a separate Part B bill instead of combining the Part B charge with the Part A bill. It is not appropriate to incur significant data entry costs for separate bills nor to place undue burden on providers for preparing separate bills unless absolutely necessary.

Consider establishing the individual providers professional component per diem rates in the provider file and automatically determining the professional component amount from the length of stay or number of outpatient visits.

RO approval is necessary if you implement either above method. After approval, supply the provider with the necessary instructions to implement the decision.

3669. RESIDENTS AND INTERNS NOT UNDER APPROVED TEACHING PROGRAMS

A. General.—A provider's cost for the services furnished by residents and interns not under approved teaching programs (including physicians employed by the provider who are authorized to practice only in a provider setting) are covered under Part B. (Part A covers only the costs of services performed for inpatients by residents and interns who are under approved teaching programs.) See §3115 for further information on the coverage of these services.

The provider determines that part of the inpatient charges which represents the cost of the services of residents and interns who are not under approved teaching programs and bills these separately under Part B, using type of bill code 121 and revenue code 96X, 97X, or 98X as applicable.

B. Provider Procedures.—The cost of Part B residents' and interns' services to inpatients is calculated on a per diem basis by the hospital in consultation with you. Apportion the total cost of such services (including fringe benefits, etc.) between inpatient and outpatient services on the basis of the time spent on each. Obtain the inpatient per diem figure by dividing the total annual inpatient cost for these services by the estimated annual number of inpatient days for all patients.

For patients who are enrolled under Part B, regardless of whether Part A benefits are payable, the provider is reimbursed for 80 percent of the cost of providing these services. The provider collects or bills the complementary insurer for 20 percent of the per diem rate for the services of residents and interns covered under Part B times the number of inpatient days provided. The administrative cost of determining Part B deductible status involving the cost of query, response, recording, and accounting on an individual basis in the aggregate, exceeds the potential patient deductible obligation. Therefore, as long as the patient is entitled to Part A benefits no determination of the patient's deductible liability need be made for inpatient Part B interns' and residents' services.

Patients not enrolled under Part B are liable for the entire cost of interns' and residents' services. The provider maintains a record of the inpatient days of these individuals so that this cost may be excluded from the amount of program obligation at the time of final cost settlement.

C. Intermediary Procedures.—Assist the provider in arriving at the inpatient per diem rate for the cost of services covered under Part B provided by residents and interns. (See Provider Reimbursement Manual, Part I, §2120 for apportioning costs between inpatient and outpatient per diem and §2406 for establishing interim rates.) The normal interim reimbursement rate applied to other provider services applies to Part B residents' and interns' services.

3670. DETECTION OF DUPLICATE CLAIMS

Whenever any of the following claim situations occur develop to prevent duplicate payment of claims. This includes:

- Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider. Do not consider outpatient services provided on the day of discharge within the inpatient dates of service.

- Outpatient bill is submitted for services on the day of an inpatient admission or the day before the day of admission to the same hospital.

- Outpatient bill overlaps an inpatient admission period.

- Outpatient bill for services matches another outpatient bill with a service date for the same revenue code at the same provider or under a different provider number.

Outpatient services means services for which you prepare an outpatient UNIBILL record from all providers.

A. History File - Paid Claims.—Maintain a history file containing information about each HCFA-1450 processed. The file may consist of the HCFA-1450 or information from it. It must contain the following minimum information:

- Beneficiary HICN;
- Beneficiary name information;
- Provider identification (name or number); and
- Billing period from the claim.

Claims or claims information in the history file may be transferred to inactive files or retired to a Federal record center per SS2980ff. of Part 2. However, you must have the facility to recall such claims or information if a claim for the beneficiary involving the same time period is received.

B. History File - Pending Claims.—Each processing system must have controls to prevent a duplicate claim being paid while two claims are in the process within the system at the same time. This may be accomplished through a special check of in-process claims or in the design of the history file for paid claims. The file should contain the same minimum information indicated in subsection A. It is desirable (but not essential) for the check to be performed prior to query to prevent occasional improper deductible postings and the corrective action which would have to follow.

C. Criteria for Detecting Potential Duplicates.—A "potential duplicate" claim is a HCFA-1450 being processed which, when compared to the history or pending file, has the following characteristics:

- Match on the beneficiary information;
- Match on provider identification; and
- One day or more overlap in billing period indicated.

Examine and compare to the prior bill any bill which is identified as a potential duplicate. For the HCFA-1450, if the services (revenue or HCPCS codes) for one claim duplicate the services for the other, check the diagnosis. If the diagnosis codes are duplicates, obtain an explanation from the provider before making payment. Required action:

o Review your records to determine if you have made payment;

o Initiate appropriate recovery action;

o Instruct the provider to refund to the beneficiary any Part B deductible and/or coinsurance collected, or use your indemnification process, as appropriate; and

o Determine what data you need to support cost settlement and arrange to prepare it.

D. Analysis of Patterns of Duplicate Claims.--Establish a system for continuing analysis of duplicate claims. This includes the systematic evaluation of returned "Explanation of Benefits" from beneficiaries and communications from providers indicating a duplicate payment has been made, as well as returned checks from any payee.

The system should provide for analyzing duplicate receipts to determine whether certain providers are responsible for duplicates and if so identify them. Contact them to reduce the number of duplicates submitted. Should duplicate claims activity continue initiate program integrity action.

best copy available

3672. COORDINATION WITH CARRIERS

A. Nonphysician Services.—For the services to be covered, hospitals must furnish either directly or under "arrangements," as defined in section 1861(w)(1) of the Act, all items and nonphysician services needed by Medicare inpatients. To insure that nonphysician services were billed only to a hospital, HCFA initiated the A/B Data Exchange. Its objective is to prevent double billing for services provided to hospital inpatients through the exchange of payment information by carriers and intermediaries.

Should you and the carrier develop a more efficient and cost-effective method of identification, discuss your alternative with the RO. The RO may approve an alternative which meets the objective and is cost-effective.

Carriers are responsible for ensuring that they do not pay for nonphysician services provided to hospital inpatients. This requires coordination and data exchange between you and them. Send the carrier a duplicate of the PROBILL record that you furnish the PRO. (See §3770.1.) Furnish the carrier a record file with the same frequency with which you furnish the PROBILL file to the PRO unless your RO has approved a different frequency. The carrier will process it in accordance with §3672.1.

B. Other Medical Items, Supplies, and Services—The following medical items, supplies, and services furnished to hospital inpatients are covered as hospital services under Part A. Consequently, they are covered by the prospective payment rate or reimbursed as reasonable costs under Part A to hospitals excluded from prospective payment.

- Laboratory services (excluding anatomic pathology services);
- Pacemakers and other prosthetic devices including lenses, and artificial limbs, knees, and hips;
- Radiology services, including computed tomography (CT) scans furnished to inpatients by a physician's office, other hospital or radiology clinic;
- Total parenteral nutrition (TPN) services; and
- Transportation including transportation by ambulance to and from another hospital or freestanding facility to receive specialized diagnostic or therapeutic services not available at the facility where the patient is an inpatient. Hospitals include the cost of these services in the appropriate ancillary service cost center, i.e., in the cost of the diagnostic or therapeutic service. They are not shown separately under revenue code 540.

Exceptions:

- Pneumococcal Vaccine

Pneumococcal vaccine is payable under Part B only and is billed by the hospital on the HCFA-1450.

- Ambulance Service Other Than That Described in Subsection B1

  For purposes of this section "hospital inpatient" means a beneficiary who has been formally admitted. It does not include a beneficiary who is in the process of being transferred from one hospital to another. Where the patient is transferred from one hospital to another, and is admitted as an inpatient to the second, the ambulance service is payable only under Part B. If transportation is by a hospital owned and operated ambulance, the hospital bills separately on form HCFA-1450. Similarly, if the hospital arranges for transportation with an ambulance operator, including paying the ambulance operator, it bills separately. However, if the hospital does not assume any financial responsibility, the billing is to the carrier by the ambulance operator or beneficiary, as appropriate.

- Anesthetist Services "Incident to" Physician Services

  If a physician's practice was to employ anesthetists and to bill on a reasonable charge basis for these services and that practice was in effect as of the last day of a hospital's most recent 12 month cost reporting period ending before September 30, 1983, the physician may continue that practice through cost reporting periods beginning October 1, 1984. However, if a physician chooses to continue this practice, the hospital may not add the costs of the anesthetist's service to its base period costs for purposes of its transition payment rates. If it is the existing or new practice of the physician to employ certified registered nurse anesthetists (CRNAs) and other qualified anesthetists and include charges for their services in his or her bills for anesthesiology services for hospital cost report periods beginning on or after October 1, 1984 and before October 1, 1987, the physician may continue to do so.

- Part B Inpatient Services

  Where Part A benefits are not payable, payment has been made to the hospital under Part B for certain medical and other health services. (See §3640.2.)

C. Exception/Waiver.--The provisions of subsections A and B have been waived for several hospitals. They are:

- Mayo Clinic
  Rochester, MN

- Rochester Methodist Hospital
  Rochester, MN

- Scott and White Memorial Hospital
  Temple, TX

- St. Marys Hospital
  Rochester, MN

- Carle Clinic and Foundation Hospital
  Urbana, IL

Instructions for these hospitals are issued by the appropriate RO.

If you service any of these hospitals, the carrier will notify you of claim payments so that an appropriate adjustment can be made to the Part A reimbursement. The carrier provides the following information:

- Beneficiary's HICN,
- Name,
- Sex,
- Hospital Provider Number,
- Supplier ID Number,
- Type and dates of service, and
- Amount allowed before application of deductible and coinsurance.

Work out the specific format with the carrier. Use the information provided to deduct the appropriate payment amount from a future payment to the hospital. It is not necessary to adjust the individual DRG payment, whether already made or not. However, make such deductions within 30 days of receipt of the carrier's notification. If the hospital contests the deduction, determine whether the deduction is appropriate. If not, inform the carrier to recover its overpayment and to educate the supplier.

3672.1 Part A Denials.—Where medical review by the PRO results in denial of services, the UNIBILL record you furnish the carrier (see §3770.2) on inpatient adjustments alerts the carrier of the need to review the bill for inappropriate payment. A "P" in the third position of type of bill on the UNIBILL identifies the record as involving a PRO medical denial. Inform the carrier of denials of SNF services by sending the carrier a copy of the denial letter unless your RO has approved other arrangements.

Send UNIBILL records to the carrier within 5 working days of preparation of the UNIBILL unless your RO has approved a different frequency. Work out specific arrangements regarding the mode. Send the SNF denial notification within 5 working days of preparation of the denial letter.

3672.2 Nonphysician Services Furnished to Hospital Inpatients Are Billed to Carrier.—A participating hospital agrees that any covered items and services, except physician services, which are furnished to an inpatient beneficiary will be furnished by it or by others under arrangements. If a supplier bills the beneficiary or the carrier for covered items and services while the beneficiary was an inpatient of a participating hospital, one of two situations exists:

- The hospital has breached the requirements of its participation agreement by permitting such billing; or

- The supplier has double billed, if both the hospital and Medicare have been billed.

In either event, corrective action is necessary.

3672.3 Corrective Action When Nonphysician Services Are Furnished to Hospital Inpatients.—Prepayment Denials - Carriers will deny claims from a beneficiary or supplier for nonphysician services furnished to hospital inpatients. These include ambulance and other services identified with "inpatient" as place of service. They will notify you of the denial using the record format shown in §3672.5 for claims with charges of $50 or more. This $50 tolerance will be reevaluated when you and the carriers have established a functioning exchange. In all cases, the carrier will notify the beneficiary and, if assigned, the supplier that action will be taken to have the services paid by the hospital, if it has not done so.

When you receive the report, determine the identity of the hospital and the corrective action to take depending upon whether the supplier has been paid by the hospital or the beneficiary, or that the supplier remains unpaid.

1. Hospital Has Paid the Supplier.—Inform the carrier to see that the supplier refunds any amount collected from the beneficiary or person acting on his behalf.

2. Hospital Has Not Paid the Supplier.—Instruct the hospital to determine whether the beneficiary has paid the supplier. If the beneficiary has, the hospital is to reimburse him. If the beneficiary has not, the hospital pays the supplier's full charge or such reduced charge as it can negotiate.

At least once every 6 months, select a valid statistical sample of cases reported by carriers and verify that the hospital has taken the required corrective action. Contact the beneficiary and/or the supplier to verify the hospital's allegations. If you find noncompliance by a hospital, ask the OIG field office for further guidance.

If the hospital is paid under the cost reimbursement system, it may include the additional payment to the supplier as a program cost (subject to the usual rules regarding reasonableness, etc.). Adjustment bills are not processed for money only adjustments.

Any PPS payment to the hospital is considered payment in full for the admission.

3672.4 Recovery of Overpayment When Nonphysician Services Furnished to Hospital Inpatient Paid by Carrier.—

A. Carrier Action.—If the carrier paid the bill, it did not know that the services were for an inpatient until its matching operations identified the problem using the periodic payment files you furnished. The carrier reports to you any cases identified in this operation using the format in §3672.5. Charges totaling $50 or less are ignored and not sent to you.

B. Intermediary Actions on Recovery.—Ascertain the identity of the hospital and determine whether:

1. The Hospital Paid the Supplier.—If so, inform the carrier.

- Assigned claim - the carrier will:
  - Contact the supplier;
  - Instruct supplier to reimburse the beneficiary any amount collected for deductible and coinsurance;
  - Recover the overpayment;

- Send adjustment queries if necessary; and
- Develop any program abuse.

- o Unassigned claims - the carrier will:

  - Contact supplier;
  - Instruct supplier to reimburse the beneficiary for the full amount beneficiary paid including deductible and coinsurance;
  - Send adjustment queries if necessary; and
  - Develop any program abuse.

2. The Hospital Has Not Paid The Supplier.—If the hospital has not paid the supplier:

- o Recover from the hospital the amount that the carrier paid. (See field 25 of the record in §3672.5.) Note, however, that if the hospital is not subject to PPS and did not bill, it may claim an appropriate related amount on the cost report. Such amount may be credited to the recovery of the overpayment as described in subsection C. Adjustment bills are not needed unless you need them to update your PS&R record.

- o Instruct the hospital to reimburse:

  - The beneficiary or someone on his behalf the amount of the paid deductible and/or coinsurance for the services in question and, for unassigned claims, the difference between the submitted charges and the approved charges.

  - The supplier (subject to possible negotiation of a lower amount). If the claim was assigned: the applied and unpaid amount for deductible and/or coinsurance, if applicable and the difference between reimbursed and actual charge. If the claim was unassigned: the difference between negotiated rate and carrier reimbursement amount. (The hospital may attempt to negotiate a lower charge with the supplier using any leverage it has based upon the supplier's desire to serve the hospital's Medicare patients in the future.)

- o If the carrier incorrectly paid the beneficiary or supplier on a Part B claim for items or services covered under Part A, the hospital is responsible for making payment to you to reimburse the Part B program for the incorrect payment.

  If the hospital is on cost reimbursement, the amount owed is a Part A cost and there would not be a payment from the hospital to the Part B program or a transfer of funds from the Part A to the Part B trust fund. If the hospital is under PPS, the hospital reimburses you in full since it was already paid. Credit the Part B trust fund.

C. Compliance Check.—At least once every 6 months, select a valid statistical sample of cases reported and verify that the hospital has taken the required corrective action. If the aberrant billing continues, notify the hospital in writing to correct its procedures. Persistent problems in violation of the hospital's participation agreement could result in a referral to the OIG for fraud and abuse.

3672.5 Format and Content of A/B Data Match Record Furnished by Carrier.—

FIELD NUMBER	TITLE	LENGTH	POSITIONS	NOTES
1	Intermediary Number	5	1-5	HCFA identifying number of intermediary requesting information.
2	HICN	12	6-17	9 numerics followed by 1 or more alphanumerics. See field #4 (UNIBILL).
3	Surname	6	18-23	Alphabetic, left justified.
4	First Initial	1	24	Alphabetic.
5	Sex	1	25	Alphabetic. M = Male F = Female
6	Provider ID	6	26-31	See field #8 (UNIBILL).
7	Admission Date	6	32-37	Numeric, YYMMDD.
8	Discharge Date	6	38-43	Numeric, YYMMDD, must be equal to or later than admission. Complete both fields.
9	Carrier Number	5	44-48	HCFA identifying number of carrier supplying extracted information.
10	Physician/Supplier ID	9	49-57	See field 11 for code describing the number shown in this field. May contain SS number, employee identification number, or other carrier assigned number.
11	Physician/Supplier Type	1	58	"1" Physicians or suppliers billing as solo-practitioners

FIELD NUMBER	TITLE	LENGTH	POSITIONS	NOTES
				for whom SS numbers are shown in the physician ID code field.
				"2" Physicians or suppliers billing as solo-practitioners for whom SS numbers are not available and the carrier's own physician ID code is shown.
				"3" Suppliers (other than sole EI proprietorship) for whom EI numbers are used in coding the ID field.
				"4" Suppliers (other than sole proprietorship) for whom EI numbers are not known and the carrier's own code has been shown.
				"5" Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers are used in coding the ID field.
				"6" Hospitals (including hospitals billing for hospital-based physicians) and independent laboratories for whom EI numbers

FIELD NUMBER	TITLE	LENGTH	POSITIONS	NOTES
				are not available and provider numbers assigned by HCFA are shown. "7" Clinics, groups, associations, or partnerships for whom EI numbers are used in coding the ID field. "8" GPPPs (as defined in §13512.2) for whom EI numbers are used in coding the ID field. "0" Clinics, groups, associations, partnerships, or GPPPs for whom EI numbers are not available and, therefore, the carrier's own physician has been assigned.
12	Physician/Supplier Name	15	59-73	Alphabetic, left justified.
13	Physician/Supplier Address	26	74-99	Alphabetic, left justified.
14	City, State, ZIP	25	100-124	Alphabetic, left justified.
15	Type Service	1	125	Code "1" - Medicare Care "2" - Surgery "3" - Consultation "4" - Diagnostic X-Ray "5" - Diagnostic Laboratory

FIELD NUMBER	TITLE	LENGTH	POSITIONS	NOTES
				"6" - Radiation Therapy "7" - Anesthesia "8" - Assistance at Surgery "9" - Other medical service "0" - Charges for whole blood or packed red blood cells
15	**Type Service (Cont.)**	1	125	Code "A" - Used DME "F" - ASC Facility Usage "L" - Renal Supplies in the home "M" - Alternative payment method for maintenance dialysis "N" - Kidney donor "V" - Pneumococcal Vaccine "Y" - Second opinions on elective surgery "Z" - Third opinions on elective surgery
16	**Place of Service**	1	126	Code "1" - Office "2" - Home "3" - Inpatient Hospital "4" - SNF and Nursing Home "5" - Outpatient Hospital "6" - Independent Laboratory "7" - Other

FIELD NUMBER	TITLE	LENGTH	POSITIONS	NOTES
				"8" - Independent Kidney Disease Treatment Center "9" - Ambulatory Surgical Centers "H" - Hospice
17	Procedure Code (HCPCS/Local)	9	127-135	Five position alpha-numeric code right justified in pos. 76-80 followed by two or more alpha-numeric modifiers in pos. 81-82 and 83-84.
18	From Date	6	136-141	Numeric, YYMMDD.
19	To Date	6	142-147	Numeric, YYMMDD. Must be equal to or later than From Date. Complete both fields.
20	Submitted Charge	7	148-154	Numeric, right justified, $$$$$.SS.
21	Assigned/Unassigned	1	155	Alphabetic, A (Assigned), U (Unassigned).
22	Allowed Charge	7	156-162	Numeric, right justified, $$$$$.SS.
23	Deductible Applied	4	163-166	Numeric, right justified, $$.SS.
24	Amount Beneficiary Paid	7	167-173	Numeric, right justified, $$$$$.SS.
25	Amount Carrier Paid	7	174-180	Numeric, right justified, $$$$$.SS.
26	Amount Carrier Denied	7	181-187	Numeric, right justified, $$$$$.SS.
27	Control Number	13	188-200	Alpha-numeric identifier of the claim from which the data is

FIELD NUMBER	TITLE	LENGTH	POSITIONS	NOTES
				extracted. Right justified.
28	No. of Services	2	201-202	Numeric, right justified.
29	Filler	18	203-220	Blank.

3674. COORDINATION WITH THE PRO

3674.1 Waiver of Liability Provision.—(See §§3430ff. for a complete explanation of the waiver of liability provision.)

The basic premise of the waiver provision of section 1879 of the Social Security Act is that beneficiaries who did not know, and did not have reason to know, that services were not covered, are protected from liability in two specific denial situations: (1) when the services are found not to be reasonable and necessary (which includes adverse level of care determinations), and (2) when custodial care is involved. If the beneficiary had knowledge of the noncoverage of services, the ultimate liability rests with the beneficiary. When neither the beneficiary nor the provider knew, or reasonably could have been expected to know, that services were not covered, the program accepts liability. Where the provider had such knowledge, liability falls upon it, i.e., the provider can not charge the beneficiary for such services (other than deductibles and coinsurance), even though no program payment will be made.

Waiver of liability may apply to Part A and Part B services furnished by participating and nonparticipating hospitals (domestic and foreign), SNFs, HHAs, and other providers. (See §3430.) Coinsurance and deductibles may be charged the beneficiary where he receives the benefit of this waiver provision.

The PRO is responsible for making waiver determinations relating to cases it reviews for the hospital and beneficiary. The PRO informs you if payment should be made through the procedures described in §3900.

Payment for services disapproved by a PRO may not be made except under the waiver of liability provision. (See §3432.3.) If neither the beneficiary nor provider is liable for denied services, and the PRO determines that additional time is required to arrange for post discharge care, payment can be made for not more than 2 days.

Medically unnecessary or custodial care days (irrespective of whether paid for under waiver of liability), including "grace days," cannot be used to satisfy the 3 day prior hospitalization requirement for SNF payment.

3674.2 Responsibilities of Hospitals, PROs, and Intermediaries For Medical Review.— The Social Security Act (Act), as amended by the Tax Equity and Fiscal Responsibility Reform Act of 1982 (TEFRA, Public Law (PL) No. 97-248), requires that a PRO (in accordance with its contract with HCFA) review services and items provided by physicians, other health care practitioners, and providers of health care services for which Medicare payment is sought. The PRO's review determines if:

- Such items and services are reasonable and medically necessary, and meet specific Medicare coverage requirements as outlined in §§3100ff. and the Coverage Issues Manual;
- Quality of such services meets professionally recognized standards of health care; and

- Services and items proposed to be provided in a hospital or other health care facility on an inpatient basis are medically appropriate, or whether they could be provided more effectively and economically on an outpatient basis or in a different type of inpatient health care facility.

In addition, the Social Security Amendments of 1983 (PL No. 98-21) specifies that in hospitals subject to PPS, PROs must review:

- The validity of diagnostic information supplied by the provider;
- The completeness, adequacy, and quality of care provided;
- The appropriateness of admissions and discharges; and
- The appropriateness of care provided or proposed to be provided for which payment is sought on an "outlier" basis.

The PRO is responsible for these determinations. You are responsible for the adjudication of other factors (e.g., eligibility and payment amount) and for making the payment. This joint responsibility requires that the PRO notify you of its denial determinations, all outlier and preadmission determinations and diagnostic or procedural coding changes.

Where medical review is done prior to billing (cost outliers, and preadmission review), the hospital reports the results of the PRO review on the HCFA-1450 in Items 87-90. (See §3610.) Where the PRO reviews bills after your processing, it reports adjustments to you utilizing procedures in §3900.

Continue to screen claims for statutorally excluded items or services (e.g., dental and cosmetic). Screen claims for items and services outlined in the Coverage Issues Manual. When you identify claims requiring medical determination, refer them to the PRO for review.

3674.3 Responsibility for Issuing Denial Notices and Making Limitations of Liability Determinations.--The PRO is responsible for issuing denial notices and making limitation of liability determinations for cases it reviews. The PRO reports the results of its medical review activity so that you can prepare adjustment bills as needed. Do not issue a denial notice to the beneficiary or the hospital for cases that have been reviewed by the PRO. The beneficiary and hospital are notified by the PRO.

You are responsible for issuing denial notices only where you make denial determinations, e.g., SNF, HHA, and outpatient bills or denials based upon eligibility.

3674.4 PRO Prepayment Review System (PRS).--

A. PRS Overview.--HCFA has developed and provided a system for you to use to provide PROs with a means to insure prepayment review of claims where it is required, e.g., pre-admission and pre-procedure review.

The system compares inpatient hospital bill information to a table of condition sets supplied by the PRO. It provides the individual PRO with the flexibility to select which claims will be subjected to prepayment review.

The system does not replace the Medicare Code Editor or other edits defined in §3770.1, nor does it perform any edits for validity of the PRO table of condition sets.

B. Installation Requirements.—Use PRS in PPS and waiver States unless all hospital inpatient claims are reviewed by the PRO on a prepayment basis, or you use a system which provides edits acceptable to the PRO and the RO has approved it. If so, continue your system.

C. Processing Requirements.—The PRS determines which claims require PRO medical review determinations prior to payment based on the table of condition sets.

Do not use PRS when:

- o Field locator 87 contains 1, 3, 4, or 6.
- o Field locator 21 contains code 30.
- o The patient is notified that he no longer needs inpatient care (value code 31 present in one of the field locators 46 through 49).

PROs review all cases involving code 31 on post-payment basis.

Each condition set within the PRO table contains the following items:

Condition Set Number, a four position alpha numeric field assigned by the PRO to identify a unique condition set.

PRO Identification Number, self-explanatory.

Action Code, a one position alpha numeric field which defines how you are to handle the claim that meets the specific conditions within the set. Possibilities are:

- o Forward to PRO for medical review or return to hospital for PRO medical review (these bills may be considered incorrect and handled as described in §3600.1.C).

  In addition, each condition set may contain the following items in any combination:

  Physician Identification Number, a 12 position alpha numeric field identifying either the attending or other physician.

  Principal Diagnosis Code, self-explanatory.

  Principal Diagnosis "Not" Flag, a one position alpha code (N) which indicates the listed principal diagnosis code would not be included in the condition set, e.g., DRG 036 without the principal diagnosis in §366.20.

  Procedure Code, self-explanatory.

Procedure Code "Not" Flag, a one position alpha code (N) which indicates the procedure code in the condition set would not be included in any procedure code position on the claim.

Admission Type Code, a one position numeric code; 1=emergency, 2=urgent, 3=elective, 4=new born, and "blank" = any type.

Days Less Than, a two position numeric field to describe a length of stay which is less than the limit defined in the condition set.

DRG Number, self-explanatory.

Admission Quarter Code, a three position code indicating the quarter and year (QYY) in which the admission occurred.

FI/PRO Code, a two position alpha numeric code which can be mutually defined for use between you and PRO e.g., the last two(2) position of the PRO preadmission authorization code.

Physician Type, a one position alpha field used to distinguish between the attending or other physician in a condition set; A= attending physician, O= other physician and "blank" = either physician.

Provider Number, self-explanatory.

Individual bill record data needed:

The PRS system requires the following data:
Provider number
Attending physician identification number
Other physician identification number
Principal diagnosis code
First procedure code
Second procedure code
Third procedure code
Admission type code
Admission date
Statement through date
DRG
FI/PRO code data
PRO identification if you process claims for more than one PRO (unless you obtain this from the provider number).

When a condition set matches data on the individual claim, the PRS returns the condition set number and the action code. The condition set number identifies the reason for the edit. The action code tells you whether to develop the claim with the hospital or the PRO, depending upon your local arrangement.

The system identifies a maximum of five (5) occurrences or condition set numbers on each claim.

Claims identification prior to implementation of this system, develop your own method of associating bills in your work-in-process record with the condition and action code output of the PRS when matches occur. The PRS does not provide identifying information for individual claims, e.g., HICN. Determine the data elements and methods of returning claims to the hospital for any necessary PRO medical review when required. Coordinate with the PRO the data elements necessary for claims identification and the method of data exchange when the claim is to be referred to the PRO for medical review activity.

D. PRO Table Requirements.—

1. Timeframes and Testing.—The PRO is responsible for providing a table of condition sets to you on a quarterly basis. The table may be provided on tape or hard copy data entry forms and delivered to you no later than 30 days before the end of the current quarter. First delivery will be by September 3, 1985. Jointly develop with the PRO a test of each table to insure the PRO's intentions are met and that it understands how to use PRS.

Allow time for at least two tests and table correction cycles, providing you and the PRO with five(5) working days to submit test results and a corrected table when the table is found to contain errors, or approval sign offs when the table is correct.

The PRO is responsible for editing its table of condition sets for the validity of codes and code combination logic.

2. Table Updates.—The PRO provides a complete table of condition sets to you on a quarterly basis. Each table contains all condition sets which apply to claims processed during the quarter.

E. PRO Responsibilities.—

1. Timely updates to the table of condition sets.

2. Testing of table of condition sets with you.

3. Evaluation and impact of condition sets and the PRS.

4. Enforcement of appropriate provider coding in field locator 87.

F. Intermediary Responsibilities.—

1. Timely installation of the PRS, including interface with your systems.

2. Timely installation of the quarterly updates to the table of condition sets.

3. Testing the table of condition sets with the PRO.

4. Proper disposition of claims matching condition sets by the specific action code.

G. Intermediary and PRO Coordinated Responsibilities.—

1. You and the PRO must coordinate the following prior to implementation:

   - The definition and subsequent disposition of claims based upon PRO action codes within the table, e.g., forwarded to PRO for medical review, returned to the hospital for PRO medical review.
   - Determine which PRO action codes take precedence when a claim matches more than one set of conditions.
   - The definition and utilization of the PRO/FI code field.
   - Definition of the claim identification information to be forwarded to the PRO as a result of matches to condition sets when the action code indicates the claim should be forwarded to the PRO and the method of data exchange. (See H below.)
   - Determining the method of updating tables; i.g., tape or hard copy data entry forms.

H. Intermediary/PRO Electronic Exchange of Data.—Where claims are forwarded to the PRO for medical review rather than to the hospital and you and the PRO have agreed upon electronic exchange of data, locally designed formats are acceptable only where you and the PRO deal exclusively with each other (i.e., where neither deals with multiple PROs or intermediaries). Where you must provide PRS records in electronic format to multiple PROs use the UNIBILL format in §3876. Use Action Code 5 in the second position to identify a PRO PRS edit and add the lst three PRS condition codes in positions 1918-1929 and an indicator in position 1930 when more than three PRS condition set codes exist on a bill. Leave unavailable data elements (e.g., Medicare Reimbursement amount, date approved) blank. Use of this format provides a national format for intermediaries dealing with multiple PROs.

PROs which must return PRS results to more than one intermediary use the adjustment record format in §3900. The PRO indicates that all charges are approved by placing a code 9 in field 7 and leaves fields 8 through 16 blank. The record is further identified by a 3 in field 20 if UNIBILL format is returned, or a 4 if the UNIBILL format is not returned.

3674.5 PRO Reporting on Medical Review.--

A. General.—Routinely provide PROs with UNIBILL data from which they determine which claims to review. See §3770.1 for a description of your responsibility for reporting.

NOTE: Report on all hospital inpatient services (PPS, non-PPS, including specialty, distinct part units and SNF swing-bed) and all outpatient surgery hospital bills as defined in §3770.1.

After completion of its MR, the PRO initiates an adjustment record when the reimbursement amount or utilization changes. The PRO reports to you and to the hospital any claims that need adjustment because of:

- o A change in the DRG;
- o Admission denied;
- o Day outlier days denied;
- o Non-PPS hospital or SNF swing-bed days denied;
- o Incorrect date for hospital to begin charging the beneficiary;
- o Failure to provide medical documentation for review;
- o Cost outlier services denied;
- o Partial or complete reversals of inpatient bills resulting from reconsiderations or appeals;
- o Change in discharge status in a PPS hospital;
- o Lack of physician attestation;
- o A change in outpatient coding;
- o Outpatient services denied; or
- o Reversals or changes in outpatient surgical claims resulting from reconsiderations or appeals.

Where volume is very low, and the RO gives approval, hardcopy may be used.

Situations that are handled outside the automatic notice process through a letter or memorandum are:

- o Coverage issues identified in the Coverage Issues Manual (HCFA-Pub. 6) which involve charges in non-PPS hospitals and exempt units;
- o Corrections to previously adjusted claims;
- o Errors detected in the UNIBILL record resulting from PRO adjustments; or
- o DRG changes resulting from a change in age or sex.

All claims, regardless of the discharge date, that have been determined to be cost outliers will be priced including the outlier portion. The PRO identifies the cost outlier claim for post-payment review when condition code 61 is in the UNIBILL record positions 352 thru 365. When charges are denied as a result of a cost outlier review, the PRO furnishes the appropriate revenue code(s) and charges for the denied services on the adjustment record. (Instructions in the Hospital Manual require the hospital to provide the PRO with the revenue code applicable to the detail charges.)

With respect to a change in the DRG, PROs report only cases where changes in coding result in changes in the DRG. The PRO uses an approved Grouper program to avoid needless reporting of adjustments.

PROs report outpatient surgery cases to you when there is a change in reimbursement (an outpatient service is denied, a HCPCS outpatient surgery code is changed, or a previous denial is reversed). However, for those procedures subject to the ASC payment limitation, PROs report to you only if the change results in assignment to a new payment group.

The format and content of the record are described in subsections D and E. The PRO furnishes the unaltered UNIBILL record to you only if you can electronically process the adjustment more effectively with it. You, the PRO, and the RO must agree upon any deviation from the standard record format.

B. Responsibility Upon Receipt of the Record.—Prepare and process an adjustment bill within 60 days of receipt of the PRO adjustment record or the batch clearance record.

Report the receipt date of the PRO Adjustment Record (hardcopy or tape) or the batch clearance tape as the date received on the debit UNIBILL record in positions 1955 thru 1960. (See §3876.) When using the batch clearance receipt date, report condition code 63 in UNIBILL positions 352 through 365.

If you receive the PRO-Report for any action reason (field 7) before receiving HCFA's batch acceptance record, you may process the adjustment and count it processed. This permits you to complete and count your adjustment action more quickly. However, if your original bill results in a RTI, you will also receive a RTI on the adjustment. Depending upon your system for handling RTIs and adjustments, you may defer processing the PRO adjustment until you receive the batch acceptance record.

A reversal or modification of the PRO's initial adjustment will be sent to you electronically in the PRO Adjustment Record. (See subsections D and E.) Process a reversal or modification as an adjustment to the previously processed PRO adjustment. Use the P indicator in the third position of bill type to show the PRO was the source of this action. The previous debit becomes the credit on reversal; change the P on the new credit to an 8.

Process inpatient adjustments through MCE, Grouper, and Pricer. Process outpatient adjustments through Medicare OCE and the ASC Pricer. Return MCE or OCE exceptions to the PRO for resolution when the error relates to PRO submitted data. Prepare an adjustment UNIBILL for HCFA, the PRO, and the carrier. Show the letter P instead of the number 7 in the last position of the type of bill. Include the control data shown by the PRO in field 18 and 19 of the adjustment record on your adjustment debit or on the RTI correction if you use that process to make the adjustment. If you use the RTI correction process to make the adjustment, show the letter P in the third position of bill type, and forward the records to the PRO.

To identify adjustments you initiated, the third position of the type of bill on the debit is an I instead of 7. When the hospital is the source of an adjustment, the third position of type of bill for the debit is 7. (See §3876.1, but note that you must use the letter P in the last position of the type of bill, regardless of facility type, if you want to receive credit for processing the PRO adjustment. You may also use the I in the third position of the type of bill regardless of facility type. HCFA does not edit these codes against facility type.)

Use debit/credit pairs on all PRO adjustments including outpatient hospital surgery records. Cancel only adjustments are not acceptable, except in cases of incorrect provider identification or HICNs. Where the PRO makes a denial on an outpatient surgical bill, place an override code of 4 in the iteration of field 40 that represents the applicable revenue center codes related to the denied charges. Enter the date you forwarded UNIBILL to the PRO in field 81 (positions 1967-1972) now entitled "Scheduled Payment Date."

NOTE: For CPEP purposes the following UNIBILL entries are used in calculating the timeliness of processing PRO adjustment bills. Field 80 "Date Approved" determines the quarter in which the adjustment bill was processed. The bill must be an adjustment, with an action code of 3 "secondary debit adjustment" and a "P" in the third position of bill type to indicate the PRO is the source of the adjustment. Calculation of timeliness is based upon the difference between field 79 "Date Received" and field 81 "Scheduled Payment Date" which, for adjustment bills is the date forwarded.

The PRO reports charges for denied services to you in the appropriate revenue codes. Add them to any other noncovered charges for the specific revenue code and to the total noncovered charges. Also, where days are denied and the provider is liable, reduce cost report days and utilization days. Reduce Pricer calculation days by the number of days shown in field 9. Add occurrence span code 76 or 77 as appropriate in UNIBILL for any "from" and "through" dates in field 9. (See §3654 for additional instructions for processing adjustment bills.)

Where the PRO's MR indicates additional days or procedures are appropriate, it indicates this in field 7, "Reason for PRO Action." This field, in conjunction with field 8, "PRO Review Adjustment Code," indicates whether days (or charges) are being added or denied.

Where day outlier days or non-PPS days are denied, the PRO reports only the accommodation charges to you because it does not know what ancillary charges are applicable. Process your adjustment, deleting accommodations only, but do not permit processing of an inpatient Part B bill for the same period. If the hospital requests to bill for inpatient Part B services for the same period, in addition to the Part B bill, require another Part A adjustment bill deleting ancillary charges for the days denied before processing the Part B bill. Do not adjust your PS&R system or the hospital's cost report because of the minimal ancillary services that are recorded under Part A instead of Part B. Whenever outlier days or non-PPS hospital days are denied by the PRO, reduce cost report days and utilization days. Reduce utilization days if there is beneficiary liability as a result of the PRO's denial. In New Jersey, there may be additional changes in utilization due to the State's waiver from PPS.

Inform the hospital of a PRO initiated adjustment, either through your remittance record or by means that you develop.

C. Operational Procedures.--Each tape received from the PRO complies with the following requirements.

1. Magnetic Tape Reel External Identification Label.—Each reel of magnetic tape is identified with an external label prepared as follows:

- File Code - PRO-REPORT;
- Sub Code - PRO Identification Number;
- Oper. Code - Date Created (MMDDYY); and
- Reel No. - 1 of 1, 1 of 2, etc.

2. Control Identification.--

- FIRST First four characters of the batch number of the first record on the reel.
- LAST First four characters of the batch number of the last record on the reel.
- RECORDING CHARACTERISTICS - 9 track, 1600 BPI.

3. File Specifications.—

- Labeling Conventions - No Internal Label.
- Record Size - 450 characters. If UNIBILL is also needed, an additional 2000 characters are included.
- Block Size - Unblocked (one record per block).

D. PRO Inpatient Adjustment Record Layout and Description.—

Fld	Description	Psn.	Picture	Just.	From-Thru
1	Intermediary Number	5	9(5)		001-005
2	Intermediary Control Number	15	X(15)	L	006-020

NOTE: The PRO reproduces any information here that you show in field 82 of the UNIBILL (positions 1973-1987). This is any data you need that is not otherwise included in the adjustment record. For PRO Adjustment Review code n, complete reversal on appeal, the PRO enters the ICN from the adjustment UNIBILL. Retrieve the prior adjustment bill from history and process as an adjustment to the adjustment.

Fld	Description	Psn.	Picture	Just.	From-Thru
3	Beneficiary HICN	12	X(12)	L	021-032
4	Medicare Provider No.	6	X(6)	L	033-038
5	Admission Date	6	9(6)		039-044

NOTE: Some PROs/FIs have agreed to use the discharge date for the purpose of record identification. Where such arrangements have been made, use the discharge date in place of the admission date.

Fld	Description	Psn.	Picture	Just.	From-Thru
6a	Record Type 1 = inpatient 2 = outpatient	1	9		045-045
6b	Filler	7			046-052
7	Reason for PRO Action 1 = MR, days or procedures denied, 2 = medical records not provided, 3 = physician attestation missing, 4 = appeal reversal, 5 = MR, approved increased days or procedures.	1	9		053-053
8	PRO Review Adjustment Code a. Entire Admission Denied (sample review, transfers to distinct part or another hospital, questionable admission from code editor, etc.). b. Non-PPS hospital days denied. (NOTE: If entire admission in non-PPS hospital is denied, the PRO uses code a.)	1	X		054-054

c. DRG change resulting from change (single or multiple) in discharge status or any diagnosis or procedure. (NOTE: Where change in age or sex appears appropriate, handle the claim outside the automatic notice process. See §3537B to resolve age or sex discrepancies.)

d. Day outlier days denied.
e. Cost outlier charges denied.
f. Incorrect date for hospital to begin charging beneficiary. From date indicates first day of beneficiary liability; no thru date shown.
g. Combination of c. and d.
h. Combination of c. and e.
i. Combination of c. and f. - (see f. above)
j. Deemed admission (covered level of care following a noncovered admission)
k. Combination of c. and j.
l. Combination of d. and j.
m. Combination of e. and j.
n. Entire previous adjustment reversed (on appeal or other review).
o. Previous adjustment modified (on appeal or other review).
p. Change in discharge status, per diem payment applicable.

9 From and Thru Dates Associated with PRO Review Adjustment Codes b, d, f, g, i, j, k, l, m, n, or o (Occurs 4 times)

	Psn.	Picture	Just.	From-Thru
a. From Date	6	X(6)	L	055-060
b. Thru Date	6	X(6)	L	061-066 Repeated as needed thru 102

NOTE: The days denied are shown for PRO Review Adjustment Codes b, d, f, g, and l. For PRO Review Adjustment Codes j - m, derive the approved admission date by adding 1 day to the last through date in field 9. For PRO Review Adjustment Codes n, and o, days approved are shown in field 9 (positions 055-102).

10 Charges Denied or Approved for Code b, d, e, g, h, l, m, n, or o (Occurs 10 Times)

a. Revenue Center Code	3	999	R	103-105
b. Units	3	9(3)	R	106-108
c. Rate (if accommodations)	7	9(5)V99	R	109-115
d. Charges	8	9(6)V99	R	116-123 Repeated as needed thru 312

NOTE: For PRO Review Adjustment Codes n and o, charges for services previously denied but now approved are shown in field 10 (positions 103-312).

Fld	Description	Psn.	Picture	Just.	From-Thru
11	Filler	49			313-361
12	Revised Grouper Input				
	a. Discharge Status	2	99	R	362-363

NOTE: DRGs 121, 122, 123, 385, 433, and 456 are changed by changes in discharge status. Therefore, changes in discharge status for DRG changes are furnished only where the old or new DRG is one of the above. Where per diem payment is involved because discharge status is changed to, or from, status code 02 (discharged/transferred to another short term hospital, see field 8, code p.)

Fld	Description	Psn.	Picture	Just.	From-Thru
	b. Principal Diagnosis	5	XXXXX	L	364-368
	c. Other Diagnoses (occurs 4 times)	20		L	369-388
	First diagnosis	5	XXXXX	L	369-373
	Second diagnosis	5	XXXXX	L	374-378
	Third diagnosis	5	XXXXX	L	379-383
	Fourth diagnosis	5	XXXXX	L	384-388
	d. Principal Procedure	4	XXXX	L	389-392
	e. Other Procedure (occurs 2 times)	8	X(8)	L	393-400
	First procedure	4	XXXX	L	393-396
	Second procedure	4	XXXX	L	397-400

NOTE: When the PRO adds surgical procedures as a result of MR, derive a date for the procedure. Assume the date of the procedure is the day after admission. Since there is no space on the PRO Adjustment Record to add an operating physician number, bypass any edits requiring one.

Fld	Description	Psn.	Picture	Just.	From-Thru
13	New DRG (based on PRO review)	3	999	R	401-403
14	Adjusted No. of Grace Days Approved	1	9		404
15	Filler	8		R	405-412
15a	Arkansas system or MDC - paid date - Julian	4	9999	L	413-416
16b	Filler	10		R	417-426
17	PRO Identification No.	5	X(5)	L	427-431
18	Processing Date at PRO (MMDDYY)	6	9(6)	L	432-437
19	PRO Control Number	12	X(12)	L	438-449

NOTE: When the PRO includes data in fields 18 or 19, reproduce this information for field 18 in positions 1900-1905 and in field 19 in positions 1906-1917 on the UNIBILL debit adjustment record.

Fld	Description	Psn.	Picture	Just.	From-Thru
20	UNIBILL Indicator	1	X(1)		450
	1 = UNIBILL not included				
	2 = UNIBILL included				
21	UNIBILL RECORD Option	2000	X(2000)		451-2450

E. PRO Outpatient Record Layout and Description.—

Fld	Description	Psn.	Picture	Just.	From-Thru
1	Intermediary Number	5	9(5)		001-005
2	Intermediary Control Number	15	X(15)	L	006-020

NOTE: The PRO reproduces any information here that you show in field 63 of the outpatient UNIBILL (positions 1973-1987). This is any data you need that is not otherwise included in the adjustment record.

Fld	Description	Psn.	Picture	Just.	From-Thru
3	Beneficiary HICN	12	X(12)	L	021-032
4	Medicare Provider No.	6	X(6)	L	033-038
5	From or Thru Date	6	9(6)		039-044
6a	Record Type	1	9		045
	2 = outpatient				
6b	Filler	7			046-052
7	Reason for PRO Action	1	9		053-053
	1 = MR, procedures or services denied (includes HCPCS coding changes)				
	2 = medical records not provided				
	4 = appeal reversal				
	5 = MR, procedures or services added				
8	PRO Review Adjustment Code	1	X		054-054
	a. Full denial				
	n. Entire previous adjustment reversed (on appeal or other review).				
	o. Previous adjustment modified (on appeal or other review).				
	q. Outpatient services and/or procedures denied (or approved)				
	r. Change in outpatient coding				
	s. Combination of q. and r.				
9	Services or HCPCS code deleted or added; to change, delete and add code must be used (occurs 14 times)				
	a. Revenue Center Code	3	999	R	055-057
	b. HCPCS Code	5	X(5)	L	058-062
	c. Units	3	9(3)	R	063-065

	d. Charges	8	9(6)V99	R	066-073
	e. Action Code 1 = deleted code 2 = added code 3 = denied procedure or service 4 = approved procedure or service	1	9		074 Repeated as need thru 334

NOTE: Action codes 1 and 2 are used only to describe changes in HCPCS coding. Action codes 3 and 4 require the reporting of charges.

10-15	Filler - Reserved for future expansion - do not use	88			335-422
16	Arkansas or MDC system-paid date Julian	4	9999	L	423-426
17	PRO Identification No.	5	X(5)	L	427-431
18	Processing Date at PRO (MMDDYY)	6	9(6)	L	432-437
19	PRO Control Number	12	X(12)	L	438-449

NOTE: When the PRO includes data in fields 18 or 19, reproduce this information for field 18 in positions 1900-1905 and field 19 in positions 1906-1917 on the UNIBILL debit adjustment record.

20	UNIBILL Indicator 1 = UNIBILL not included 2 = UNIBILL is included	1	X(1)		450
21	UNIBILL RECORD Option	2000	X(2000)		451-2450

3674.6 Edits for PRO Report on Medical Review.--

A. Intermediary Edits.—Use the following edits to the PRO Report on Medical Review. Return adjustment records which fail the edits with the report format in D.

Fields that are not needed for your processing are not edited. For example, if you do not use the initial bill intermediary control number or the admission date in your adjustment process, do not edit these fields. Also, do not return the record for a missing intermediary number if you can find the proper record in your system. Fields 18 and 19, Processing Date at PRO and PRO Control Number, need not be edited; however, reproduce data shown in these fields on the UNIBILL debit adjustment record.

Process PRO adjustments which involve Revised Grouper Input, field 13, through the MCE to identify coding inconsistencies. Errors which involve nonspecific principal diagnosis, questionable admission, nonspecific O.R. procedures, and open biopsy check may be ignored since these codes are approved by the PRO. Return all other errors resulting from the MCE based upon the assumption that keying errors have occurred. Process PRO outpatient adjustments with revised coding through Medicare OCE and the ASC Pricer.

B. Edits for PRO Report to Intermediary on Medical Review (Adjustment Record).—

Inpatient

	Field	Edit	
2.	Intermediary Control Number (if used)	2a.	If used, either incomplete or invalid.
		2b.	Absent.
3.	HICN	3a.	Missing.
		3b.	No match to intermediary file.
4.	Medicare Provider No.	4a.	Incomplete or missing.
		4b.	No match to intermediary file.
		4c.	Not a hospital provider number see §3507.2.
5.	Admission Date (if used)	5a.	Incomplete, invalid, or missing
		5b.	No match to any admission date on file for this HICN and provider number.

Field	Edit	
7. Reason for PRO Action	7a.	Missing.
	7b.	Invalid, not a 1, 2, 3, 4 or 5.
8. PRO Adjustment Code	8a.	Missing.
	8b.	Invalid, not a through "p."
9. From and Thru Dates	9a.	Invalid, incomplete, or missing.

NOTE: The adjustment codes f and i have a from date without a thru date.

	9b.	Dates not within from and thru dates of matching bill.
10. Charges for Services Denied or Approved		
a. Revenue Center Code	10a.1.	Invalid, incomplete, or missing (at least one revenue center code must be shown for PRO Review. For adjustment codes b, d, and e, revenue codes should be 10X thru 15X or 20X or 21X).
b. Units	10b.1.	Missing (units must be shown for revenue center codes 10X thru 15X or 20X and 21X).
c. Rate	10c.1.	Missing (rate must be present when units are present).
d. Charges	10d.1.	Invalid, incomplete, or missing (see 10a.1.).
	10d.2.	Denied or approved charges are more than billed charges for revenue code.
12. Revised Grouper Input		

NOTE: Adjustments with revised Grouper input must process through the MCE.

a. Discharge Status	12.a.	Not always required, but if present, must be 01, 02, 03, 04, 05, 06, 07, 20, or 30.
b. Principal Diagnosis	12.b.1.	Must be present where field 8 equals c, g, h, or i.
13. New DRG	13.a.	Invalid or incomplete, must be 001 through 473 or effective with 10/1/85 discharges, 471.

Field		Edit	
14.	Adjusted No. of Grace Days Approved	14.a.	Invalid (must be 1 or 2).
17.	PRO Identification	17.a.	Incomplete, must be 5 position alpha numeric.
20.	UNIBILL Indicator	20.a.	Invalid (must be a 1 or 2).
21.	UNIBILL Record Option	21.a.	Absent and field 20 = 2.

In addition to the above edits, MCE errors that are applicable are:

Error	Edit
MCE 1	Age conflict - (e.g., 27 year old newborn).
MCE 2	Sex conflict - (e.g., male hysterectomy).
MCE 3	Invalid diagnoses or procedures - Codes which are not valid ICD-9-CM codes.
MCE 4	Invalid 4th and 5th digit - Codes for which the 4th or 5th digit is invalid or missing.
MCE 5	E-code as principal diagnosis - No E-code is allowed as a principal diagnosis, since E-codes are "cause" codes (accidents, etc.).
MCE 6	Manifestation code as principal diagnosis -Manifestation codes are not allowed as principal diagnoses because they are manifestations of some other underlying disease.
MCE 8	Unacceptable principal diagnosis - These are selected "V" codes which are unacceptable as principal diagnoses. For example, V659 (unspecified reason for consultation).
MCE 11	Noncovered procedures - These are procedures not covered by Medicare. An implantation of electromagnetic hearing aid is an example.
MCE 13	Invalid age - These are ages that are not between 0 years and 124 years. When an invalid age is reported, any diagnosis that is subject to an age check will show the related error message to the right of the diagnosis.
MCE 14	Invalid sex - These are sex codes that are not reported as 1 (male) or 2 (female). When an invalid sex code is reported, any diagnosis and/or procedure that is subject to a gender check will show the related error message to the right of the diagnosis and/or procedure.

C. Edits for PRO Report on Medical Review (Adjustment Record).--

Outpatient

	Field		Edit
2.	Intermediary Control Number	2a.	If used, either incomplete or invalid.
	(if used)	2b.	Absent.
3.	HICN	3a.	Missing.
		3b.	No match to intermediary file.
4.	Medicare Provider No.	4a.	Incomplete or missing.
		4b.	No match to intermediary file.
		4c.	Not a hospital provider number see §3507.2.
5.	From or Thru Date	5a.	Incomplete, invalid, or missing.
6.	Record Type	6a.	Absent.
		6b.	Invalid not a 1 or 2.
7.	Reason for PRO Action	7a.	Missing.
		7b.	Invalid, not a 1, 2, 3, 4, or 5.
8.	PRO Adjustment Code	8a.	Missing.
		8b.	Invalid, not q, r, s, t, or u.
9.	From and Thru Dates	9a.	Invalid, incomplete, or missing.
		9b.	Dates not within from and thru dates of matching bill.
10.	Charges for Services Denied		
	a. Revenue Center Code	10a.1.	Invalid, incomplete, or missing.
	b. Units	10b.1.	Missing.
	c. Charges Denied	10c.1.	Invalid, incomplete, or missing.
		10c.2.	Denied charges are more than billed charges for revenue code.

	Field	Edit	
12.	HCPCS Code		

NOTE: Adjustments with revised HCPCS code must process through the OCE.

	Field	Edit	
a.	Revenue Center Code	12.a.	Invalid, incomplete or missing.
b.	HCPCS Code	12.b.1.	Invalid, incomplete or missing.
c.	Units	12.c.1	Missing
d.	Charges Denied	12.d.1	Invalid, incomplete or missing.
e.	Action Code	12.e.1	Invalid, (must be 1 or 2).
16a	Arkansas or MDC System Paid Date	16.a	Invalid, incomplete or missing.
17.	PRO Identification	17.a.	Incomplete, must be 5 position alpha numeric.
20.	UNIBILL Indicator	20.a.	Invalid (must be a 1 or 2).
21.	UNIBILL Record Option	21.a.	Absent and field 20 = 2.

In addition to the above edits, OCE errors that are applicable are:

Error	Edit
OCE 1	Invalid diagnoses or procedures - Each diagnosis code is checked against a table of valid ICD-9-CM diagnosis codes and each procedure code is checked against a table of valid HCPCS codes.
OCE 2	Invalid 4th and 5th digit - Codes which require a 4th or 5th digit for which the 4th or 5th digit is invalid or missing.
OCE 3	E-code as principal diagnosis - No E-code is allowed as a principal diagnosis, since E-codes are "cause" codes (accidents, etc.).
OCE 4	Age conflict - There is a conflict between any diagnosis or procedure and the patient's age.
OCE 5	Sex conflict - There is a conflict between any diagnosis or procedure and the patient's sex (e.g., male hysterectomy).
OCE 6	Questionable Covered Procedures - These are procedures which may be covered under the Medicare program, depending on the medical circumstances.
OCE 7	Noncovered procedures - These are procedures not covered by Medicare. An implantation of electromagnetic hearing aid is an example.

Error	Edit
OCE 8	Medicare as secondary payer - MSP alert - Addendum E, pages E-61-68 identify situations that may involve automobile medical, no-fault or liability insurance. See §§33419.5 and 3489.4B for processing instructions and tolerances.
OCE 9	Invalid age - If the age is not between 0 years and 124 years, the OCE assumes the age is in error.
OCE 10	Invalid sex - The sex code reported must be either 1 (male) or 2 (female).
OCE 11	Date range - The OCE checks the from date in Item 22 on Form HCFA-1450. Billing dates not in the acceptable range of 7/1/87 through 9/30/88 are not edited. Continue processing the bill in your system.
OCE 12	Valid date - The OCE checks the month, day, and year from Item 22 (from date). If the date is impossible, return the bill to the hospital and request a corrected bill with a valid date.
OCE 13	Unlisted procedures - These are codes for surgical procedures (i.e., codes generally ending in 99). For listings of these codes and development instructions, see §3626.4.

D. Data Records to Return to the PRO.--Edit PRO adjustment records. If any of the following situations occur, generate the proper record as shown below and send the record to the PRO and the RO.

o Adjustment records which fail the edits as described in subsection B may be considered incorrect and handled as described in §3600.1D; return to the PRO using the associated error code with this message:

> "The following cases contained errors on the PRO report to the intermediary on MR. Please correct these errors and return them."

In the following situations, send the summary report to the PRO with this message:

> "Delete from your pending file; no adjustment is necessary."

o Inpatient adjustment records for PPS hospitals containing changes which do not result in a change in DRG, a denial, or a change in discharge status.

o Inpatient adjustment records for other than PPS hospitals that do not result in a change in reimbursement.

- o Outpatient surgical records subject to the ASC payment limitation for which the payment group does not change.

- o Inpatient adjustment records requesting a change in utilization where none is appropriate.

TO: Name and Address of PRO

FROM: Intermediary, Name, and Number

SUBJECT: FI Report to PRO on Nonprocessable Adjustment Records

PRO Control Number (if provided)	HICN	Provider#	Adms. Date (if provided; if you and PRO have agreed to use discharge date, show that date)	Reason for Return	Error Code
				a. PRO error. b. No denial, change in DRG, or discharge status for PPS hospital. c. No change in reimbursement for non-PPS hospital bill. d. No change in utilization. (Applies only to NJ.) e. No change in payment group for outpatient surgical claims.	

3676. ENFORCEMENT OF PROVIDER BILLING TIMELINESS AND ACCURACY STANDARD TO CONTINUE PIP

A. General.—To remain on PIP, providers, with the exception of HHAs, must submit 85 percent of its bills timely and accurately. Timely and accurately means that 85 percent of its bills (excluding those listed below) are submitted within 30 days of discharge and pass your front-end edits for consistency and completeness. A bill is not considered received unless it can pass your edits. Accumulate statistics on inpatient and SNF billing performance for each PIP provider to monitor whether it meets this requirement. Accumulate statistics for home health and use internally as an alert for potential problems. Assist the HHAs in identifying and correcting inaccuracies. These instructions do not effect bi-weekly payments for pass-thrus (Provider Reimbursement Manual §2405.2) and for adjustments to indirect cost for medical education (PRM §2405.3).

The evaluation for timeliness of billing should be consistent with the frequency for monitoring the payment amounts under the PIP program. Thus, for non-PPS providers the evaluation process is scheduled at 3 month intervals and PPS providers are evaluated every 4 months. The evaluation includes data from the entire 3 or 4 month period. In determining whether a provider submitted its bills within 30 days of discharge or thru date on interim bills, count the date from item 22 to the date you receive it. If the provider does not meet the criteria, discontinue PIP immediately, except for HHAs. The periodic performance report that you provide in accordance with subsection B will constitute advance notice before discontinuing PIP.

Exclude the following:

- MSP cases (value codes 12-16);
- PRO prepayment review cases (code 1 or 3 in Item 87);
- Discharge before October 1, 1985;
- Any other special situations identified by the provider or you that are documented as beyond provider control. Exclusions must be approved by the RO; and
- Bills that have not passed your front-end edits for acceptance. (Such bills are counted only when acceptable to your edit processes.)

Accumulate statistics monthly. Summarize them for the entire evaluation period.

B. Procedure for Measuring and Reporting to Providers.—Accumulate a record for each bill that passes your front-end edits. Count the bill in the month received regardless of the discharge month. No later than 10 work days after the end of the month, provide a report to each provider, except HHAs, for the month indicating the following:

- The total number of bills received;
- The number not excluded;

- The number not excluded received in 30 days or less;
- The percentage not excluded received in 30 days or less.

Also, for providers that fail to meet the standard, provide individual case identification of claims that were not billed within 30 days of discharge. List only claims that are not excluded identified in subsection A. Furnish the report in electronic media, unless you determine paper listing would be cheaper to process. If electronic media is used, use the following record format. Determine the physical characteristics of the file.

Fld.	Description	Psn.	Picture	Just.	From	Thru
1	Provider Number	6	X(6)	L	001	006
2	Blank	3	X(3)		007	009
3	Blank	1	X		010	
4	HIC Number	12	X(12)	L	011	022
5	Blank	1	X		023	
6	Beneficiary Surname	6	X(6)	L	024	029
7	Blank	1	X		030	
8	Patient Control Number	17	X(17)	L	031	047
9	Blank	1	X		048	
10	From Date	6	9(6)		049	054
11	Blank	1	X		055	
12	Discharge or Thru Date	6	9(6)		056	061
13	Blank	1	X		062	
14	Date Bill Received	6	9(6)		063	068
15	Blank	1	X		069	
16	Days Elapsed	4	9(4)	R	070	073

If sub-provider identification is used, positions 7, 8, and 9 may be utilized.

C. Reinstatement of PIP.—Do not reinstate PIP for a provider until it meets all criteria in PRM §§2405.1B and 2407 and has met the requirements in subsection A for timeliness and accuracy for 6 consecutive months.

D. New Request for PIP.—Evaluate new requests for PIP as in subsections A and B. At least 3 months experience is required for new requests, (except for new providers with less experience).

E. Hospitals on 100 Percent PRO Prepayment Review.—The 30 day requirements for submitting bills to intermediaries is not applicable. The RO makes determinations of timely and accurate bill submission by hospitals for which the PRO reviews 100 percent of the discharges before payment. However, other standards remain applicable for retaining PIP in such cases. See PRM §§2405.1B and 2407 for the requirements.

F. Intermediary Electronic Reporting of Provider Remittance Data.—At the provider's option send an electronic remittance record to an institutional provider for each claim submitted electronically. The recommended format is the format of the UNIBILL file which you submit to HCFA (§§387ff.); however, use any format mutually acceptable to you and provider. Items to negotiate with the provider:

- Physical file characteristics.
- Electronic media by which data will be sent.
- Frequency of transmission.
- Coordination of remittance file with provider payments.

  Remittance file goes directly to providers.
  Remittance file goes through third party billers.

1. Association of Remittance Data With Provider Records.—To assist in the association of the remittance record with the provider's files, return to the provider an association number it supplied on the related provider bill. This number could be Item 3, Patient Control Number on the HCFA-1450 or the medical record number, whichever you and the provider agree upon.

2. Scope of Remittance to be Electronically Reported.—Within these procedures we contemplate only the transmission of remittance data directly associated with a claim. Report separately adjustments such as provider suspensions, accelerated payments.

3. Implementation of Capability to Electronically Report Provider Remittance Data.—Initiate contacts with electronic billers to set up arrangements for supplying the appropriate electronic remittance records. Negotiate with the provider the specific implementation dates.

3678. ESTABLISHING PACEMAKER REGISTRY RECORDS - PACEMAKER RELATED ICD-9-CM PROCEDURE CODES

A. General.—Public Law 98-369 requires the Secretary to provide a registry for all permanent pacemaker devices and leads for which payment is made under Medicare. For inpatient services rendered through September 30, 1987 edit all hospital bills for ICD-9-CM codes 37.70 and/or 37.73-37.85 inclusive. For inpatient services rendered beginning October 1, 1987 edit all hospital bills for new ICD-9-CM codes 37.70-37.77 and/or 37.80-37.89 inclusive. For outpatient services rendered beginning January 1, 1988 edit all hospital bills for CPT-4 codes 33200-33208, 33212, 33216, 33218, 33219, and 33232. Where any of these are present, request additional data from the provider. If the hospital refuses to supply the information, deny the claim. The hospital may not charge the beneficiary in such cases, except for deductible and coinsurance.

Submit the collected data to HCFA using the format in subsection B, and the instructions below.

You have several options as to how to request the data.

- o Mail the letter shown in subsection E to the provider. Print it locally;
- o Supply your providers with a stock of letters that they can complete as they prepare bills involving pacemakers and leads; or
- o Give your providers an electronic format for wire submission. Use specifications identical or similar to those in subsection B to facilitate retransmittal to HCFA. An electronic format enables you to refuse bills without accompanying pacemaker data, reducing your processing costs by avoiding postpayment denials.

Under any of these methods establish a control to assure that the pacemaker registry data is obtained.

The report from the hospital identifies all components implanted, explanted, or replaced in the specific procedure. Prepare a separate electronic record to send to HCFA on a quarterly basis for each device implanted or explanted during the subject procedure. For example, if a pulse generator were replaced, prepare two records: one for the explanted and one for the implanted pulse generator. In the case of implanted leads, there may not be an explant since leads that are replaced are often not explanted.

Submit the file to HCFA by the 15th day of the month following the end of each calendar quarter. Include all registry data collected since your last transmission.

Quarter Ends	Submit by
3/31	4/15
6/30	7/15
9/30	10/15
12/31	1/15

Submit a magnetic tape file conforming to the following physical characteristics.

Physical File Specifications - Magnetic Tape.—Tape characteristics - 9 track, 8 1/2" to 10 1/2" reels with silver mylar reflector (standard reels) with write ring removed.

Parity - Odd
Recording Density - 1600 bytes per inch
Recording Code - Extended Binary Coded Decimal
File Label - None. The tape must have an end of file mark. The first data record on the file contains the acronym PACEMAKER in the first nine positions of the record, blanks in the remaining positions and serves the function of a file label.

Physical Record Length 148 characters

Block Size 148 characters

The external label on the reel must appear as follows:

From: ______*______

To:
HCFA-BDMS, PCDMB
Pacemaker Registry F-3EQ17
Date tape created (MMDDYY)
Equitable Bldg.
1717 Whitehead Rd.
Baltimore, MD 21207

(Use this new address effective 10/1/87)

*Identification of Intermediary

If you have had no pacemaker activity during the quarter, submit a note to that effect to the address shown above.

B. Data Format for Submission to HCFA.—

Field Number	Field Name	Picture	Justified	Positions
1	Provider Number	X(6)	L	1-6
2	HICN	X(12)	L	7-18
3	Patient Name			
	Last	X(6)	L	19-24
	First Initial	X		25-25
	Middle Initial	X		26-26
4	Procedure Date (MMDDYY)	9(6)	L	27-32
5	Ordering Physician Number	X(16)	L	33-48
6	Ordering Physician Name	X(13)	L	49-61
7	Operating Physician Number	X(16)	L	62-77
8	Operating Physician Name	X(13)	L	78-90
9	Record Identification Code	X		91-91
10	Manufacturer Identification	XXX	L	92-94
11	Model Number	X(15)	L	95-109
12	Serial Number	X(20)	L	110-129
13	Warranty Expiration Date (MMDDYY)	X(6)	L	130-135
14	Implant Date (explanted or replaced device) (MMDDYY)	X(6)	L	136-141
15	Lead Left in Patient yes(Y) no(N)	X		142-142
16	Returned to Manufacturer yes(Y) no(N)	X		143-143
17	Intermediary Number	X(5)	L	144-148

C. Field Definitions.—

1. Provider Number: The Medicare provider number identifying the hospital in which this procedure was performed.

2. HICN: The Health Insurance Claim Number of the beneficiary receiving this procedure.

3. Patient Name: The name of the patient receiving this procedure.

4. Procedure Date: The date this procedure was performed. (MMDDYY)

5. Ordering Physician Number: The identification number of the physician who ordered the implant or explant. Use the number established for the PRO.

6. Ordering Physician Name: The last name of the physician who ordered the implant or explant.

7. Operating Physician Number: The identification number of the physician performing this procedure. Use the number established for the PRO.

8. Operating Physician Name: The last name of the physician performing this procedure.

9. Record Identification Code:

A one position code identifying the type of procedure. Where multiple procedures are performed submit a separate record for each.

1 = Implanted Pulse Generator
2 = Implanted Atrial Lead
3 = Implanted Ventricular Lead
5 = Explanted Pulse Generator
6 = Explanted Atrial Lead
7 = Explanted Ventricular Lead

10. Manufacturer Identification: The following list has been revised to cross-refer models and brand names (which had been incorrectly listed as manufacturers) with appropriate manufacturers. Clarifying information is in parenthesis. Use the code indicated in parenthesis to identify the correct manufacturer. This information identifies the manufacturer of the implanted or explanted device. Identification numbers follow.

001	American Medical Instruments (formerly R.E. Brown - a lead mfg)
002	Bently Laboratories
003	Biostim Inc.
004	Biotronik Sales
005	Cardiac Control Systems Inc.
006	Cardiac Pacemakers Inc. (Div. of Eli Lilly)
007	Cardio-Pace Medical
008	Cook Pacemaker Corp.
009	Coratomic Inc.
010	Cordis Corp.
011	Ela Medical
012	Intermedics Inc.
013	Medtronic Inc.
014	Pacesetter Systems Inc.
015	Siemens-Elema Pacemaker Systems
016	Teletronics
017	Synthemed
018	Vitatron Medical*
019	A W Showell (Surgicraft)
020	Alto Development Corp.
021	AMP, Inc.
022	Bloom Associates, Ltd.
023	Cardioframe - Compagnie Francaise D'Elect (Cardio France)
024	Coats Pacesetter, Ltd. (British Firm)
025	Cordis Europa, N.V. (European Div. of Cordis-code 010)
026	Criticon, Inc.
027	Daig Corp.
028	Eastlake Corp.
029	Electro-Catheter Corp.

030	Ethicon, Inc. (Lead Mfg.)
031	Gardio - Pace Med Inc. (Cardio - Pace-code 007)
032	Gatron Corp.
033	KMA, Inc.
034	Mancock/Extracorporeal (Hancock - Extracorporeal)
035	Medi-Dyne Instruments Inc. (Lead Mfg.)
036	Norland Corp.
037	Omikron Scientific Ltd.
038	Siemens Elema (Siemens-Elema Pacemaker Systems-code 015)
039	Stockert Instrumente (Lead Mfg.)
040	Transpace, Inc.
041	Vascular Products, Inc. (Lead Mfg.)
042	Win Hirsch and Associates (Lead Mfg.)
043	ARCO Medical Products
044	Encor Paramus
*045	Tel Autima II (A Pacemaker made by Teletronics-code 016)
*046	AFP (A Pacemaker made by Pacesetter-code 014)
*047	Cosmos (A Pacemaker made by Intermedics-code 012)
*048	Spectrax (A Pacemaker made by Medtronic-code 013)
*049	Quantum (A Pacemaker made by Intermedics-code 012)
050	General Electric
051	Unipolar
052	Cardio Dynamics
053	Oscor Medical Corp.
054	USCI Div., C.R. Bard Inc. (C.R. Bard, Inc. - Lead Mfg.)
055	Medcor
056	Future Tech
057	Pace Medical Inc.
*058	Optima - MPT (A Pacemaker made by Teletronics-code 016)
*059	Minilith (A Pacemaker made by Cardiac Pacemakers, Inc.-code 006)
*060	Symbios (A Pacemaker made by Medtronic-code 013)
061	Trans Venus
062	Kyrel
063	Edwards
*064	Cyberlith (Pacemaker made by Intermedics-code 012)
*065	Activitrax (Pacemaker made by Medtronic-code 013)
066	American Optical
067	American Technology Inc.
068	Micro-Thin

* Brand Names or Model Designation.

11. Model Number: The model number of the device implanted or explanted in this procedure.

12. Serial Number: A number that uniquely identifies the specific device.

13. Warranty Expiration Date: The expiration date of the warranty on the particular device (MMDDYY). If there is a lifetime warranty, use code 999999. If no warranty exists, use code NNNNNN. If unknown, use code UUUUUU. (Code UUUUUU is acceptable for explants only.)

14. Implant Date (explanted or replaced device): For explanted or replaced devices only (Record Identification Codes 5, 6, or 7) give the date of implant for the explanted or replaced device (MMDDYY). If unknown, fill the field with Us (i.e., UUUUUU).

15. Lead Left in Patient: A code to indicate whether a lead explant was performed in connection with an implant (Record Identification codes 2, and 3) or whether the former lead was left in the patient. Use this coding for implant records only. Y = Former lead left in patient; N = Former lead explanted or no former lead exists.

16. Returned to Manufacturer: A code to indicate whether a device which has been explanted has been returned to the manufacturer. Y = Returned; N = Not Returned.

17. Intermediary Number: The Medicare number of the intermediary servicing the provider identified in this record.

D. Edit Specifications.—

Field

1 Provider Number - 1st 2 positions - Valid State code; 3rd position may be alpha or numeric. If alpha: S=Psychiatric Unit, T=Rehabilitation Unit, U=Swing-Bed Hospital, and V=Alcohol Drug Unit.

Check that the last four digits are correct for that type of provider.

0001-0999, 1200-1299, 2000-2299, 3025-3099, 3300-3399, 4000-4499.

2 HICN

If the HICN starts with a number, it should conform to the following specifications:

The 1st three digits, the "area," must fall within the ranges 001-626 or 697-729.

The next two digits, the "Group" must fall within the range 01-99 (00 is not assigned).

The last four digits, the "serial" must fall within the range 0001-9999 (0000 is not assigned).

The next position must contain one of the following tellers:

A, B, C, D, E, F, J, K, or W.

A is followed by a blank.

B is followed by a blank, 1-9, A, D, G, H, J, K, L, N, P, Q, R, T, W, or Y.

C must be followed by any number 1-9, or any letter A-Z.

D may be followed by a blank, 1-9, A, C, D, G, H, J-N, P-T, or V-Z.

E may be followed by a blank, 1-9, A-D, F-H, J, L, or M.

F must be followed by 1-8.

J must be followed by 1-4.

K must be followed by 1-9, A-H, J, L, or M.

W may be followed by a blank, 1-9, B, C, F, G, J, R, or T.

T may be followed by a blank, A-H, J-N, Q-Z, 2-9.

M may be followed by a blank.

If the HICN starts with a letter, it should conform to the following specifications:

If the letter is A, it is followed by 000001-991273, 995000-999999.

If the first two characters are MA, WA, CA, or PA, or the first 3 characters are WCA, the next six characters must be in the ranges 000001-415935, 995000-999999.

RRB HICN must conform to the following specifications:

A. Six Digit Numbers

Prefix	6 Digit Number
A, MA, WA, CA, WCA, PA, JA	000001-991273, 995000-999999
WD, WCD, PD	000001-415935, 995000-999999
H, MH, WH, WCH, PH	000001-049159, 995000-999999

B. Nine Digit Numbers

The valid prefixes are as shown on A, above. The number portion must meet the same specifications as a non-RRB HICN.

3.	Patient Name	No edits.
4.	Procedure Date (MMDDYY)	Month portion must be 01-12 Day portion must be 01-31 Year portion must be greater than 84, but not greater than the year tape created.
5.	Ordering Physician Number	Edit according to specifications of PRO physicians number.
6.	Ordering Physician Name	Blank is not acceptable.

7. Operating Physician Number	See 5, above.
8. Operating Physician Name	Blank is not acceptable.
9. Record Identification Code	Must be in range 1-7 excluding 4.
10. Manufacturer Identification	Must be valid number as shown in field definition.
11. Model Number	Blank is not acceptable.
12. Serial Number	Blank is not acceptable. For explanted devices whose serial numbers cannot be read, enter UUUUUU in the first six positions of the field. (It is not necessary to fill the 20 position field with Us, but you may do so in the interest of saving programming costs.)
13. Warranty Expiration Date	Must be valid date greater than, or equal to field 4 (this applies only to implants; i.e., record codes 1, 2, and 3). Enter: . NNNNNN if no warranty exists, . UUUUUU if unknown, or . 999999 if a lifetime warranty.
14. Implant Date of Explanted or Replaced Device	Must be valid date less than field 4 above or UUUUUU if unknown.
15. Lead Left in Patient	Must be "Y" or "N."
16. Returned to Manufacturer	Must be "Y" or "N."
17. Intermediary Number	Constant - must be your intermediary number.

Duplicate Records:

Effective with the quarter ending 9/30/86, a new check is being added to the pacemaker computer process. When exact duplicate records (all 148 fields alike) are submitted, the first duplicate record will be processed normally (it may have field rejects or be accepted). All subsequent duplicates will reject with a message—

"******DUPLICATE RECORD******" printed on line one above the PROV, HICN, and NAME fields.

E. Sample Letter To Secure Pacemaker Data From Providers

1.Date:________ (MMDDYY)

2.Name of Hospital:____________________ **3.Provider Number:**____________

4.Patient Name:________________________________ **5.HICN:**____________ **6.Date of Admission:**________ (MMDDYY)

7.ICD-9-CM Procedure Code:_____ **8.Procedure Date:**________ (MMDDYY) **9.Medical Record #:**__________________ **10.Patient Control #:**__________________

The medical information on the claim you recently submitted for the above confinement indicates pacemaker related services. Section 2304 of P.L. 98-369 requires that we obtain from you the information listed below for inclusion in the Food and Drug Administration's Pacemaker Registry. Your response to this request within 60 days of the date of this letter is appreciated. Please see Section 449.F for instructions on completing the form.

11.Physician Identification: Physician Ordering Implant/Explant Operating Physician

Number a.__________________ Number c.__________________

Name b.__________________ Name d.__________________

12.Pacemaker Information:

Component	Mfgr	Model#	Serial #	Warranty Expiration Date (MMDDYY)	IMPLANTS ONLY Leads Left In Patient	EXPLANTS ONLY Returned To Mfgr	Date Device Implanted (MMDDYY)
Implants							
(1)Pulse Generator	a)____	b)________	c)____________________	d)________			
(2)Atrial Lead	a)____	b)________	c)____________________	d)________	e)Y_ or N_		
(3)Ventricular Lead	a)____	b)________	c)____________________	d)________	e)Y_ or N_		
Explants							
(5)Pulse Generator	a)____	b)________	c)____________________	d)________		f)Y_ or N_	g)__________
(6)Atrial Lead	a)____	b)________	c)____________________	d)________		f)Y_ or N_	g)__________
(7)Ventricular Lead	a)____	b)________	c)____________________	d)________		f)Y_ or N_	g)__________

F. Use of Sample Letters to Secure Pacemaker Data from Providers.—The sample letter to secure pacemaker data from providers must have the header information entered by you. Fill-in items 1-10 at the top of the sample letter and send it to the provider for completion. You may manage the sample letter as needed to fit your equipment (e.g., if you choose to, it may be turned sidewise).

Upon receipt of the completed form from the provider, key the following items: (If you key in the following order, no reformatting will be necessary.)

3. Provider Number;

5. HIC Number;

4. Patient Name (as defined in the data format, subsection B above);

8. Procedure Date;

11. a, b, c, and d, the physician name and number for both ordering and operating physicians. (When keying physician name, key first 13 letters of surname only.);

12. (1), (2), (3), (5), (6), or (7) if more than one line is filled in, you have to create a separate record, repeating all of the above elements for each such line. In any event, key a-d for each line keyed and e) Lead Left in Patient for implant lines (2), or (3) keyed, and f)-g) Returned to Manufacturer and Prior Implant Date for each explant ((5), (6), or (7)) line keyed.); and

You must also key your intermediary number.

Follow the Data Format for Submissions to HCFA shown in subsection B above. Prior to submission perform all the edits specified in subsection D. HCFA will also perform these edits.

G. Rejected Records.—Records you submit that fail edits in subsection D. will be listed and sent to you by CO in the format shown below. Incorrect fields will be marked with asterisks. Make necessary corrections and include the corrected records in the pacemaker tape you submit the following quarter.

```
REJECTED PACEMAKER RECORDS FROM INTER _____ BLUE CROSS OF _______________________          QTR ENDING: 12-31-85

REC# PROV    HICN           NAME     P-DATE PHYS:NUMBER-NAME PHYS-ORD/OPER R MFG MODEL-NUM      SERIAL-NUM       W-DATE O-DATE LM
---- ------  -------------- -------  ------ ---------------- ------------- - --- -------------  ---------------  ------ ------ --
                                            A0123456         SMITH B                                            ******
  1                                                                                                                           
     012344                 SMITH A  041885 A0123444         JONES C       5 013 5983           MC0000101R       060583 060579  Y

                                            A0123456         SMITH B                                                           *
  2
     044321                 JONES J  060685 A0123456         SMITH B       1 013 4011-58        IB0040061V       999999         Y

                                            K3956080         SMITH Z                                            ******
  3
     033876                 JONES M  093085 K3956080         SMITH Z       5 006 520            PG000001         081184 081180  Y

********* ( R E J E C T E D  F I E L D S  A R E  H I G H L I G H T E D  W I T H  A S T E R I S K S ) *********
```

The column headings above cross refer in general to field definitions shown in subsection C, with the following exceptions:

REC# - Sequential record numbers assigned to failed edits encountered within a specific quarterly data submittal.

PHYS:NUMBER-NAME - Two numbers, which may be identical, must be shown. The top one represents the ordering physician, the bottom one the operating physician.

PHYS-ORD/OPER - Two names, which may be identical, must be shown. The top one represents the ordering physician, the bottom one the operating physician.

R - Record identification code (1-3 or 5-7)

W-DATE - Warranty expiration date for this particular device.

O-DATE - Implant date of the explanted or replaced device.

L - Lead left in patient? Y = yes N = no

M - Device returned to manufacturer? Y = yes N = no

H. Payment Denial for Failure to Submit Required Pacemaker Registry Data.--For implants provided September 21, 1987 or later, either implement edits to refuse bills received without accompanying pacemaker data or continue your post-payment development process. If you continue your post-payment development process, deny claims and recover payments when the registry data is not furnished. Send written notice of your denial determination to the beneficiary with a copy to the provider. Inform the beneficiary that the hospital may not charge him/her for such services, with the exception of the deductible and coinsurance. State the reason for the determination and the effective date and grant the provider 45 days from the date of this notice to submit information or evidence to demonstrate that the determination is in error. Also, inform the provider of its right to a hearing.

If you install a prepayment edit (use edit criteria in subsection D to assure accurate data) that precludes payment until registry data is furnished and the provider insists on payment, issue a denial letter and follow the above instructions.

When receiving tapes from providers refer to §3600, Addendum A, B, C, and D.

For magnetic tape records, record type number 81 must be included for procedure codes listed in §3678A.

When processing paper bills return incomplete bills to providers for required pacemaker data before payment.

Records failing edits are returned to you each quarter. Correct them and resubmit them with new pacemaker records for the next quarter.

Billing in Situations Where Medicare is Secondary Payer
Cost Reimbursement Providers

3679. BILLING PROCEDURES WHERE SERVICES ARE REIMBURSABLE UNDER WORKERS' COMPENSATION

A. General.--Payment may not be made under Medicare for any items and services to the extent that payment has been made, or can reasonably be expected to be made for such items or services under a WC law or plan of the United States or a State. For an explanation of these provisions see §§3407-3416.

Expenses for services for which Medicare payment may not be made because of these provisions are not counted toward Part A or Part B deductible amounts or against the number of inpatient care days available to the beneficiary.

Where Medicare is determined to be the primary payer, Medicare is shown on line A of Item 57. Where Medicare is secondary, Medicare is shown on line B. In addition, where the provider is billing Medicare because the WC plan denied payment, occurrence code 24 (insurance denied) and the date of denial are shown in Items 28-32 (occurrence codes). The reason for the denial is shown in remarks (Item 94). All bills where Medicare is not primary payer because of these provisions are prepared in accordance with the following instructions. In applying the guidelines, it may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §3683 for instructions to determine this amount.

B. Inpatient Bills - Full Payment by WC.--If the payment from the WC plan for Medicare covered services (as determined by the formula in subsection C5) equals or exceeds the provider's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the provider accepts, or is required under the WC law to accept, the payment as payment in full, no payment is due from Medicare and no utilization is charged. However, the provider submits a bill for determining the benefit period. Process the bill in accordance with §3604 with the following modifications:

o The provider completes the total and noncovered charges columns as if there had been no other payment.

The provider shows total covered and noncovered days in the usual manner. Days paid by the WC plan are counted as covered days.

The provider enters the amount paid by the WC plan for Medicare covered services in value codes (Items 46-49).

The provider enters condition 77 in Items 35-39 when it accepts, or is required under the WC law to accept, the WC plan's payment as payment in full.

o Do not complete the nonpayment code.

Enter in field 22 of the UNIBILL RECORD the days you determine to be charged to the beneficiary's Medicare utilization record. This figure should be zero.

Enter in field 24 of the UNIBILL RECORD zero days.

Enter in field 39 of the UNIBILL RECORD value code 15 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount Medicare would have paid in the absence of the WC plan's payment. (Do not record this amount on the PS&R report.)

Do not record days or charges on the PS&R report.

Submit the bill to HCFA in the format described in §3876.

C. Inpatient Bills - Partial Payment by WC.—If the payment from the WC plan for Medicare covered services (as determined by the formula in 5) is less than the provider's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the provider does not accept, and is not required under the WC law to accept, the payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining covered and noncovered charges

The provider completes the total and noncovered charges columns as if there had been no other payment.

2. Determining covered and noncovered days

The provider shows total covered and noncovered days in the usual manner. Days paid by the WC plan are counted as covered days.

Calculate the days to be charged to the beneficiary as determined in subsection 3 below and report this result in the appropriate field of the UNIBILL RECORD as described in 7 below.

3. Determining utilization and coinsurance

Where the stay involves coinsurance days, determine utilization chargeable to the beneficiary if the provider cannot. Complete Items 25 and 61 (coinsurance) accordingly. No adjustment to Item 23 (covered days) is made based on this determination. The provider completes Item 23 in the usual manner.

Charge utilization as follows:

o Subtract the WC plan's payment that applies to Medicare covered services as determined under subsection 5 and any applicable deductible and coinsurance amounts from the Medicare interim reimbursement for the stay (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

o Divide this amount by the amount Medicare would have paid as primary payer (i.e., the Medicare interim reimbursement for the stay reduced by deductible and coinsurance).

- o Multiply this percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more.

EXAMPLE I: Deductible Involved

An individual was hospitalized 15 days, for which the total charges were $5,000. The WC plan paid $2,400 for Medicare covered services. No part of the Medicare inpatient deductible of $520 had been met. The current Medicare interim reimbursement (without regard to deductible or coinsurance) for the services in the absence of the WC plan's payment would have been $3,600. This amount minus the WC plan's payment and the inpatient deductible is $680 ($3,600 - $2,400 - $520). Medicare would have paid $3,080 as primary payer ($3,600 - $520). Calculate the beneficiary's utilization as follows: $680 divided by $3,080 = .220 x 15 days = 3.31 or 3 days when rounded.

EXAMPLE II: Coinsurance Involved

An individual was hospitalized for 20 days (all of which were LTR days) for which total charges were $14,000. The WC plan paid $6,000 for Medicare covered services. The applicable coinsurance amount was $5,200. The current Medicare interim reimbursement amount (without regard to deductible or coinsurance) for the services, in absence of the WC plan's payment, would have been $12,000. The Medicare secondary payment amount is $800 (the current Medicare interim reimbursement amount of $12,000 minus the WC plan's payment of $6,000 and the applicable coinsurance amount of $5,200). Medicare would have paid $6,800 as primary payer ($12,000 - $5,200). Calculate the beneficiary's utilization as follows: $800 divided by $6,800 = .117 x 20 days = 2.35 or 2 days when rounded.

Charge coinsurance days as follows:

- o If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed.
- o If the days resulting from the utilization calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the provider performs the utilization calculation above, perform the same calculation to verify that Items 25 and 61 (coinsurance) have been completed correctly. Advise the provider of any discrepancies.

EXAMPLE 1:

A beneficiary has 17 full days available at the time of admission. The hospital stay was 20 days. The provider bills 20 days in covered days as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed. In the absence of another insurer's payment, 3 days would have been billed in Item 25 (coinsurance).

Enter in field 24 of the UNIBILL RECORD, 20 days.

EXAMPLE 2:

A beneficiary has 30 coinsurance days available at the time of admission. The hospital stay was 20 days. The provider bills 20 days in covered days as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed. In the absence of another insurer's payment, 20 days would have been billed in Item 25 (coinsurance).

Enter in field 25 or 26 of the UNIBILL RECORD, 10 days. In addition, enter in field 24 of the UNIBILL RECORD, 20 days.

4. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Occurrence code 04 and the associated date is shown in Items 28-32. Condition code 02 is shown in Items 35-39. Value code 15, with the amount paid is shown in value codes (Items 46-49). The address of the WC plan is shown in Item 34 or remarks (Item 94).

5. Determining amount of primary payer payment that applies to Medicare covered services

The provider indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49).

EXAMPLE: Total charges were \$5,000. Medicare covered charges were \$4,000. The WC plan's payment was \$3,000. Since the provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$4,000}{\$5,000} \times \$3,000 = \$2,400$$

The provider shows \$2,400 in value codes (Items 46-49).

6. Determining the amount of Medicare payment

Subtract the payment by the WC plan for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §3683 and apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1:

Inpatient care was furnished to a Medicare beneficiary whose WC plan was the primary payer. The covered charges were $4,000. The WC plan paid $2,400 for Medicare covered services as determined in 5. No part of the Medicare inpatient deductible of $520 had been met previously. The Medicare interim reimbursement (without regard to deductible or coinsurance) at 90 percent of charges ($4,000 x 90 percent) would be $3,600. The deductible is determined as follows:

The lesser of $520 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $3,600 - $2,400 = $1,200 which exceeds $520. The deductible amount charged to the beneficiary is $520

As secondary payer, Medicare pays: The current Medicare interim reimbursement minus the WC plan's payment for Medicare covered services minus the inpatient deductible: $3,600 - $2,400 - $520 = $680. Medicare pays $680.

EXAMPLE 2:

Same facts as in Example 1 except the covered charges were $1,000, the primary payer's payment was $900 and the Medicare interim reimbursement (without regard to deductible or coinsurance) at 98 percent of charges was $980. The deductible is determined as follows:

The lesser of $520 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $980 - $900 = $80. Since $80 is less than $520 the deductible amount charged to the beneficiary is $80.

As secondary payer Medicare pays: The current Medicare interim reimbursement minus the WC plan's payment for Medicare covered services minus the inpatient deductible: $980 -$900 - $80 = 0.

The patient's liability is $80, the remaining $440 of the deductible will be due if the patient is rehospitalized during the same benefit period.

7. UNIBILL entries

Enter in field 22 of the UNIBILL RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in field 24 of the UNIBILL RECORD the covered days reported by the provider in item 23. This figure is used to validate the Medicare days shown on the cost report.

Enter in field 39 of the UNIBILL RECORD value code 15 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount paid by the WC plan for Medicare covered services that appears in value codes (Items 46-49).

D. Part B Inpatient Services.—These provisions apply for ancillary services to individuals who have exhausted or who are not entitled to Part A benefits. Handle billing as described in subsections E and F. If Part A benefits are exhausted during the inpatient stay, the Part B billing should not be prepared until the effect of the primary payment on Part A utilization is determined.

E. Outpatient Bills - Full Payment by WC.—If the payment from the WC plan for Medicare covered services (as determined by the formula in subsection F3) equals or exceeds the provider's charges for those services, or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the provider accepts, or is required under the WC law to accept the payment as payment in full, the provider does not submit a bill.

F. Outpatient Bills - Partial Payment by WC.—If the payment from the WC plan for Medicare covered services (as determined by the formula in 3) is less than the provider's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the provider does not accept, and is not required under the WC law to accept the payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining covered charges

The provider shows in the covered charges column Medicare covered charges including those covered by the WC plan's payment.

2. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Occurrence code 04 and the associated date is shown in Items 28-32. Condition code 02 is shown in Items 35-39. Value code 15, with the amount paid is shown in value codes (Items 46-49). The address of the WC plan is shown in item 34 or remarks (Item 94).

3. Determining amount of primary payer payment that applies to Medicare covered services

The provider indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes. The provider must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE: Total charges were $200. Medicare covered charges were $180. The WC plan's payment was $55. Since the provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$180}{\$200} \times \$55 = \$50$$

The provider shows $50 in value codes (Items 46-49).

4. Determining the amount of Medicare payment

Subtract the payment by the WC plan for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §3683. Apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1:

Outpatient care was furnished to a Medicare beneficiary whose WC plan was primary payer. The charges for the services were $180. No part of the beneficiary's Part B deductible had been met previously. The WC plan paid $50 for Medicare covered services as determined in Item 3. The Medicare interim reimbursement (without regard to deductible or coinsurance) for these services at 90 percent of charges (the provider's interim rate) would be $162. The deductible and coinsurance are calculated as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $162 - $50 = $112 which exceeds $75. The Part B deductible amount charged to the beneficiary is $75.

The coinsurance is the charges minus the primary payer's payment minus the deductible times 20 percent. $180 (charges) - $50 (primary payer's payment) = $130 (charges subject to deductible and coinsurance) - $75 (deductible) = $55 x 20 percent = $11 coinsurance.

As secondary payer Medicare pays: The current Medicare interim reimbursement minus the WC plan's payment for Medicare covered services minus the deductible and coinsurance: $162 -$50 - $75 - $11 = $26. Medicare pays $26.

EXAMPLE 2:

Same facts as in Example 1 except the covered charges were $100, the primary payer's payment was $60 and the Medicare interim reimbursement (without regard to deductible or coinsurance) for the services at 90 percent of charges (the provider's interim rate) was $90. The deductible and coinsurance are calculated as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $90 - $60 = $30. Since $30 is less than $75, the Part B deductible amount charged to the beneficiary is $30.

Since the $75 Part B deductible is not met there is no coinsurance amount and there is no Medicare payment. The patient's liability is $30 of the $75 deductible.

5. UNIBILL entries

Enter in field 30 of the UNIBILL RECORD value code 15 to identify the primary payer.

Enter in field 31 of the UNIBILL RECORD the amount paid by the WC plan for Medicare covered services that appears in value codes (Items 46-49).

G. Christian Science Sanatorium Bills - Full Payment by WC.--If the payment from the WC plan for Medicare covered services (as determined by the formula in subsection H5) equals or exceeds the sanatorium's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the sanatorium accepts, or is required under the workers' compensation law to accept, the payment as payment in full, no payment is due from Medicare and no utilization is charged to the beneficiary. However, the sanatorium submits a bill for determining the benefit period. Process the bill in accordance with §3604 with the following modifications:

o The sanatorium completes the total and noncovered charges columns as if there had been no other payment.

The sanatorium shows total covered and noncovered days in the usual manner. Days paid by the WC plan are counted as covered days.

The sanatorium enters the amount paid by the WC plan for Medicare covered services in value codes (Items 46-49).

The sanatorium enters condition code 77 in Items 35-39 when it accepts, or is required under the WC law to accept, the WC plan's payment as payment in full.

o Do not complete the nonpayment code.

Enter in field 22 of the UNIBILL RECORD the days you determine to be charged to the beneficiary's Medicare utilization record. This figure should be zero.

Enter in field 24 of the UNIBILL RECORD zero days.

Enter in the field 39 of the UNIBILL RECORD value code 15 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount Medicare would have paid in the absence of the WC plan's payment. (Do not record this amount on the PS&R report.)

Do not record days or charges on the PS&R report.

Submit the bill to HCFA in the format described in §3876.

H. Christian Science Sanatorium Bills-Partial Payment by WC.—If the payment by the WC plan for Medicare covered services (as determined by the formula in 5) is less than the sanatorium's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the sanatorium does not accept, and is not required under the WC law to accept, the payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining covered and noncovered charges

The sanatorium completes the total and noncovered charges columns as if there had been no other payment.

2. Determining covered and noncovered days

The sanatorium shows total covered and noncovered days in the usual manner. Count days paid by the WC plan as covered days.

Calculate the days to be charged to the beneficiary as determined in 3 and report this result in the appropriate field of the UNIBILL RECORD as described in 7.

3. Determining utilization and coinsurance

Where the stay involves coinsurance days, determine utilization chargeable to the beneficiary if the sanatorium cannot. Complete Items 25 and 61 (coinsurance) accordingly. No adjustment to Item 23 (covered days) is made based on this determination. The sanatorium completes Item 23 in the usual manner.

Charge utilization as follows:

- Subtract the WC plan's payment that applies to Medicare covered services as determined under 5 and any applicable deductible and coinsurance amounts from the Medicare interim reimbursement for the stay (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

- Divide this amount by the amount Medicare would have paid as primary payer (i.e., the Medicare interim reimbursement for the stay reduced by deductible and coinsurance).

- Multiply this percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more. (See §3679C3 for utilization examples.)

Charge coinsurance days as follows:

- o If the days resulting from the calculation are fewer than the full days available for the stay, no coinsurance days are billed.

- o If the days resulting from the calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the sanatorium performs the utilization calculation perform the same calculation to verify that Items 25 and 61 (coinsurance) have been completed correctly. Advise the sanatorium of any discrepancies.

EXAMPLE 1:

A beneficiary has 17 full days available at the time of admission. The sanatorium inpatient stay was 20 days. The sanatorium bills 20 days in Item 27 (covered days) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed. In the absence of another insurer's payment, 3 days would have been billed in Item 25 (coinsurance).

Enter in field 24 of the UNIBILL RECORD, 20 days.

EXAMPLE 2:

A beneficiary has 30 coinsurance days available at the time of admission. The sanatorium inpatient stay was 20 days. The sanatorium bills 20 days in Item 27 (covered days) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed. In the absence of another insurer's payment, 20 days would have been billed in Item 25 (coinsurance).

Enter in field 25 or 26 of the UNIBILL RECORD, 10 days. In addition, enter in field 24 of the UNIBILL RECORD, 20 days.

4. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Occurrence code 04 and the associated date is shown in Items 28-32. Condition code 02 is shown in Items 35-39. Value code 15, with the amount paid is shown in value codes (Items 46-49). The address of the WC plan is shown in Item 34 or remarks (Item 94).

5. Determining amount of primary payer payment that applies to Medicare covered services

The sanatorium indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the sanatorium cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49).

EXAMPLE: Total charges were $5,000. Medicare covered charges were $4,000. The WC plan's payment was $3,000. Since the sanatorium cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$4{,}000}{\$5{,}000} \times 3{,}000 = \$2{,}400$$

The sanatorium shows $2,400 in value codes (Items 46-49).

6. Determining the amount of Medicare payment

Subtract the payment by the WC plan for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §3683. Apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1:

A sanatorium furnished inpatient care to a Medicare beneficiary whose WC plan was primary payer. The covered charges were $4,000. The WC plan paid $2,400 for Medicare covered services as determined in Item 5. No part of the Medicare inpatient deductible of $520 had been met previously. The Medicare interim reimbursement (without regard to deductible or coinsurance) at 90 percent of charges ($4,000 x 90 percent) would be $3,600. The deductible is determined as follows:

The lesser of $520 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $3,600 - $2,400 = $1,200 which exceeds $520. The deductible amount charged to the beneficiary is $520.

As secondary payer Medicare pays: The current Medicare interim reimbursement minus the WC plan's payment for Medicare covered services minus the inpatient deductible: $3,600-$2,400-$520 = $680. Medicare pays $680.

EXAMPLE 2:

Same facts as in Example 1 except the covered charges were $1,000, the primary payer's payment was $900, and the Medicare interim reimbursement (without regard to deductible or coinsurance) at 98 percent of charges was $980. The deductible is determined as follows:

The lesser of $520 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $980 - $900 = $80. Since $80 is less than $520 the deductible amount charged to the beneficiary is $80.

As secondary payer Medicare pays: The current Medicare interim reimbursement minus the WC plan's payment for Medicare covered services minus the inpatient deductible: $980 -$900 - $80 = 0.

The patient's liability is $80, the remaining $440 of the deductible will be due if the patient reenters the sanatorium during the same benefit period.

7. UNIBILL entries

Enter in field 22 of the UNIBILL RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in field 24 of the UNIBILL RECORD the covered days reported by the sanatorium in Item 23. This figure is used to validate the Medicare days shown on the cost report.

Enter in field 39 of the UNIBILL RECORD value code 15 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount paid by the WC plan for Medicare covered services that appears in value codes (Items 46-49).

I. HHA Bills - Full Payment by WC.--If the payment from the WC plan for Medicare covered services (as determined by the formula in subsection J3) equals or exceeds the HHA's charges for those services or the current Medicare interim reimbursement amount or the HHA accepts, or is required under the WC law to accept the payment as payment in full, no payment is due from Medicare. The HHA does not submit a bill.

J. HHA Bills - Partial Payment by WC.--If the payment from the WC plan for Medicare covered services (as determined by the formula in 3) is less than the HHA's charges for those services and the current Medicare interim reimbursement amount and the HHA does not accept, and is not required under the WC law to accept, the payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining charges and visits

The HHA shows in the charges and visits columns of the bill Medicare covered charges and visits including those covered by the WC plan's payment.

2. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Occurrence code 04 and the associated date is shown in Items 28-32. Condition code 02 is shown in Items 35-39. Value code 15, with the amount paid is shown in value codes (Items 46-49). The address of the WC plan is shown in Item 34 or remarks (Item 94).

3. Determining amount of primary payer payment that applies to Medicare covered services

The HHA indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the HHA cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). The HHA must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE: Total charges were $550. Medicare covered charges were $500. The WC plan's payment was $330. Since the HHA cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

The HHA shows $300 in value codes (Items 46-49).

4. Determining the amount of Medicare payment

Subtract the payment by the WC plan for Medicare covered services from the current Medicare interim reimbursement amount.

EXAMPLE 1: Per Visit Method

A beneficiary received 10 visits for which the HHA's current Medicare interim reimbursement amount at $50 per visit interim rate was $500. The WC plan paid $300 for Medicare covered services as determined in Item 3. As secondary payer Medicare pays:

- The Medicare interim reimbursement minus the WC plan's payment for Medicare covered services: $500-$300=$200. Medicare pays $200.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits for which the HAA charged $50 per visit. The Medicare interim rate was 90 percent ($500 x 90 percent) which equaled $450. The WC plan paid $300 for Medicare covered services as determined in Item 3. As secondary payer Medicare pays:

- The Medicare interim reimbursement minus the WC plan's payment for Medicare covered services: $450-$300 = $150. Medicare pays $150.

5. UNIBILL entries

Enter in field 30 of the UNIBILL RECORD value code 15 to identify the primary payer .

Enter in field 31 of the UNIBILL RECORD the amount paid by the WC plan for Medicare covered services that appears in value codes (Items 46-49).

K. Conditional Payments.—Conditional Medicare benefits may be paid while a WC claim is contested. Where a claim is contested, the provider bills Medicare as usual. The provider requests conditional payment by entering occurrence code 04 and the associated date in Items 28-32, occurrence codes; and condition code 02 in Items 35-39. The provider enters value code 15 with zero value in Items (46-49) to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of Item 57, the identifying information about the insured is shown on line A of Items 65-68 and the address of the WC plan is shown in Item 34 or remarks (Item 94). In addition, an explanation of why the conditional payment is justified is shown in remarks (Item 94). (See §3412 for a more detailed explanation of conditional payment situations for contested WC claims and for follow-up procedures when conditional payments have been made.)

Process conditional payment bills following normal procedures. In addition, enter in the appropriate field of the UNIBILL record value code 15 and zero value to indicate that a conditional payment was made. Show this code and zero value in fields 39 and 40 for inpatient and Christian Science Sanatorium bills, and in fields 30 and 31 for outpatient, HHA, and other bills.

3680. BILLING PROCEDURES WHERE SERVICES ARE REIMBURSABLE UNDER AUTOMOBILE MEDICAL OR NO-FAULT INSURANCE, OR ANY LIABILITY INSURANCE

A. General.—Payment may not be made under Medicare for otherwise covered items or services to the extent that payment has been made, or can reasonably be expected to be made, for the items or services under automobile medical or no-fault insurance. In the case of liability insurance, primary Medicare benefits are paid conditionally and then recovered. For an explanation of these provisions see §§3419-3419.10 for liability insurance and §§3489-3489.9 for automobile medical or no-fault insurance.

Expenses for services for which Medicare payment may not be made because of these provisions are not counted toward Part A or Part B deductible amounts or against the number of inpatient care days available to the beneficiary.

Where Medicare is determined to be the primary payer, Medicare is shown on line A of Item 57. Where Medicare is secondary, Medicare is shown on line B. All bills where Medicare is not primary payer because of automobile medical or no-fault insurance are prepared in accordance with the following instructions. In applying the guidelines, it may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §3683 to determine this amount. Where liability insurance is involved, follow subsection L.

B. Inpatient Bills - Full Payment by Automobile Medical or No-Fault Insurance.—If the payment from the automobile medical or no-fault insurer for Medicare covered services (as determined by the formula in subsection C5) equals or exceeds the provider's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the provider accepts, or is obligated to accept, the payment as payment in full, no payment is due from Medicare and no utilization will be charged to the beneficiary. However, the provider submits a bill for determining the benefit period. Process the bill in accordance with §3604 with the following modifications:

o The provider completes the total and noncovered charges columns as if there had been no other payment.

The provider shows total covered and noncovered days in the usual manner. Days paid by the automobile medical or no-fault insurer are counted as covered days.

The provider enters the amount paid by the automobile medical or no-fault insurer for Medicare covered services in value codes (Items 46-49).

The provider enters condition code 77 in Items 35-39 when it accepts, or is obligated to accept, the automobile medical or no-fault insurer's payment as payment in full.

o Do not complete the nonpayment code.

Enter in field 22 of the UNIBILL RECORD the days you determine to be charged to the beneficiary's Medicare utilization record. This figure should be zero.

Enter in field 24 of the UNIBILL RECORD zero days.

Enter in field 39 of the UNIBILL RECORD value code 14 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount Medicare would have paid in the absence of the automobile medical or no-fault insurer's payment. (Do not record this amount on the PS&R report.)

Do not record days or charges on the PS&R report.

Submit the bill to HCFA in the format described in §3876.

C. Inpatient Bills - Partial Payment by Automobile Medical or No-Fault Insurance.--If the payment from the automobile medical or no-fault insurer for Medicare covered services (as determined by the formula in 5) is less than the provider's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the payment as payment in full, process the bill in accordance with §3670 with the following modifications:

1. Determining covered and noncovered charges

The provider completes the total and noncovered charges columns as if there had been no other payment.

2. Determining covered and noncovered days

The provider shows total covered and noncovered days in the usual manner. Days paid by the automobile medical or no-fault insurer are counted as covered days.

Calculate the days to be charged to the beneficiary as determined in 3 and report this result in the appropriate field of the UNIBILL RECORD as described in 7.

3. Determining utilization and coinsurance

Where the stay involves coinsurance days, determine utilization chargeable to the beneficiary if the provider cannot. Complete Items 25 and 61 (coinsurance) accordingly. No adjustment to Item 23 (covered days) is made based on this determination. The provider completes Item 23 in the usual manner.

Charge utilization as follows:

o Subtract the automobile medical or no-fault insurer's payment that applies to Medicare covered services as determined under 5 and any applicable deductible and coinsurance amounts from the Medicare interim reimbursement for the stay (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

o Divide this amount by the amount Medicare would have paid as primary payer (i.e., the Medicare interim reimbursement for the stay reduced by deductible and coinsurance).

- Multiply this percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more.

EXAMPLE I: Deductible Involved

An individual was hospitalized 15 days, for which the total charges were $5,000. The automobile insurer paid $2,400 for Medicare covered services. No part of the Medicare inpatient deductible of $540 had been met. The current Medicare interim reimbursement (without regard to deductible or coinsurance) for the services in the absence of the automobile insurer's payment would have been $3,600. This amount minus the automobile insurer's payment and the inpatient deductible is $660 ($3,600 - $2,400 - $540). Medicare would have paid $3,060 as primary payer ($3,600 - $540). Calculate the beneficiary's utilization as follows: $660 divided by $3,060 = .215 x 15 days = 3.23 or 3 days when rounded.

EXAMPLE II: Coinsurance Involved

An individual was hospitalized for 20 days (all of which were LTR days) for which total charges were $14,000. The automobile insurer paid $6,000 for Medicare covered services. The applicable coinsurance amount was $5,400. The current Medicare interim reimbursement amount (without regard to deductible or coinsurance) for the services in absence of the automobile insurer's payment would have been $12,000. The Medicare secondary payment amount is $600 (the current Medicare interim reimbursement amount of $12,000 minus the automobile insurer's payment of $6,000 and the applicable coinsurance amount of $5,400). Medicare would have paid $6,600 as primary payer ($12,000 - $5,400). Calculate the beneficiary's utilization as follows: $600 divided by $6,600 = .090 x 20 days = 1.81 or 2 days when rounded.

Charge coinsurance days as follows:

- If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed.

- If the days resulting from the utilization calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the provider performs the utilization calculation above, perform the same calculation to verify that Items 25 and 61 (coinsurance) have been completed correctly. Advise the provider of any discrepancies.

EXAMPLE 1:

A beneficiary has 17 full days available at the time of admission. The hospital stay was 20 days. The provider bills 20 days in covered days as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed. In the absence of another insurer's payment, 3 days would have been billed in Item 25 (coinsurance).

Enter in field 24 of the UNIBILL RECORD, 20 days.

EXAMPLE 2:

A beneficiary has 30 coinsurance days available at the time of admission. The hospital stay was 20 days. The provider bills 20 days in covered days as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed. In the absence of another insurer's payment, 20 days would have been billed in Item 25 (coinsurance).

Enter in field 25 or 26 of the UNIBILL RECORD, 10 days. In addition, enter in field 24 of the UNIBILL RECORD, 20 days.

4. Special entries on the bill

The identifying information is shown in Items 57-68 on the first payer line. Occurrence code 01 or 02, as appropriate and the associated date is shown in Items 28-32. Value code 14, with the amount paid is shown in value codes (Items 46-49). The address of the automobile medical or no-fault insurer, is shown in Item 34 or remarks (Item 94).

5. Determining amount of primary payer payment that applies to Medicare covered services

The provider indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49).

EXAMPLE: Total charges were \$5,000. Medicare covered charges were \$4,000. The automobile medical insurer's payment was \$3,000. Since the provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$4,000}{\$5,000} \times \$3,000 = \$2,400$$

The provider shows \$2,400 in value codes (Items 46-49).

6. Determining the amount of Medicare payment

Subtract the payment by the automobile medical or no-fault insurer for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per S3683. Apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1:

Inpatient care was furnished to a Medicare beneficiary whose automobile medical insurer was the primary payer. The covered charges were $4,000. The automobile medical insurer paid $2,400 for Medicare covered services as determined in Item 5. No part of the Medicare inpatient deductible of $540 had been met previously. The Medicare interim reimbursement (without regard to deductible or coinsurance) at 90 percent of charges ($4,000 x 90 percent) would be $3,600. The deductible is determined as follows:

The lesser of $540 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $3,600 -$2,400 = $1,200 which exceeds $540. The deductible amount charged to the beneficiary is $540.

As secondary payer, Medicare pays: The current Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services minus the inpatient deductible: $3,600 - $2,400 - $540 = $660. Medicare pays $660.

EXAMPLE 2:

Same facts as in Example 1 except the covered charges were $1,000, the primary payer's payment was $900 and the Medicare interim reimbursement (without regard to deductible or coinsurance) at 98 percent of charges was $980. The deductible is determined as follows:

The lesser of $540 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $980 - $900 = $80. Since $80 is less than $540, the deductible amount charged to the beneficiary is $80.

As secondary payer Medicare pays: The current Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services minus the inpatient deductible: $980 - $900 - $80 = 0.

The patient's liability is $80, the remaining $460 of the deductible will be due if the patient is rehospitalized during the same benefit period.

7. UNIBILL entries

Enter in field 22 of the UNIBILL RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in field 24 of the UNIBILL RECORD the covered days reported by the provider in Item 23. This figure is used to validate the Medicare days shown on the cost report.

Enter in field 39 of the UNIBILL RECORD value code 14 to identify the primary payer.

Enter in field 40 the UNIBILL RECORD the amount paid by the automobile medical or no-fault insurer for Medicare covered services that appears in value codes (Items 46-69).

D. Part B Inpatient Services.--These provisions apply for ancillary services to individuals who have exhausted or who are not entitled to, Part A benefits. Handle billing as described in subsections E and F. If Part A benefits are exhausted during the inpatient stay, the Part B billing should not be prepared until the effect of the primary payment on Part A utilization is determined.

E. Outpatient Bills - Full Payment by Automobile Medical or No-Fault Insurance.--If the payment from the automobile medical or no-fault insurer for Medicare covered services (as determined by the formula in subsection F3) equals or exceeds the provider's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the provider accepts, or is obligated to accept, the payment as payment in full, the provider does not submit a bill.

F. Outpatient Bills - Partial Payment by Automobile Medical or No-Fault Insurance.--If the payment from the automobile medical or no-fault insurer for Medicare covered services (as determined by the formula in 3) is less than the provider's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the payment as payment in full, process the in accordance with §3604 with the following modifications:

1. Determining covered charges

The provider shows in the covered charges column, Medicare covered charges including those covered by the automobile medical or no-fault insurer's payment.

2. Special entries on the bill

The identifying information is shown in Items 57-68 on the first payer line. Occurrence code 01 or 02, as appropriate and the associated date is shown in Items 28-32. Value code 14, with the amount paid is shown in value codes (Items 46-49). The address of the automobile medical or no-fault insurer, is shown in Item 34 or remarks (Item 94).

3. Determining amount of primary payer payment that applies to the Medicare covered services

The provider indicates the primary payer's allocation of its payment between covered and noncovered Medicare services, by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). The provider must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE: Total charges were $200. Medicare covered charges were $180. The automobile medical insurer's payment was $55. Since the provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$180}{\$200} \times \$55 = \$50$$

The provider shows $50 in value codes (Items 46-49).

4. Determining the amount of Medicare payment

Subtract the payment by the automobile medical or no-fault insurer for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §3683. Apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1:

Outpatient care was furnished to a Medicare beneficiary whose automobile medical insurer was primary payer. The charges for the services were $180. No part of the beneficiary's Part B deductible had been met previously. The automobile medical insurer paid $50 for Medicare covered services as determined in Item 3. The Medicare interim reimbursement (without regard to deductible or coinsurance) for these services at 90 percent of charges (the provider's interim rate) would be $162. The deductible and coinsurance are calculated as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $162 - $50 = $112 which exceeds $75. The Part B deductible amount charged to the beneficiary is $75.

The coinsurance is the charges minus the primary payer's payment minus the deductible times 20 percent. $180 (charges) - $50 (primary payer's payment) = $130 (charges subject to deductible and coinsurance) - $75 (deductible) = $55 X 20 percent = $11 coinsurance.

As secondary payer, Medicare pays: The current Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services minus the deductible and coinsurance: $162 - $50 - $75 - $11 = $26. Medicare pays $26.

EXAMPLE 2:

Same facts as in Example 1 except the covered charges were $100, the primary payer's payment was $60, and the Medicare interim reimbursement (without regard to deductible or coinsurance) for the services at 90 percent of charges (the provider's interim rate) was $90. The deductible and coinsurance are calculated as follows:

The deductible is the lesser of $75 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $90 - $60 = $30. Since $30 is less than $75, the Part B deductible amount charged to the beneficiary is $30.

Since the $75 Part B deductible is not met, there is no coinsurance amount and there is no Medicare payment. The patient's liability is $30 of the $75 deductible.

5. UNIBILL entries

Enter in field 30 of the UNIBILL RECORD value code 14 to identify the primary payer.

Enter in field 31 of the UNIBILL RECORD the amount paid by the automobile medical or no-fault insurer for Medicare covered services that appears in value codes (Items 46-49).

G. Christian Science Sanatorium Bills - Full Payment by Automobile Medical or No-Fault Insurance.--If the payment from the automobile medical or no-fault insurer for Medicare covered services (as determined by the formula in subsection H5) equals or exceeds the sanatorium's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the sanatorium accepts, or is obligated to accept, the payment as payment in full, no payment is due from Medicare and no utilization is charged to the beneficiary. However, the sanatorium submits a bill for determining the benefit period. Process the bill in accordance with §3604 with the following modifications:

o The sanatorium completes the total and noncovered charges columns as if there had been no other payment.

The sanatorium shows total covered and noncovered days in the usual manner. Days paid by the automobile medical or no-fault insurer are counted as covered days.

The sanatorium enters the amount paid by the automobile medical or no-fault insurer for Medicare covered services in value codes (Items 46-49).

The sanatorium enters condition code 77 in Items 35-39 when it accepts, or is obligated to accept, the automobile medical or no-fault insurer's payment as payment in full.

o Do not complete the nonpayment code.

Enter in field 22 of the UNIBILL RECORD the days you determine to be charged to the beneficiary's Medicare utilization record. This figure should be zero.

Enter in field 24 of the UNIBILL RECORD zero days.

Enter in field 39 of the UNIBILL RECORD value code 14 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount Medicare would have paid in the absence of the automobile medical or no-fault insurer's payment. (Do not record this amount on the PS&R report.)

Do not record days or charges on the PS&R report.

Submit the bill to HCFA in the format described in §3876.

H. Christian Science Sanatorium Bills - Partial Payment by Automobile Medical or No-Fault Insurance.--If the payment by the automobile medical or no-fault insurer for Medicare covered services (as determined by the formula in 5) is less than the sanatorium's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the sanatorium does not accept, and is not obligated to accept, the payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining covered and noncovered charges

The sanatorium completes the total and noncovered charges columns as if there had been no other payment.

2. Determining covered and noncovered days

The sanatorium shows total covered and noncovered days in the usual manner. Days paid by the automobile medical or no-fault insurer are counted as covered days.

Calculate the days to be charged to the beneficiary as determined in 3 and report this result in the appropriate field of the UNIBILL RECORD as described in 7.

3. Determining utilization and coinsurance

Where the stay involves coinsurance days, determine utilization chargeable to the beneficiary if the sanatorium cannot and complete Items 25 and 61 (coinsurance) accordingly. No adjustment to Item 23 (covered days) is made based on this determination. The sanatorium completes Item 23 in the usual manner.

Charge utilization as follows:

o Subtract the automobile medical or no-fault insurer's payment that applies to Medicare covered services as determined under 5 below and any applicable deductible and coinsurance amounts from the Medicare interim reimbursement for the stay (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

o Divide this amount by the amount Medicare would have paid as primary payer (i.e., the Medicare interim reimbursement for the stay reduced by deductible and coinsurance.)

o Multiply this percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more. (See §3680C3 for utilization examples.)

Charge coinsurance days as follows:

o If the days resulting from the above calculation are fewer than the full days available for the stay, no coinsurance days are billed.

- If the days resulting from the above calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the sanatorium performs the utilization calculation, perform the same calculation to verify that Items 25 and 61 (coinsurance) have been completed correctly. Advise the sanatorium of any discrepancies.

EXAMPLE 1:

A beneficiary has 17 full days available at the time of admission. The sanatorium inpatient stay was 20 days. The sanatorium bills 20 days in Item 27 (covered days) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed. In the absence of another insurer's payment, 3 days would have been billed in Item 25 (coinsurance).

Enter in field 24 of the UNIBILL RECORD, 20 days.

EXAMPLE 2:

A beneficiary has 30 coinsurance days available at the time of admission. The sanatorium inpatient stay was 20 days. The sanatorium will bill 20 days in Item 27 (covered days) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed. In the absence of another insurer's payment, 20 days would have been billed in Item 25 (coinsurance).

Enter in field 25 or 26 of the UNIBILL RECORD, 10 days. In addition, enter in field 24 of the UNIBILL RECORD, 20 days.

4. Special entries on the bill

The identifying information is shown in Items 57-68 on the first payer line. Occurrence code 01 or 02, as appropriate and the associated date is shown in Items 28-32. Value code 14, with the amount paid is shown in value codes (Items 46-49). The address of the automobile medical or no-fault insurer is shown in Item 34 or remarks (Item 94).

5. Determining amount of primary payer payment that applies to Medicare covered services

The sanatorium indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward medicare covered services in value codes (Item 46-49). Where the sanatorium cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49).

EXAMPLE: Total charges were $5,000. Medicare covered charges were $4,000. The automobile medical insurer's payment was $3,000. Since the sanatorium cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$4,000}{\$5,000} \times \$3,000 = \$2,400$$

The sanatorium shows $2,400 in value codes (Items 46-49).

6. Determining the amount of Medicare payment

Subtract the payment by the automobile medical or no-fault insurer for Medicare covered services from the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) per §3683. Apply any applicable deductible and/or coinsurance to the remainder.

EXAMPLE 1:

A sanatorium furnished inpatient care to a Medicare beneficiary whose automobile medical insurer was the primary payer. The covered charges were $4,000. The automobile medical insurer paid $2,400 for Medicare covered services as determined in Item 5. No part of the Medicare inpatient deductible of $540 had been met previously. The Medicare interim reimbursement (without regard to deductible or coinsurance) at 90 percent of charges ($4,000 x 90 percent) would be $3,600. The deductible is determined as follows:

The lesser of $540 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $3,600 - $2,400 = $1,200 which exceeds $540. The deductible amount charged to the beneficiary is $540.

As secondary payer Medicare pays: The current Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services minus the inpatient deductible: $3,600 - $2,400 - $540 = $660. Medicare pays $660.

EXAMPLE 2:

Same facts as in Example 1 except the covered charges were $1,000, the primary payer's payment was $900, and the Medicare interim reimbursement (without regard to deductible or coinsurance) at 98 percent of charges was $980. The deductible is determined as follows:

The lesser of $540 or the current Medicare interim reimbursement amount less the primary payer amount for Medicare covered services. In this case: $980 - $900 = $80. Since $80 is less than $540, the deductible amount charged to the beneficiary is $80.

As secondary payer Medicare pays: The current Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services minus the inpatient deductible: $980 - $900 - $80 = 0.

The patient's liability is $80, the remaining $460 of the deductible will be due if the patient reenters the sanatorium during the same benefit period.

7. UNIBILL entries

Enter in field 22 of the UNIBILL RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in field 24 of the UNIBILL RECORD the covered days reported by the sanatorium in Item 23. This figure is used to validate the Medicare days shown on the cost report.

Enter in field 34 of the UNIBILL RECORD value code 14 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount paid by the automobile medical, no-fault, or liability insurer for Medicare covered services that appears in value codes (Items 46-49).

I. HHA Bills - Full Payment by Automobile Medical or No-Fault Insurance.--If the payment from the automobile medical or no-fault insurer for Medicare covered services (as determined by the formula in subsection J3) equals or exceeds the HHA's charges for those services or the current Medicare interim reimbursement amount or the HHA accepts, or is obligated to accept, the payment is as payment in full, no payment is due from Medicare. The HHA does not submit a bill.

J. HHA Bills - Partial Payment by Automobile Medical or No-Fault Insurance.--If the payment from the automobile medical or no-fault insurer for Medicare covered services (as determined by the formula in 3) is less than the HHA's charges for those services and the current Medicare interim reimbursement amount and the HHA does not accept, and is not obligated to accept, the payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining charges and visits

The HHA shows in the charges and visits columns of the bill Medicare covered charges and visits including those covered by the automobile medical or no-fault insurer's payment.

2. Special entries on the bill

The identifying information is shown in Items 57-68 on the first payer line. Occurrence code 01 or 02, as appropriate with the associated date is shown in Items 28-32. Value code 14, with the amount paid is shown in value codes (Items 46-49). The address of the automobile medical or no-fault insurer is shown in Item 34 or remarks (Item 94).

3. Determining amount of primary payer payment that applies to Medicare covered services

The HHA indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the HHA cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). The HHA must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE: Total charges were $550. Medicare covered charges were $500. The automobile medical insurer's payment was $330. Since the HHA cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

The HHA shows $300 in value codes (Items 46-49).

4. Determining the amount of Medicare payment

Subtract the payment by the automobile medical or no-fault insurer for Medicare covered services from the current Medicare interim reimbursement amount.

EXAMPLE 1: Per Visit Method

A beneficiary received 10 visits for which the HHA's current Medicare interim reimbursement amount at $50 per visit was $500. The automobile medical insurer paid $300 for Medicare covered services as determined in Item 3. As secondary payer Medicare pays:

o The Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services: $500 - $300 = $200. Medicare pays $200.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits for which the HHA charged $50 per visit. The Medicare interim rate was 90 percent ($500 x 90 percent) which equaled $450. The automobile medical insurer paid $300 for Medicare covered services as determined in Item 3 above. As secondary payer Medicare pays:

- The Medicare interim reimbursement minus the automobile medical insurer's payment for Medicare covered services: $450 - $300 = $150. Medicare pays $150.

5. UNIBILL entries

Enter in field 30 of the UNIBILL RECORD value code 14 to identify the primary payer.

Enter in field 31 of the UNIBILL RECORD the amount paid by the automobile medical or no-fault insurer for Medicare covered services that appears in value codes (Items 46-49).

K. Automobile Medical or No-Fault Insurer Does Not Make Payment.--If the services are related to an automobile accident and an automobile insurer has been billed but does not make payment, e.g., the services are not covered under automobile medical or no-fault insurance or the individual's insurance coverage expired, the provider bills Medicare as usual. In addition, the proper occurrence code as indicated below is shown in Items 28-32, occurrence code 24 is completed to show the date the other payer denied the claim and the reason for denial is shown in Remarks (Item 94).

01 - auto accident

02 - auto accident, no-fault insurance

If the claim is contested by an automobile medical or no-fault insurer or for any other reason there will be a substantial delay, pay conditional primary benefits. The provider enters value code 14 with zero value in Items (46-49) to indicate the type of other insurer and that conditional payment is requested. The identity of the other payer is shown on line A of Item 57, the identifying information about the insured is shown on line A of Items 65-68. Show the proper occurrence code in items 28-32 and the address of the insurer in Item 34 or Remarks (Item 94). In addition, an explanation of why the conditional payment is justified is shown in Remarks (Item 94). (See S3489.4E for an explanation of policy and procedures for conditional payment situations for contested or delayed automobile medical or no-fault claims.

Process these conditional payment bills following normal procedures. In addition, enter in the appropriate field of the UNIBILL RECORD value code 14 and zero value to indicate that a conditional payment was made. Show this code and zero value in fields 39 and 40 for inpatient and Christian Science Sanatorium bills, and fields 30 and 31 for outpatient, HHA, and other bills.

L. Conditional Liability Claims.—If the services are related to an accident as defined in §3419.2 or a diagnosis/trauma code listed in §3419.5 is shown, and there is no potential primary payers other than a liability insurer, the provider bills Medicare for conditional primary payments. It bills Medicare even if it believes that there is a reasonable likelihood that the liability insurer will pay promptly. The claim is completed and processed in accordance with the last two paragraphs of subsection K. (See §§3419ff. for an explanation of policy and procedures for liability claims and §3419.7 for actions to take where a liability claim is filed.)

3681. BILLING PROCEDURES WHERE MEDICARE BENEFITS ARE SECONDARY TO EMPLOYER GROUP HEALTH PLANS WHEN INDIVIDUALS ARE ENTITLED TO BENEFITS SOLELY ON THE BASIS OF ESRD

A. General.--Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP) in the case of individuals who are entitled to benefits solely on the basis of end stage renal disese (ESRD), during a period of up to 12 months. This provision is effective for items and services furnished on or after October 1, 1981, to beneficiaries whose 12-month period began in, or after, October 1981. For an explanation of these provisions see §§3490-3490.17.

Payment made by the ESRD-EGHP can be used to satisfy unmet deductibles and the individual's coinsurance. However, the portion of the stay paid for by the ESRD-EGHP is not charged to the beneficiary's Medicare utilization record.

Where Medicare is determined to be the primary payer, Medicare is shown on line A of Item 57. Where Medicare is secondary, Medicare is shown on line B. In addition, where the provider is billing Medicare because the ESRD-EGHP denied payment, occurrence code 24 (insurance denied) and the date of denial are in Items 28-32 (occurrence codes). The reason for the denial is in remarks (Item 94). All bills where Medicare is not primary payer because of coverage of an ESRD beneficiary by an EGHP are prepared in accordance with the following instructions. In applying the guidelines, it may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §3683 to determine this amount.

When processing current claims in which you are first aware of ESRD-EGHP coverage, consider the possibility of prior incorrect payments. See §3490.4.

B. Inpatient Bills - Full Payment By ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined by the formula in subsection C5) equals or exceeds the provider's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the provider accepts, or is obligated to accept, the ESRD-EGHP payment as payment in full, no payment is due from Medicare and no utilization will be charged to the beneficiary. However, the provider submits a bill for determining the benefit period. In addition, ESRD-EGHP payments can be used to satisfy unmet deductibles. Process the bill in accordance with §3604 with the following modifications:

o The provider completes the total and noncovered charges columns as if there had been no other payment.

Where blood is involved, the provider completes the blood items. (This data is for the beneficiary's utilization records only and is not to be used for the PS&R report.)

The provider does not complete coinsurance (no days are charged). However, inpatient deductible and total deductions are completed when applicable. (This data is for the beneficiary's utilization records only and is not to be used for the PS&R report.)

The provider shows total covered and noncovered days in the usual manner. Count days paid by the ESRD-EGHP are counted as covered days.

The provider enters the amount paid by the ESRD-EGHP for Medicare covered services in value codes (Items 46-49).

The provider enters occurrence code 33 and the first month of the 12 month period in Items 28-32.

The provider enters condition code 77 in Items 35-39 when it accepts, or is obligated to accept, the ESRD-EGHP payment as payment in full.

- Do not complete the nonpayment code.

Enter in field 22 of the UNIBILL RECORD the days you determine to be charged to the beneficiary's Medicare utilization record. This figure should be zero.

Enter in field 24 of the UNIBILL RECORD zero days.

Enter in field 39 of the UNIBILL RECORD value code 13 to identify the primary payer.

Enter in or field 40 of the UNIBILL RECORD the amount Medicare would have paid in the absence of the ESRD-EGHP's payment. (Do not record this amount on the PS&R report.)

Do not record days or charges on the PS&R report.

Submit the bill to HCFA in the format described in §3876. HCFA CO uses data reported in the blood deductible and inpatient deductible items to update deductibles. (This data is not to be used for the PS&R report.)

C. Inpatient Bills - Partial Payment by ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined by the formula in 5) is less than the provider's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the ESRD-EGHP payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining covered and noncovered charges

The provider completes the total and noncovered charges columns as if there had been no other payment.

2. Determining covered and noncovered days

The provider shows total covered and noncovered days in the usual manner. Count days paid by the ESRD-EGHP as covered days.

Calculate the days to be charged to the beneficiary as determined in 3 and report this result in the appropriate field of the UNIBILL RECORD as described in 7.

3. Determining utilization and coinsurance

Where an ESRD-EGHP pays an amount for Medicare covered services that is equal to, or less than, the deductible and coinsurance that would apply if Medicare was the primary payer, utilization is not reduced. Therefore, coinsurance is calculated in the usual manner. (See C6, example 4.)

Where an ESRD-EGHP pays an amount for Medicare covered services that is more than the deductible and coinsurance that would apply if Medicare was the primary payer, follow the procedures below to determine utilization and coinsurance.

Where the stay involves coinsurance days, determine utilization chargeable to the beneficiary if the provider cannot. Complete Items 25 and 61 (coinsurance) accordingly. No adjustment to Item 23 (covered days) is made based upon this determination. The provider completes Item 23 or 28 in the usual manner.

Charge utilization as follows:

- o Subtract the ESRD-EGHP payment that applies to Medicare covered services as determined under 5 from the Medicare interim reimbursement for the stay (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.
- o Divide this amount by the amount Medicare would have paid as primary payer (i.e., the Medicare interim reimbursement for the stay reduced by deductible and coinsurance).
- o Multiply this percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more.

EXAMPLE I: Deductible Involved

An individual was hospitalized 15 days, for which the total charges were $5,000. The ESRD-EGHP paid $2,400 for Medicare covered services. No part of the Medicare inpatient deductible of $520 had been met. The current Medicare interim reimbursement amount (without regard to deductible or coinsurance) for the services in absence of the ESRD-EGHP payment would have been $3,600. This amount minus the ESRD-EGHP payment is $1,200 ($3,600 - $2,400). Medicare would have paid $3,080 as primary payer ($3,600 - $520). Calculate the beneficiary's utilization as follows: $1,200 divided by $3,080 = .389 x 15 days = 5.84 or 6 days when rounded.

EXAMPLE II: Coinsurance Involved

An individual was hospitalized for 20 days (all of which were LTR days) for which total charges were $12,000. The ESRD-EGHP paid $6,000 for Medicare covered services. The applicable coinsurance amount was $5,200. The current Medicare interim reimbursement amount (without regard to deductible or coinsurance) for the services in absence of the ESRD-EGHP payment would have been $10,000. The Medicare secondary payment amount is $4,000 (the current Medicare interim reimbursement amount of $10,000 minus the ESRD-EGHP payment of $6,000). Medicare would have paid $4,800 as primary payer ($10,000 - $5,200). Calculate the beneficiary's utilization as follows: $4,000 divided by $4,800 = .833 x 20 days = 16.6 or 17 days when rounded. If the ESRD-EGHP payment in this example had been $5,200 or less, utilization would not be reduced. The beneficiary would have been charged with 20 days utilization.

Use this formula even when the ESRD-EGHP pays for only a specified number of days of a stay because of a payment limitation under the plan on the number of benefit days available. For example, a provider furnished 20 days of inpatient care. The ESRD-EGHP paid all of the charges for only the first 10 days. These charges were $4,500. No part of the Medicare inpatient deductible of $520 had been met. The current Medicare interim reimbursement (without regard to deductible or coinsurance) which Medicare could have paid for the 20 day stay in the absence of ESRD-EGHP coverage was $7,000. That amount minus the ESRD-EGHP payment was $2,500 ($7,000 - $4,500). Medicare would have paid $6,480 as primary payer ($7,000 - $520). The utilization charged to the beneficiary is calculated as follows: $2,500 divided by $6,480 = .385 x 20 days = 7.71 or 8 days when rounded.

Charge coinsurance days as follows:

o If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed.

o If the days resulting from the utilization calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the provider performs the utilization calculation above, perform the same calculation to verify that Items 25 and 61 (coinsurance) have been completed correctly. Advise the provider of any discrepancies.

EXAMPLE 1:

A beneficiary has 17 full days available at the time of admission. The hospital stay was 20 days. The provider bills 20 days in covered days as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed. In the absence of another insurer's payment, 3 days would have been billed in Item 25 (coinsurance).

Enter in field 24 of the UNIBILL RECORD, 20 days.

EXAMPLE 2:

A beneficiary has 30 coinsurance days available at the time of admission. The hospital stay was 20 days. The provider bills 20 days in covered days as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed. In the absence of another insurer's payment, 20 days would have been billed in Item 25 (coinsurance).

Enter in field 25 or 26 of the UNIBILL RECORD, 10 days. In addition, enter in field 24 of the UNIBILL RECORD, 20 days.

4. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Value code 13, with the amount paid is shown in value codes (Items 46-49). Occurrence code 33 and the first month of the 12-month period is shown in Items 28-32. In addition, the address of the ESRD-EGHP is shown in Item 34 or remarks (Item 94).

5. Determining amount of primary payer payment that applies to Medicare covered services

The provider indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount it paid toward Medicare covered services in value codes (items 46-49). Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49).

EXAMPLE: Total charges were $5,000. Medicare covered charges were $4,000. The ESRD-EGHP payment was $3,000. Since the provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$4,000}{\$5,000} \times \$3,000 = \$2,400$$

The provider shows $2,400 in value codes (Items 46-49).

6. Determining the amount of Medicare payment

The Medicare payment is the lower of:

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 minus the amount paid by the ESRD-EGHP for Medicare covered services;

or

o The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 minus any applicable deductible or coinsurance amount.

This is accomplished by applying the following formulas:

Per Diem Reimbursement - Covered days times per diem rate minus the larger of:

o Total Deductions (The sum of Items 60-61);

or

o Amount paid by ESRD-EGHP for Medicare covered services (amount shown in value codes, Items 46-49).

Periodic Interim Payment (PIP) - Covered days times the gross per diem as determined in §3683 minus the larger of:

o Total Deductions (The sum of Items 60-61);

or

o Amount paid by ESRD-EGHP for Medicare covered services (amount shown in value codes, Items 46-49).

Percentage of Charge - Total charges (sum of covered and noncovered) identified by revenue code 001 less any Medicare noncovered charges times the percentage of charges, minus the larger of:

o Total Deductions (The sum of Items 60-61);

or

o Amount paid by ESRD-EGHP for Medicare covered services (amount shown in value codes, Items 46-49).

EXAMPLE 1: Per Diem or PIP Reimbursement Method

Inpatient care was furnished for 8 covered days to a Medicare beneficiary whose ESRD-EGHP was primary payer. The covered charges were $4,000. The ESRD-EGHP paid $2,400 for Medicare covered services as determined in Item 5. No part of the Medicare inpatient deductible of $520 had been met previously. The Medicare interim reimbursement (without regard to deductible or coinsurance) at $450 a day (8 x $450) would be $3,600. As secondary payer Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $3,600-$2,400 = $1,200.

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the inpatient deductible: $3,600-$520 = $3,080.

Medicare pays $1,200. The provider cannot charge the beneficiary since the $520 inpatient deductible was satisfied by the ESRD-EGHP payment.

EXAMPLE 2: Percentage of Charge Method

Inpatient care was furnished to a Medicare beneficiary whose ESRD-EGHP was primary payer. The covered charges were $4,000. The ESRD-EGHP paid $2,400 for Medicare covered services as determined in Item 5. No part of the Medicare inpatient deductible of $520 had been met previously. The Medicare interim reimbursement without regard to deductible or coinsurance) at 90 percent of charges ($4,000 x 90 percent) would be $3,600. As secondary payer Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $3,600-$2,400 = $1,200.

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the inpatient deductible: $3,600-$520 = $3,080.

Medicare pays $1,200. The provider cannot charge the beneficiary since the $520 inpatient deductible was satisfied by the ESRD-EGHP payment.

EXAMPLE 3:

Same facts as in Example (2) above except the ESRD-EGHP payment for Medicare covered services is $300.

As secondary payer Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $3,600 - $300 = $3,300.

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the inpatient deductible: $3,600 - $520 = $3,080.

Medicare pays $3,080. The beneficiary's liability is $220 (the amount the provider can charge the beneficiary). The beneficiary's $520 inpatient deductible is satisfied: $300 by the ESRD-EGHP payment and $220 by the beneficiary.

EXAMPLE 4:

Same facts as in Example (2) except the deductible has previously been met, the beneficiary was hospitalized for 20 days and only coinsurance days are available.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $3,600 - $2,400 = $1,200.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable coinsurance: $3,600 - $2,600 (20 coinsurance days at $130 per day) = $1,000.

Medicare pays $1,000. Since the ESRD-EGHP payment ($2,400) is less than the coinsurance ($2,600), utilization is not reduced and coinsurance is determined in the usual manner. Therefore, the beneficiary's liability is $200 (the $2,600 coinsurance minus the EGHP payment of $2,400).

7. UNIBILL entries

Enter in field 22 of the UNIBILL RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in field 24 of the UNIBILL RECORD the covered days reported by the provider in Item 23. This figure is used to validate the Medicare days shown on the cost report.

Enter in field 39 of the UNIBILL RECORD value code 13 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount paid by the ESRD-EGHP for Medicare covered services that appears in value codes (Items 46-49). (For the PS&R report, record the primary payment amount minus the amount in "Total Deductions.)"

D. Part B Inpatient Services.--These provisions apply for ancillary services for individuals who have exhausted their Part A benefits. Handle billing as described in sections E and F below. If Part A benefits are exhausted during the inpatient stay, the Part B billing should not be prepared until the effect of the primary payment on Part A utilization is determined.

E. Outpatient Bills - Full Payment by ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined by the formula in subsection F3) equals or exceeds the provider's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the provider accepts, or is obligated to accept, the ESRD-EGHP payment as payment in full, and the provider knows the individual has already met his deductible, no bill is submitted. If an ESRD-EGHP payment equals or exceeds the composite rate (without regard to deductible or coinsurance) and the hospital-based renal dialysis facility knows the individual has already met his deductible, no bill is submitted. However, a bill is submitted to inform you of charges where the deductible may not yet be met. Although no payment can be made by Medicare, the expenses can be applied to the beneficiary's deductible. The provider completes the bill in the usual manner. In addition:

o The provider determines the charges as usual including those covered by the ESRD-EGHP's payment.

The provider enters the amount paid by the ESRD-EGHP for Medicare covered services in value codes (Items 46-49).

The provider enters occurrence code 33 and the first month of the 12 month period in Items 28-32.

The provider enters condition code 77 in Items 35-39 when it accepts, or is obligated to accept, the ESRD-EGHP payment as payment in full.

o Treat the charges shown in total charges as noncovered for reimbursement purposes.

Query to update the deductible but the bill need not be processed any further except to discontinue systems controls in internal operations. (The deductible should not be used for the PS&R report).

F. Outpatient Bills - Partial Payment by ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined by the formula in 3) is less than the provider's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the ESRD-EGHP payment as payment in full, or is less than the composite rate (without regard to deductible and coinsurance), process the bill in accordance with §3604 with the following modifications:

1. Determining covered charges

The provider shows in the covered charges column, Medicare covered charges, including those covered by the ESRD-EGHP's payment.

2. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Value code 13, with the amount paid is shown in value codes (Items 46-49). Occurrence code 33 and the first month of the 12-month period are shown in Items 28-32. In addition, the address of the ESRD-EGHP is shown in Item 34 or remarks (Item 94).

3. Determining amount of primary payer payment that applies to Medicare covered services

The provider indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount it paid toward Medicare covered services in value codes. Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). The provider must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE: Total charges were $110. Medicare covered charges were $90. The ESRD-EGHP payment was $88. Since the provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$90}{\$110} \times \$88 = \$72$$

The provider shows $72 in value codes (Items 46-49).

4. Determining the amount of Medicare payment

The Medicare payment is the lower of:

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 or the composite rate (without regard to deductible or coinsurance) minus the amount paid by the ESRD-EGHP for Medicare covered services;

or

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 or the composite rate (without regard to deductible or coinsurance) minus any applicable deductible or coinsurance amount.

That portion of the total charges equal to the ESRD-EGHP payment is credited toward any unmet deductible. Include this amount in any query to update the deductible.

NOTE: Examples 1 through 4 below are based upon percentage of billed charges.

EXAMPLE 1: ESRD-EGHP payment is less than unmet deductible

Outpatient services were furnished to a Medicare beneficiary for which the covered charges were $90. No part of the beneficiary's $75 Part B deductible had been met previously. The ESRD-EGHP paid $72 for Medicare covered services as determined in item 3. The Medicare interim reimbursement (without regard to deductible or coinsurance) for these services at 90 percent of charges (the provider's interim rate) would be $81. As secondary payer, Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $81-$72 = $9.

or

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81-$75-$3* = $3.

*The coinsurance is calculated as follows:

$90 charges - $75 deductible = $15 x 20 percent = $3 coinsurance.

Medicare pays $3. The beneficiary's liability is $6 ($3 of the deductible and the $3 coinsurance). The beneficiary's $75 deductible is satisfied: $72 by the ESRD-EGHP payment and $3 by the beneficiary. (For the PS&R, record $75 deductible and $3 coinsurance.)

EXAMPLE 2: ESRD-EGHP payment is more than unmet deductible

Same facts as in Example (1) except the ESRD-EGHP's payment for Medicare covered services is $80.

As secondary payer Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $81-$80 = $1.

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81-$75-$3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $1. The provider may not charge the beneficiary since the deductible and coinsurance were met by the ESRD-EGHP payment. (For the PS&R report, record $75 deductible, $3 coinsurance, and $2 primary payment).

best copy available

EXAMPLE 3: ESRD-EGHP payment equals unmet deductible

Same facts as in Example (1) except the ESRD-EGHP's payment for Medicare covered services is $75.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $81-$75 = $6.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible or coinsurance: $81-$75-$3*= $3.

*See Example (1) for coinsurance calculation.

Medicare pays $3. The provider may bill the beneficiary $3 for coinsurance. The $75 deductible is satisfied by the ESRD-EGHP payment. (For the PS&R report, record $75 deductible and $3 coinsurance.)

EXAMPLE 4: Deductible met prior to ESRD-EGHP payment

Same facts as in Example (1) except the deductible had been met previously.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $81-$72 = $9.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus any applicable deductible or coinsurance: $81-$18* = $63.

*The coinsurance is calculated as follows:

$90 charge x 20 percent = $18 coinsurance.

Medicare pays $9. The hospital may not charge the beneficiary since the coinsurance is paid by ESRD-EGHP payment. (For the PS&R report, record $18 coinsurance and $54 primary payment.)

NOTE: Examples 5 through 7 below are based upon the composite rate

EXAMPLE 5:

An individual received 8 dialysis treatments for which a hospital-based renal dialysis facility charged $160 per treatment for a total of $1,280. No part of the beneficiary's $75 Part B deductible had been met previously. The ESRD-EGHP paid $1,024 for Medicare covered services. The composite rate per dialysis treatment is $131 or $1,048 for 8 treatments. As secondary payer, Medicare pays the lower of:

o The composite rate (without regard to deductible or coinsurance) minus the EGHP payment: $1,048-$1,024 = $24.

o The composite rate (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $1,048-$75-$194.60* = $778.40.

*The coinsurance is calculated as follows:

$1,048 composite rate - $75 deductible = $973 x 20 percent = $194.60.

Medicare pays $24. The renal dialysis facility may not charge the beneficiary since the deductible and coinsurance were met by the ESRD-EGHP payment. (For the PS&R report, record $75 deductible, $194.60 coinsurance, and $754.40 primary payment.)

EXAMPLE 6:

An individual received 12 peritoneal dialysis treatments over a 1 month period for which an independent facility charged $150 per treatment. The facility bills on a monthly basis and its per treatment composite rate is $130 ($1,560 for 12 treatments). The facility also billed the individual separately billable parenteral items for which it charged $45. The Medicare reasonable charge for these services is $36. The beneficiary's $75 Part B deductible was previously met. The ESRD-EGHP paid 80 percent of the facility's charges, or $1,476 for Medicare covered services. As secondary payer, Medicare pays the lower of:

o The composite rate plus the Medicare reasonable charge for the separately billable services (without regard to deductible or coinsurance) minus the ESRD-EGHP payment: $1,560 + $36 = 1,596 - $1,476 = $120.

o The composite rate plus the Medicare reasonable charge for the separately billable services (without regard to deductible or coinsurance) minus the applicable coinsurance: $1,560 + $36 - $319.20* = $1,276.80.

* The coinsurance is calculated as follows:

$1,596 x 20 percent = $319.20

Medicare pays $120. The facility may not charge the beneficiary since the coinsurance was met by the ESRD-EGHP payment. (For the PS&R report, record $319.20 coinsurance and $1,156.80 primary payment.)

5. UNIBILL entries

Enter in field 30 of the UNIBILL RECORD value code 13 to identify the primary payer.

Enter in field 31 of the UNIBILL RECORD the amount paid by the ESRD-EGHP for Medicare covered services that appears in value codes (Items 46-49).

G. Christian Science Sanatorium Bills - Full Payment by ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined by the formula in subsection H5) equals or exceeds the sanatorium's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the sanatorium accepts, or is obligated to accept, the ESRD-EGHP payment as payment in full, no payment is due from Medicare and no utilization will be charged to the beneficiary. However, the sanatorium submits a bill for determining the benefit period. In addition, ESRD-EGHP payments can be used to satisfy unmet deductibles. Process the bill in accordance with §3604 with the following modifications:

o The sanatorium completes the total and noncovered charges columns as if there had been no other payment.

The sanatorium does not complete coinsurance (no days are charged). However, inpatient deductible and total deductions are completed when applicable. (This data is for the beneficiary's utilization records only and is not to be used for the PS&R report.)

The sanatorium shows total covered and noncovered days in the usual manner. Count days paid by the ESRD-EGHP as covered days.

The sanatorium enters the amount paid by the ESRD-EGHP for Medicare covered services in value codes (Items 46-49).

The sanatorium enters code 33 and the first month of the 12 month period in Items 28-32.

The sanatorium enters condition code 77 in Items 35-39 when it accepts, or is obligated to accept, the ESRD-EGHP payment as payment in full.

o Do not complete the nonpayment code.

Enter in field 22 of the UNIBILL RECORD the days you determine to be charged to the beneficiary's Medicare utilization record. This figure should be zero.

Enter in field 24 of the UNIBILL RECORD zero days.

Enter in field 39 of the UNIBILL RECORD value code 13 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount Medicare would have paid in the absence of the ESRD-EGHP's payment. (Do not record this amount on the PS&R report.)

Do not record days or charges on the PS&R report.

Submit the bill to HCFA in the format described in §3876. CO uses data reported in inpatient deductible to update the deductible. (This data is not to be used for the PS&R report).

H. Christian Science Sanatorium Bills - Partial Payment by ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined by the formula in 5) is less than the sanatorium's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the sanatorium does not accept, and is not obligated to accept, the ESRD-EGHP payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining covered and noncovered charges

The sanatorium completes the total and noncovered charges columns as if there had been no other payment.

2. Determining covered and noncovered days

The sanatorium shows total covered and noncovered days in the usual manner. Days paid by the ESRD-EGHP are counted as covered days.

Calculate the days to be charged to the beneficiary as determined in 3 and report this result in the appropriate field of the UNIBILL RECORD as described in 7.

3. Determining utilization and coinsurance

Where an ESRD-EGHP pays an amount for Medicare covered services that is equal to, or less than, the deductible and coinsurance that would apply if Medicare was the primary payer, utilization is not reduced. Therefore, coinsurance is calculated in the usual manner. (See C6, example 4.)

Where an ESRD-EGHP pays an amount for Medicare covered services that is more than the deductible and coinsurance that would apply if Medicare was the primary payer, follow the procedures below to determine utilization and coinsurance.

Where the stay involves coinsurance days, determine utilization chargeable to the beneficiary if the sanatorium cannot. Complete Items 25 and 61 (coinsurance) accordingly. No adjustment to Item 23 (covered days) is made based upon this determination. The sanatorium completes Item 23 in the usual manner.

Charge utilization as follows:

o Subtract the ESRD-EGHP payment that applies to Medicare covered services as determined under subsection 5 from the Medicare interim reimbursement for the stay (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

- Divide this amount by the amount Medicare would have paid as primary payer (i.e., the Medicare interim reimbursement for the stay reduced by deductible and coinsurance).

- Multiply the percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more. (See §3681C3 for utilization examples.)

Charge coinsurance days as follows:

- If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed.

- If the days resulting from utilization the calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the sanatorium performs the utilization calculation above, perform the same calculation to verify that Items 25 and 61 (coinsurance) have been completed correctly. Advise the sanatorium of any discrepancies.

EXAMPLE 1:

A beneficiary has 17 full days available at the time of admission. The sanatorium inpatient stay was 20 days. The sanatorium bills 20 days in Item 27 (covered days) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed. In the absence of another insurer's payment, 3 days would have been billed in Item 25 (coinsurance).

Enter in field 24 of the UNIBILL RECORD, 20 days.

EXAMPLE 2:

A beneficiary has 30 coinsurance days available at the time of admission. The sanatorium inpatient stay was 20 days. The sanatorium bills 20 days in Item 27 (covered days) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed. In the absence of another insurer's payment, 20 days would have been billed in Item 25 (coinsurance).

Enter in field 25 or 26 of the UNIBILL RECORD, 10 days. In addition, enter in field 24 of the UNIBILL RECORD, 20 days.

4. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Value code 13, with the amount paid are shown in value codes (Items 46-49). Occurrence code 33 and the first month of the 12-month period is shown in Items 28-32. In addition, the address of the ESRD-EGHP is shown in Item 34 or remarks (Item 94).

5. Determining amount of primary payer payment that applies to Medicare covered services

The sanatorium indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount it paid toward Medicare covered services in value codes (Items 46-49). Where the sanatorium cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49).

EXAMPLE: Total charges were $5,000. Medicare covered charges were $4,000. The ESRD-EGHP payment was $3,000. Since the sanatorium cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$4,000}{\$5,000} \times \$3,000 = \$2,400$$

The sanatorium shows $2,400 in value codes (Items 46-49).

6. Determining the amount of Medicare payment

The Medicare payment is the lower of:

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 minus the amount paid by the ESRD-EGHP for Medicare covered services;

or

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 minus any applicable deductible or coinsurance amount.

This is accomplished by the formulas in subsection C6.

For examples, see subsection C6.

7. UNIBILL entries

Enter in field 22 of the UNIBILL RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in field 24 of the UNIBILL RECORD the covered days reported by the sanatorium in Item 23. This figure is used to validate the Medicare days shown on the cost report.

Enter in field 39 of the UNIBILL RECORD value code 13 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount paid by the ESRD-EGHP for Medicare covered services that appears in value codes (Items 46-49). (For the PS&R, record the primary payment amount minus the amount in "Total Deductions").

I. HHA Bills - Full Payment by ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined by the formula in subsection J3) equals or exceeds the HHA's charges for those services or the current Medicare interim reimbursement amount or the HHA accepts, or is obligated to accept, the ESRD-EGHP payment as payment in full, no payment is due from Medicare. The HHA does not submit a bill.

J. HHA Bills - Partial Payment by ESRD-EGHP.--If an ESRD-EGHP payment for Medicare covered services (as determined by the formula in 3) is less than the HHA's charges for those services and the current Medicare interim reimbursement amount and the HHA does not accept, and is not obligated to accept, the ESRD-EGHP payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining charges and visits

The HHA shows in the charges and visits columns of the bill, Medicare covered charges and visits, including those covered by the ESRD-EGHP payment.

2. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Value code 13, with the amount paid are shown in value codes (Items 46-49). Occurrence code 33 and the first month of the 12-month period are in Items 28-32. In addition, the address of the ESRD-EGHP is shown in Item 34 or remarks (Item 94).

3. Determining amount of primary payer payment that applies to Medicare covered services

The HHA indicates the primary payer's allocation of its payment between covered and noncovered Medicare services, by entering the amount it paid toward Medicare covered services in value codes (Items 46-49). Where the HHA cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). The HHA must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE: Total charges were $550. Medicare covered charges were $500. The ESRD-EGHP payment was $330. Since the HHA cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

The HHA shows $300 in value codes (Items 46-49).

4. Determining the amount of Medicare payment.

Subtract the payment by the ESRD-EGHP for Medicare covered services from the current Medicare interim reimbursement amount.

EXAMPLE 1: Per Visit Method

A beneficiary received 10 visits for which the HHA's current Medicare interim reimbursement amount at $50 per visit interim rate was $500. The ESRD-EGHP paid $300 for Medicare covered services as determined in Item 3. As secondary payer Medicare pays:

- o The Medicare interim reimbursement minus the ESRD-EGHP payment for Medicare covered services: $500-$300 = $200. Medicare pays $200.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits for which the HHA charged $50 per visit. The Medicare interim rate was 90 percent ($500 x 90 percent) which equaled $450. The ESRD-EGHP paid $300 for Medicare services as determined in Item 3. As secondary payer Medicare pays:

- o The Medicare interim reimbursement minus the ESRD-EGHP payment for Medicare covered services: $450-$300 = $150. Medicare pays $150.

5. UNIBILL entries

Enter in field 30 of the UNIBILL RECORD value code 13 to identify the primary payer.

Enter in field 31 of the UNIBILL RECORD the amount paid by the ESRD-EGHP for Medicare covered services that appear in value codes (Items 46-49).

K. ESRD-EGHP Denies Claim for Primary Benefits.--Pay primary Medicare benefits (if the beneficiary is not appealing the ESRD-EGHP denial) when an ESRD-EGHP denies a claim for primary benefits because:

o The beneficiary is not in a 12-month coordination period as defined in §§3490.5 and 3490.6;
o The beneficiary is not entitled to benefits under the plan;
o Benefits under the ESRD-EGHP are exhausted for the services involved; or
o The services are not covered by the ESRD-EGHP.

Where an ESRD-EGHP denies payment for any of these reasons, the provider shows occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, it provides the reason for the denial in Remarks (Item 94). Process these bills following normal billing procedures.

If an ESRD-EGHP denies a claim for primary benefits on the grounds that the services are not covered by the plan and you have reason to believe that the plan does cover the services or that the plan offers only secondary coverage of services covered by Medicare, do not pay Medicare benefits (primary or conditional). Deny the claim. The provider enters occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, it enters the annotation "Plan indicates services are not covered (and reason)" or "Plan offers only secondary coverage of services covered by Medicare" as appropriate in Remarks (Item 94). (See §§3490.4F and 3490.4G6 for action to take and §3722.4 for denial language.)

L. Conditional Payments.--If the beneficiary has appealed or is protesting the ESRD-EGHP's denial of the claim for any reason other than that it offers only secondary coverage of services covered by Medicare or because the time limit for filing the claim has expired (whether appealed or not) conditional primary Medicare benefits may be paid.

The provider requests conditional primary payment by entering value code 13 with zero value in Items (46-49) to indicate the type of other insurer and that conditional payment is requested. It also enters occurrence code 24 (insurance denied) and date of denial by the ESRD-EGHP in Items 28-32 (occurrence codes). The identity of the ESRD-EGHP is on line A of Item 57, the identifying information about the insured is on line A of Items 65-75, and the address of the ESRD-EGHP is in Item 34 or Remarks (Item 94). In addition, the annotation "Beneficiary has appealed or is protesting ESRD-EGHP denial" or "Time limit for filing the claim with the ESRD-EGHP has expired" as appropriate appears in Remarks (Item 94). (See §3490.4E for actions to take when making conditional primary payments.)

Process these bills following normal billing procedures. In addition, enter in the appropriate field of the UNIBILL RECORD value code 13 and zero value to indicate that a conditional payment was made. Show this code and zero value in fields 39 and 40 for inpatient bills, and in fields 30 and 31 for outpatient, HHA and other bills.

3682. BILLING PROCEDURES FOR WHERE MEDICARE BENEFITS ARE SECONDARY TO GROUP HEALTH PLANS FOR EMPLOYED BENEFICIARIES/SPOUSES AND THE DISABLED

A. General.—Medicare benefits are secondary to benefits payable under EGHPs for employed individuals age 65 or over and the spouses age 65 or over of employed individuals of any age. For items and services furnished from January 1, 1985 - April 30, 1986, Medicare was secondary payer for employed individuals age 65-69 and spouses age 65-69 of employed individuals of any age through 69. For items and services furnished from January 1, 1983 - December 31, 1984, Medicare was secondary payer for employed individuals age 65-69 and their spouses age 65-69. For an explanation of these provisions see §§3491-3491.18.

Effective for items and services provided on or after January 1, 1987 and before January 1, 1992, Medicare benefits are secondary to benefits payable under large group health plans (LGHPs), i.e., plans that have at least one employer of 100 or more employees for disabled beneficiaries under age 65. When this provision applies, providers enter value code 43 and the amount paid by the LGHP for Medicare covered services in Items 46-49. Process these bills as described below. This provision does not apply to beneficiaries entitled to benefits solely on the basis of ESRD.

NOTE: Whenever the term EGHP appears in this section, and in §§3683, 3685, 3688, 3694, and 3695, it applies to both the working aged and the disabled.

Payment made by the EGHP can be used to satisfy unmet deductibles and the individual's coinsurance. However, the portion of the stay paid by the EGHP is not charged to the beneficiary's Medicare utilization record.

Where Medicare is determined to be the primary payer, Medicare is shown on line A of Item 57. Where Medicare is secondary, Medicare is shown on line B. All bills where Medicare is not the primary payer because of EGHP coverage are prepared in accordance with the following instructions. In applying the guidelines, it may be necessary to determine the current Medicare interim reimbursement amount (without regard to deductible or coinsurance). See §3683 to determine this amount.

When processing current claims in which you are first aware of EGHP coverage, consider the possibility of prior incorrect payments. See §3491.6 if such a prior claim is identified.

B. Inpatient Bills - Full Payment by EGHP.—If an EGHP payment for Medicare covered services (as determined by the formula in subsection C5) equals or exceeds the provider's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the provider accepts, or is obligated to accept, the EGHP payment as payment in full, no payment is due from Medicare and no utilization charged to the beneficiary. However, the provider submits a bill for determining the benefit period. In addition, EGHP payments can be used to satisfy unmet deductibles. Process the bill in accordance with §3604 with the following modifications:

- The provider completes the total and noncovered charges columns as if there had been no other payment.

Where blood is involved, the provider completes the blood items. (This data is for the beneficiary's utilization records only and is not to be used for the PS&R report.)

The provider does not complete coinsurance (no days are charged). However, inpatient deductible and total deductions are completed when applicable. (This data is for the beneficiary's utilization records only and is not to be used for the PS&R report.)

The provider shows total covered and noncovered days in the usual manner. Count days paid by the EGHP as covered days.

The provider enters the amount paid by the EGHP for Medicare covered services in value codes (Items 46-49).

The provider enters condition code 77 in Items 35-39 when it accepts, or is obligated to accept, the EGHP payment as payment in full.

- Do not complete the nonpayment code.

Enter in field 22 of the UNIBILL RECORD the days you determine to be charged to the beneficiary's Medicare utilization record. This figure should be zero.

Enter in field 24 of the UNIBILL RECORD zero days.

Enter in field 39 of the UNIBILL RECORD value code 12 or 43 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount Medicare would have paid in the absence of the EGHP's payment. (Do not record this amount on the PS&R report.)

Do not record days or charges on the PS&R report.

Submit the bill to HCFA in the format described in §3876. CO uses data reported in the blood deductible and inpatient deductible items to update deductibles. (This data is not to be used for the PS&R report.)

C. Inpatient Bills - Partial Payment by EGHP.--If an EGHP payment for Medicare covered services (as determined by the formula in 5) is less than the provider's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the EGHP payment as payment in full, process the bill in accordance with §3604 with the following modifications:

- o Determining covered and noncovered charges

The provider completes the total and noncovered charges columns as if there had been no other payment.

- o Determining covered and noncovered days

The provider shows total covered and noncovered days in the usual manner. Count days paid by the EGHP as covered days.

Calculate the days to be charged to the beneficiary as determined in 3 below and report this result in the appropriate field of the UNIBILL RECORD as described in 7 below.

3. Determining utilization and coinsurance

Where an EGHP pays an amount for Medicare covered services that is equal to, or less than, the deductible and coinsurance that would apply if Medicare was the primary payer, utilization is not reduced. Therefore, coinsurance is calculated in the usual manner. (See C6, example 4.)

Where an EGHP pays an amount for Medicare covered services that is more than the deductible and coinsurance that would apply if Medicare was primary payer, follow the procedures below to determine utilization and coinsurance.

Where the stay involves coinsurance days, determine utilization chargeable to the beneficiary if the provider cannot. Complete Items 25 and 61 (coinsurance) accordingly. No adjustment to Item 23 (covered days) is made based on this determination. The provider completes Item 23 or 28 in the usual manner.

Charge utilization as follows:

- o Subtract the EGHP payment that applies to Medicare covered services as determined under subsection 5 from the Medicare interim reimbursement for the stay (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

- o Divide this amount by the amount Medicare would have paid as primary payer (i.e., the Medicare interim reimbursement for the stay reduced by deductible and coinsurance).

- o Multiply this percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more.

EXAMPLE I: Deductible Involved

An individual was hospitalized 15 days, for which the total charges were $5,000. The EGHP paid $2,400 for Medicare covered services. No part of the Medicare inpatient deductible of $520 had been met. The current Medicare interim reimbursement amount (without regard to deductible or coinsurance) for the services in absence of the EGHP payment would have been $3,600. This amount minus the EGHP payment is $1,200 ($3,600 - $2,400). Medicare would have paid $3,080 as primary payer ($3,600 - $520). Calculate the beneficiary's utilization as follows: $1,200 divided by $3,080 = .389 x 15 days = 5.84 or 6 days when rounded.

EXAMPLE II: Coinsurance Involved

An individual was hospitalized for 20 days (all of which are LTR days) for which total charges were $12,000. The EGHP paid $6,000 for Medicare covered services. The applicable coinsurance amount was $5,200. The current Medicare interim reimbursement amount (without regard to deductible or coinsurance) for the services in absence of the EGHP payment would have been $10,000. The Medicare secondary payment amount is $4,000 (the current Medicare interim reimbursement amount of $10,000 minus the EGHP payment of $6,000). Medicare would have paid $4,800 as primary payer ($10,000 - $5,200). Calculate the beneficiary's utilization as follows: $4,000 divided by $4,800 = .833 x 20 days = 16.6 or 17 days when rounded. If the EGHP payment in this example had been $5,200 or less, utilization would not be reduced. The beneficiary would have been charged with 20 days utilization.

Use this formula even when the EGHP only pays for a specified number of days of a stay because of a payment limitation under the plan on the number of benefit days available. For example, a provider furnished 20 days of inpatient care. An EGHP paid all of the charges for the first 10 days. These charges were $4,500. No part of the Medicare inpatient deductible of $520 had been met. The current Medicare interim reimbursement (without regard to deductible or coinsurance) which Medicare would have paid for the 20 day stay in the absence of EGHP coverage was $7,000. That amount minus the EGHP payment was $2,500 ($7,000 - $4,500). Medicare would have paid $6,480 as primary payer ($7,000 - $520). The utilization charged to the beneficiary is calculated as follows: $2,500 divided by $6,480 = .385 X 20 days = 7.71 days or 8 days when rounded.

Charge coinsurance days as follows:

- o If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed.

- o If the days resulting from the utilization calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the provider performs the utilization calculation above, perform the same calculation to verify that Items 25 and 61 (coinsurance) have been completed correctly. Advise the provider of any discrepancies.

EXAMPLE 1:

A beneficiary has 17 full days available at the time of admission. The hospital stay was 20 days. The provider bills 20 days in covered days as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed. In the absence of another insurer's payment, 3 days would have been billed in Item 25 (coinsurance).

Enter in field 24 of the UNIBILL RECORD, 20 days.

EXAMPLE 2:

A beneficiary has 30 coinsurance days available at the time of admission. The hospital stay was 20 days. The provider bills 20 days in covered days as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed. In the absence of another insurer's payment, 20 days would have been billed in Item 25 (coinsurance).

Enter in field 25 or 26 of the UNIBILL RECORD, 10 days. In addition, enter in field 24 of the UNIBILL RECORD, 20 days.

4. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Value code 12 or 43, with the amount paid are shown in value codes (Items 46-49). The address of the EGHP is shown in Item 34 or remarks (Item 94).

5. Determining amount of primary payer payment that applies to Medicare covered services

The provider indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49).

EXAMPLE: Total charges were $5,000. Medicare covered charges were $4,000. The EGHP payment was $3,000. Since the provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$4,000}{\$5,000} \times \$3,000 = \$2,400$$

The provider shows $2,400 in value codes (Items 46-49).

6. Determining the amount of Medicare payment

The amount of Medicare payment is the lower of:

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 minus the amount paid by the EGHP for Medicare covered services;

or

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 minus any applicable deductible or coinsurance amount.

This is accomplished by applying the following formulas:

Per Diem Reimbursement - Covered days times per diem rate minus the larger of:

- Total Deductions (the sum of Items 60-61);

or

- Amount paid by EGHP for Medicare covered services (amount shown in value codes, Items 46-49).

Periodic Interim Payment (PIP) - Covered days times the gross per diem as determined in §3683 minus the larger of:

- Total Deductions (the sum of Items 60-61);

or

- Amount paid by EGHP for Medicare covered services (amount shown in value codes, Items 46-49).

Percentage of Charge - Total charges (sum of covered and noncovered) identified by revenue code 001 less any Medicare noncovered charges times the percentage of charges, minus the larger of:

- Total Deductions (the sum of Items 60-61);

or

- Amount paid by EGHP for Medicare covered services (amount shown in value codes, Items 46-49).

EXAMPLE 1: Per Diem or PIP Reimbursement Method

Inpatient care was furnished for 8 covered days to a Medicare beneficiary whose EGHP was primary payer. The covered charges were $4,000. The EGHP paid $2,400 for Medicare covered services as determined in Item 5. No part of the Medicare inpatient deductible of $520 had been met previously. The Medicare interim reimbursement (without regard to deductible or coinsurance) at $450 a day (8 x $450) would be $3,600. As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $3,600-$2,400 = $1,200.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the inpatient deductible: $3,600-$520 = $3,080.

Medicare pays $1,200. The provider cannot charge the beneficiary since the $520 inpatient deductible was satisfied by the EGHP payment.

EXAMPLE 2: Percentage of Charge Method

Inpatient care was furnished to a Medicare beneficiary whose EGHP was primary payer. The covered charges were $4,000. The EGHP paid $2,400 for Medicare covered services as determined in Item 5. No part of the Medicare inpatient deductible of $520 had been met previously. The Medicare interim reimbursement (without regard to deductible or coinsurance) at 90 percent of charges ($4,000 x 90 percent) would be $3,600. As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $3,600-$2,400 = $1,200.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the inpatient deductible: $3,600-$520 = $3,080.

Medicare pays $1,200. The provider cannot charge the beneficiary since the $520 inpatient deductible was satisfied by the EGHP payment.

EXAMPLE 3:

Same facts as in Example (2) above except the EGHP payment for Medicare covered services is $300.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $3,600 - $300 = $3,300.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the inpatient deductible: $3,600 - $520 = $3,080.

Medicare pays $3,080. The beneficiary's liability is $220 (the amount the provider can charge the beneficiary). The beneficiary's $520 inpatient deductible is satisfied: $300 by the EGHP payment and $220 by the beneficiary.

EXAMPLE 4:

Same facts as in Example (2) except the deductible has previously been met, the beneficiary was hospitalized for 20 days and only coinsurance days are available.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $3,600 - $2,400 = $1,200.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable coinsurance: $3,600 - $2,600 (20 coinsurance days at $130 per day) = $1,000.

Medicare pays $1,000. Since the EGHP payment ($2,400) is less than the coinsurance ($2,600), utilization is not reduced and coinsurance is determined in the usual manner. Therefore, the beneficiary's liability is $200 (the $2,600 coinsurance minus the EGHP payment of $2,400).

7. UNIBILL entries

Enter in field 22 of the UNIBILL RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in field 24 of the UNIBILL RECORD the covered days reported by the provider in Item 23. This figure is used to validate the Medicare days shown in the cost report.

Enter in field 39 of the UNIBILL RECORD value code 12 or 43 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount paid by the EGHP for Medicare covered services that appears in value codes (Items 46-49). (For the PS&R report, record the primary payment amount minus the amount in "Total Deductions".)

D. Part B Inpatient Services.—These provisions apply for ancillary services for individuals who have exhausted their Part A benefits. Handle billing as described in subsections E and F. If Part A benefits are exhausted during the inpatient stay, the Part B billing should not be prepared until the effect of the primary payment on Part A utilization is determined.

E. Outpatient Bills - Full Payment by EGHP.—If an EGHP payment for Medicare covered services (as determined by the formula in subsection F3) equals or exceeds the provider's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) or the provider accepts, or is obligated to accept, the EGHP payment as payment in full, and the provider knows the individual has already met his deductible, no bill is submitted. However, a bill is submitted to inform you of charges where the deductible may not yet be met. Although no payment can be made by Medicare, the expenses can be applied to the beneficiary's deductible. The provider completes the bill in the usual manner. In addition:

o The provider determines the charges as usual, including those covered by the EGHP's payment.

The provider enters the amount paid by the EGHP for Medicare covered services in value codes (Items 46-49).

The provider enters condition code 77 in Items 35-39 when it accepts, or is obligated to accept, the EGHP payment as payment in full.

o Treat the charges shown in total charges as noncovered for reimbursement purposes.

Query to update the deductible but the bill need not be processed any further except to discontinue systems controls in internal operations. (The deductible should not be used for the PS&R report.)

F. Outpatient Bills - Partial Payment by EGHP.—If an EGHP payment for Medicare covered services (as determined by the formula in 3) is less than the provider's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible or coinsurance) and the provider does not accept, and is not obligated to accept, the EGHP payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining covered charges

The provider shows in the covered charges column, Medicare covered charges, including those covered by the EGHP's payment.

2. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Value code 12 or 43, with the amount paid are shown in value codes (Items 46-49), and the address of the EGHP is shown in Item 34 or remarks (Item 94).

3. Determining amount of primary payer payment that applies to Medicare covered services

The provider indicates the primary payer's allocation of its payment between covered and noncovered Medicare services, by entering the amount it paid toward Medicare covered services in value codes (Items 46-49). Where the provider cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). The provider must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE:

Total charges were $110. Medicare covered charges were $90. The EGHP payment was $88. Since the provider cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$90}{\$110} \times \$88 = \$72$$

The provider shows $72 in value codes (Items 46-49).

4. Determining the amount of Medicare payment

The Medicare payment is the lower of:

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 minus the amount paid by the EGHP for Medicare covered services;

or

- The current Medicare interim reimbursement (without regard to deductible or coinsurance) per §3683 minus any applicable deductible or coinsurance amount.

That portion of the total charges equal to the EGHP payment is credited toward any unmet deductible. Include this amount in any query to update the deductible.

EXAMPLE 1: EGHP payment is less than unmet deductible

Outpatient services were furnished to a Medicare beneficiary for which covered charges were $90. No part of the beneficiary's $75 Part B deductible had been met previously. The EGHP paid $72 for Medicare covered services as determined in Item 3 above. The Medicare interim reimbursement (without regard to deductible or coinsurance) for these services at 90 percent of charges (the provider's interim rate) would be $81. As secondary payer, Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81-$72 = $9.

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81-$75-$3* = $3.

*The coinsurance is calculated as follows:

o $90 charges - $75 deductible = $15 x 20 percent = $3 coinsurance.

Medicare pays $3. The beneficiary's liability is $6 ($3 of the deductible and the $3 coinsurance). The beneficiary's $75 deductible is satisfied: $72 by the EGHP payment and $3 by the beneficiary. (For the PS&R, record $75 deductible and $3 coinsurance.)

EXAMPLE 2: EGHP payment is more than unmet deductible

Same facts as in Example (1) except the EGHP's payment for Medicare covered services is $80.

As secondary payer Medicare pays the lower of:

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: $81-$80 = $1.

o The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: $81-$75-$3* = $3.

*See Example (1) for coinsurance calculation.

Medicare pays $1. The provider may not charge the beneficiary since the deductible and coinsurance were met by the EGHP payment. (For the PS&R, record $75 deductible, $3 coinsurance, and $2 primary payment.)

EXAMPLE 3: EGHP payment equals unmet deductible

Same facts as in Example (1) except the EGHP's payment for Medicare covered services is $75.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: \$81-\$75 = \$6.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: \$81-\$75-\$3* = \$3.

*See Example (1) for coinsurance calculation.

Medicare pays \$3. The provider may bill the beneficiary \$3 for coinsurance. The \$75 deductible is satisfied by the EGHP payment. (For the PS&R report, record \$75 deductible and \$3 coinsurance.)

EXAMPLE 4: Deductible met prior to EGHP payment

Same facts as in Example (1) except the deductible has been met previously.

As secondary payer Medicare pays the lower of:

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the EGHP payment: \$81-\$72 = \$9.

- The Medicare interim reimbursement (without regard to deductible or coinsurance) minus the applicable deductible and coinsurance: \$81-\$18* = \$63.

*The coinsurance is calculated as follows:

\$90 charges x 20 percent = \$18 coinsurance.

Medicare pays \$9. The hospital may not charge the beneficiary since the coinsurance is paid by the EGHP payment. (For the PS&R report, record \$18 coinsurance and \$54 primary payment.)

5. UNIBILL entries

Enter in field 30 of the UNIBILL RECORD value code 12 or 43 to identify the primary payer.

Enter in field 31 of the UNIBILL RECORD the amount paid by the EGHP for Medicare covered services that appears in value codes (Items 46-49).

G. Christian Science Sanatorium Bills - Full Payment by EGHP.--If an EGHP payment for Medicare covered services (as determined by the formula in subsection H5) equals or exceeds the sanatorium's charges for those services or the current Medicare interim reimbursement amount (without regard to deductible and coinsurance) or the sanatorium accepts, or is obligated to accept, the EGHP payment as payment in full, no payment is due from Medicare and no utilization will be charged to the beneficiary. However, the sanatorium submits a bill for determining the benefit period. In addition, EGHP payments can be used to satisfy unmet deductibles. Process the bill in accordance with §3604 with the following modifications:

- The sanatorium completes the total and noncovered charges columns as if there had been no other payment.

The sanatorium does not complete coinsurance (no days are charged). However, inpatient deductible and total deductions are completed when applicable. (This data is for the beneficiary's utilization records only and is not to be used for the PS&R report.)

The sanatorium shows total covered and noncovered days in the usual manner. Count days paid by the EGHP as covered days.

The sanatorium enters the amount paid by the EGHP for Medicare covered services in value codes (Items 46-49).

The sanatorium enters condition code 77 in Items 35-39 when it accepts, or is obligated to accept, the EGPH payment as payment in full.

- Do not complete the nonpayment code.

Enter in field 22 of the UNIBILL RECORD the days you determine to be charged to the beneficiary's Medicare utilization record. This figure should be zero.

Enter in field 24 of the UNIBILL RECORD zero days.

Enter in field 39 of the UNIBILL RECORD value code 12 or 43 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount Medicare would have paid in the absence of the EGHP's payment. (Do not record this amount on the PS&R report.)

Do not record days or charges on the PS&R report.

Submit the bill to HCFA in the format described in §3876. CO uses data reported in inpatient deductible to update the deductible. (This data is not to be used for the PS&R report.)

H. Christian Science Sanatorium Bills - Partial Payment by EGHP.—If an EGHP payment for Medicare covered services (as determined by the formula in 5) is less than the sanatorium's charges for those services and the current Medicare interim reimbursement amount (without regard to deductible and coinsurance) and the sanatorium does not accept, and is not obligated to accept, the EGHP payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining covered and noncovered charges

The sanatorium completes the total and noncovered charges columns as if there had been no other payment.

2. Determining covered and noncovered days

The sanatorium shows total covered and noncovered days in the usual manner. Count days paid by the EGHP as covered days.

Calculate the days to be charged to the beneficiary as determined in 3 below and report this result in the appropriate field of the UNIBILL RECORD as described in 7 below.

3. Determining utilization and coinsurance

Where an EGHP pays an amount for Medicare covered services that is equal to, or less than, the deductible and coinsurance that would apply if Medicare was the primary payer, utilization is not reduced. Therefore, coinsurance is calculated in the usual manner. (See subsection C6, example 4.)

Where an EGHP pays an amount for Medicare covered services that is more than the deductible and coinsurance that would apply if Medicare was the primary payer, follow the procedures below to determine utilization and coinsurance.

Where the stay involves coinsurance days, determine utilization chargeable to the beneficiary, if the sanatorium cannot. Complete Items 25 and 61 (coinsurance) accordingly. No adjustment to Item 23 (covered days) is made based upon this determination. The sanatorium completes Item 23 in the usual manner.

Charge utilization as follows:

- o Subtract the EGHP payment that applies to Medicare covered services as determined under 5 from the Medicare interim reimbursement for the stay (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

- o Divide this amount by the amount in Medicare would have paid as primary payer (i.e., the Medicare interim reimbursement for the stay reduced by deductible and coinsurance.)

- o Multiply the percentage by the number of covered days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more. (See §3682C3 for utilization examples.)

Charge coinsurance days as follows:

- o If the days resulting from the utilization calculation are fewer than the full days available for the stay, no coinsurance days are billed.

- o If the days resulting from the utilization calculation are greater than the full days available for the stay, coinsurance days are billed for the excess days.

Where the sanatorium performs the utilization calculation above, perform the same calculation to verify that Items 25 and 51 (coinsurance) have been completed correctly. Advise the sanatorium of any discrepancies.

EXAMPLE 1:

A beneficiary has 17 full days available at the time of admission. The sanatorium inpatient stay was 20 days. The sanatorium bills 20 days in Item 27 (covered days) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, no coinsurance days are billed. In the absence of another insurer's payment, 3 days would have been billed in Item 25 (coinsurance).

Enter in field 24 of the UNIBILL RECORD, 20 days.

EXAMPLE 2:

A beneficiary has 30 coinsurance days available at the time of admission. The sanatorium inpatient stay was 20 days. The sanatorium bills 20 days in Item 27 (covered days) as if there were no other payer involved. After performing the calculation to determine utilization chargeable, it is determined that the beneficiary can be charged with 10 days. Therefore, only 10 coinsurance days are billed. In the absence of another insurer's payment 20 days would have been billed in Item 25 (coinsurance).

Enter in field 25 or 26 of the UNIBILL RECORD, 10 days. In addition, enter in field 24 of the UNIBILL RECORD, 20 days.

4. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Value code 12 or 43, with the amount paid are shown in value codes (Items 46-49). The address of the EGHP is shown in Item 34 or remarks (Items 94).

5. Determining amount of primary payer payment that applies to Medicare covered services

The sanatorium indicates the primary payer's allocation of its payment between covered and noncovered services, by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the sanatorium cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49).

EXAMPLE: Total charges were $5,000. Medicare covered charges were $4,000. The EGHP payment was $3,000. Since the sanatorium cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$4,000}{\$5,000} \times \$3,000 = \$2,400$$

The sanatorium shows $2,400 in value codes (Items 46-49).

6. Determining the amount of Medicare payment

The Medicare payment is the lower of:

o The current Medicare interim reimbursement (without regard to deductible and coinsurance amounts) per §3683 minus the amount paid by the EGHP for Medicare covered services;

or

o The current Medicare interim reimbursement (without regard to deductible and coinsurance) per §3683 minus any applicable deductible and coinsurance amount.

This is accomplished by applying the formulas in subsection C6.

For examples, see subsection C6.

7. UNIBILL entries

Enter in field 22 of the UNIBILL RECORD the days to be charged to the beneficiary's Medicare utilization record as determined in 3.

Enter in field 24 of the UNIBILL RECORD the covered days reported by the sanatorium in Item 23. This figure is used to validate the Medicare days shown on the cost report.

Enter in field 39 of the UNIBILL RECORD value code 12 or 43 to identify the primary payer.

Enter in field 40 of the UNIBILL RECORD the amount paid by the EGHP for Medicare covered services that appears in value codes (Items 46-49). (For the PS&R, record the primary payment amount minus the amount in "Total Deductions.")

I. HHA Bills - Full Payment by EGHP.—If the EGHP payment for Medicare covered services (as determined by the formula in subsection J3) equals or exceeds the HHA's charges for those services or the current Medicare interim reimbursement amount or the HHA accepts, or is obligated to accept, the EGHP payment as payment in full, no payment is due from Medicare. The HHA does not submit a bill.

J. HHA Bills - Partial Payment by EGHP.—If an EGHP payment for Medicare covered services (as determined by the formula in 3) is less than the HHA's charges for those services and the current Medicare interim reimbursement amount and the HHA does not accept, and is not obligated to accept, the EGHP payment as payment in full, process the bill in accordance with §3604 with the following modifications:

1. Determining charges and visits

The HHA shows in the charges and visits columns of the bill Medicare covered charges and visits including those covered by the EGHP payment.

2. Special entries on the bill

The identifying information is shown in Items 57-75 on the first payer line. Value code 12 or 43, with the amount paid are shown in value codes (Items 46-49). The address of the EGHP is shown in Item 34 or remarks (Item 94).

3. Determining amount of primary payer payment that applies to Medicare covered services

The HHA indicates the primary payer's allocation of its payment between covered and noncovered Medicare services, by entering the amount it paid toward Medicare covered services in value codes (Items 46-49). Where the HHA cannot determine the services covered by the primary payer, it applies a ratio of Medicare covered charges to total charges for the services to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). The HHA must be able to validate its ratio of covered and noncovered charges if so requested.

EXAMPLE: Total charges were $550. Medicare covered charges were $500. The EGHP payment was $330. Since the HHA cannot determine the allocation of the primary payer's payment, it determines the allocation as follows:

$$\frac{\$500}{\$550} \times \$330 = \$300$$

The HHA shows $300 in value codes (Items 46-49).

4. Determining amount of Medicare payment

Subtract the payment by the EGHP for Medicare covered services from the current Medicare interim reimbursement amount.

EXAMPLE 1: Per Visit Method

A beneficiary received 10 visits for which the HHA's current Medicare interim reimbursement amount at $50 per visit interim rate was $500. The EGHP paid $300 for Medicare covered services as determined in Item 3 above. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the EGHP payment for Medicare covered services: $500-$300 = $200. Medicare pays $200 as secondary payer.

EXAMPLE 2: Percentage of Billed Charges Method

A beneficiary received 10 visits for which the HHA charged $50 per visit. The interim rate was 90 percent ($500 x 90 percent) which equaled $450. The EGHP paid $300 for Medicare covered services as determined in Item 3. As secondary payer Medicare pays the following:

The Medicare interim reimbursement minus the EGHP payment for Medicare covered services: $450-$300 = $150. Medicare pays $150.

5. UNIBILL entries

Enter in field 30 of the UNIBILL RECORD value code 12 or 43 to identify the primary payer.

Enter in field 31 of the UNIBILL RECORD the amount paid by the EGHP for Medicare covered services that appears in value codes (Items 46-49).

K. EGHP Denies Claim for Primary Benefits.--Pay primary Medicare benefits (if the beneficiary is not appealing the EGHP denial) when an EGHP denies a claim for primary benefits because:

- o The employer does not employ 20 or more employees;
- o The beneficiary is not entitled to benefits under the plan;
- o Benefits under the EGHP are exhausted for the services involved; or
- o The services are not covered by the EGHP.

Where an EGHP denies payment for any of these reasons, the provider shows occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, it provides the reason for the denial in remarks (Item 94). Process these bills following normal billing procedures. (See §3491.11A.)

If an EGHP denies a claim for primary benefits because the plan offers only secondary coverage of services covered by Medicare and it does not allege that the employer has fewer than 20 employees, Medicare benefits may not be paid (primary or conditional). Deny the claim unless the EGHP or provider alleges that the employer has fewer than 20 employees. The provider enters occurrence code 24 (insurance denied) and the date of denial in Items 28-32 (occurrence codes). In addition, it enters the annotation "Plan offers secondary coverage of services covered by Medicare." (See §3491.11C for actions to take and §3722.4 for denial language.) If the provider indicates that the employer has fewer than 20 employees, pay primary Medicare benefits. The provider enters the annotation "Plan offers only secondary coverage of services covered by Medicare/EGHP has fewer than 20 employees" in remarks "Item 94" to avoid development of the claim by you.

L. Conditional Payments.--If the beneficiary has appealed or is protesting the EGHP denial of the claim for any reason other than that the EGHP offers only secondary coverage of services covered by Medicare or because the time limit for filing the claim with it has expired (whether appealed or not) conditional primary Medicare benefits may be paid.

The provider requests conditional primary payment by entering value code 12 with zero value in Items (46-49) to indicate the type of other insurer and that conditional payment is requested. It also enters occurrence code 24 (insurance denied) and date of denial by the EGHP in Items 28-32 (occurrence codes). The identity of the EGHP is on line A of Item 57, the identifying information about the insured is on line A of Items 65-75, and the address of the EGHP is in Item 34 or remarks (Item 94). In addition, the annotation "Beneficiary has appealed or is protesting EGHP denial" or "Time limit for filing the claim with the EGHP has expired" as appropriate appears in remarks (Item 94). (See §3491.11B, for actions to take when making conditional primary payments.)

Process these bills following normal billing procedures. In addition, enter in the appropriate field of the UNIBILL RECORD value code 12 and zero value to indicate that a conditional payment was made. Show this code and zero value in fields 39 and 40 for inpatient and Christian Science Sanatorium bills, and in fields 30 and 31 for outpatient, HHA and other bills.

3683. HOW TO DETERMINE CURRENT MEDICARE INTERIM REIMBURSEMENT AMOUNT

When the procedure requires determining the current Medicare interim reimbursement amount, use the following guidelines before adjustment for the other insurance payment:

- Per diem (per visit) reimbursement - Multiply the per diem (per visit) interim rate times the number of covered days (visits). Do not make any reduction for deductible or coinsurance.

- Percentage of billed charges - Multiply the current percentage of charges used for the interim rate by the total covered charges. Do not make any reduction for deductible or coinsurance.

- Periodic Interim Payments (PIP) - Determine a gross per diem or per visit (without reduction for deductibles or coinsurance) based on the provider's current PIP amount (See HCFA-PUB 15-1 §2407). Multiply this amount by the number of covered days (visits).

Use the above per diem (per visit) or percentage of billed charges rate in calculating Medicare liability for prior year claims processed in the current year.

Providers also use these guidelines. Therefore, inform providers of the applicable per diem (per visit) or percentage rates and of any changes.

For providers not on PIP, a provider's interim reimbursement on a bill-by-bill basis will be eliminated or reduced. (See §§3679, 3680, 3681, and 3682.)

For providers on PIP, a reduction in interim reimbursement received through PIP is necessary. Where Medicare is determined not to have any liability, reduce the PIP amount to reflect that no interim reimbursement is due. Where Medicare is determined to be secondarily liable and the primary payer is an insurer addressed in §3679 or §3680 reduce the PIP amount to reflect the primary payment. Where Medicare is determined to be secondarily liable and the primary payer is an EGHP as addressed in §3681 or §3682, reduce the PIP amount to reflect any excess of the primary payment over the applicable deductible and coinsurance.

Accomplish any reduction in the PIP amount by offset against the next payment or by taking estimated deductions into account in establishing the PIP amount.

NOTE: No reduction is made to the PIP amount with regard to conditional payments since in these situations payment is made, although conditionally, as if Medicare were fully liable for the stay.

3684. BENEFITS EXHAUSTED SITUATIONS WHEN MEDICARE IS SECONDARY PAYER FOR COST REIMBURSMENT PROVIDERS

If Medicare has secondary liability for an inpatient stay, services that would otherwise not be covered because the beneficiary had exhausted benefits may be covered after the impact of the primary payment on utilization is determined. Since the primary payment extends the covered portion of the beneficiary's stay, the primary payment effects Medicare covered charges in benefits exhausted situations. At the same time, the ratio of Medicare covered charges to total charges determines the portion of the primary payment that is allocated to Medicare covered services. The primary payment's effect on Medicare covered services must be considered before allocating the primary payment.

To determine Medicare covered charges in benefits exhausted situations in other than a PPS hospital, proceed as in the example below. For PPS hospitals, see §3685.

EXAMPLE

Facts:

Total Charges	$ 5,000
Medicare Covered Charges (without regard to benefits exhausted)	$ 4,500
Medicare Covered Charges for Day 1-7	$ 3,000
Primary Payment (unallocated)	$ 3,000
Remaining Benefit Days	3
Covered Medicare Days (without regard to benefits exhausted)	10
Currrent Medicare Per Diem Interim Reimbursement Rate	$ 480

Steps:

Determine what the current Medicare interim reimbursement would be if benefits were not exhausted (and no primary payments were involved).

EXAMPLE: $480 X 10 days = $4,800

Determine the amount of the primary payment that would apply to Medicare services if benefits were not exhausted.

- o If the primary payer's allocation can be determined, use it.

  EXAMPLE: Not applicable

- o If the primary payer's allocation cannot be determined, apply a ratio of Medicare covered charges (without regard to benefits exhausted) to total charges for the stay to the total primary payment to determine the portion that would be attributable to Medicare.

EXAMPLE: $\frac{\$4,500}{\$5,000} \times \$3,000 = \$2,700$

Determine the Medicare secondary payment that would be made in the absence of benefits exhausted (without regard to deductible or coinsurance) by subtracting Step 2 from Step 1.

EXAMPLE: $4,800 - $2,700 = $2,100

Determine the benefit days that would be chargeable absent benefits exhausted by applying a ratio of Step 3 to Step 1 to the number of Medicare covered days without regard to benefits exhausted.

EXAMPLE: $\frac{\$2,100}{\$4,800} \times 10 = 4.375$

Determine the number of days for which benefits are actually available.

EXAMPLE: 3 days

If the number of days in Step 5 is greater than the number of days in Step 4, the primary payment extends Medicare coverage over the entire stay. The case no longer involves benefits exhaustion. All otherwise covered days and charges are reported as covered for statistical and reimbursement purposes. The amount in Step 3 is the Medicare secondary payment (without regard to deductible or coinsurance) and the number of days determined in Step 4 are charged to the beneficiary's utilization record.

EXAMPLE: Not applicable since Step 5 is less than Step 4

If the number of days in Step 5 is less than the number of days in Step 4, the beneficiary does not have sufficient benefit days available to cover the entire stay. Proceed as follows:

- o Charge the days in Step 5 to the beneficary's utilization record

EXAMPLE: 3 days

- o Multiply the number of Medicare covered days without regard to benefits exhausted by the ratio of the number of days in Step 5 to the number of days in Step 4 to determine the days recorded as covered for statistical purposes.

EXAMPLE: $\frac{3}{4.375} \times 10 = 6.86 = 7$ days

Charges for days 1-7 are shown as covered on the bill. Charges for days 8-10 are reported as noncovered.

- Redetermine the allocation of the primary payer's payment for covered services based upon the revised Medicare covered charges.

  EXAMPLE: $\frac{\$3,000}{\$5,000}$ X \$3,000 = \$1,800

- Determine Medicare current interim reimbursement for days recorded as covered for statistical purposes.

  EXAMPLE: \$480 X 7 days = \$3,360

- Determine Medicare's secondary payment.

  EXAMPLE: \$3,360 - \$1,800 = \$1,560

3685. BILLING PROCEDURES FOR HOSPITALS ON PROSPECTIVE PAYMENT WHEN MEDICARE IS SECONDARY PAYER

A. General.—Instructions for processing claims in which Medicare is secondary payer are provided in §§3679-3684. Special instructions applicable only to services furnished by hospitals under PPS are below.

1. Determining the Medicare Payment Rate.—The Medicare payment rate is the amount Medicare would otherwise pay under PPS on an interim basis. The payment rate consists of the total prospective payment amount for the discharge and interim payments for those items that will be reimbursed . It is determined without regard to deductible or coinsurance. The amount is computed in the same manner for PIP and non-PIP hospitals and is the sum of:

o The total prospective payment amount, including any outlier payment, as determined by PRICER for the DRG;

o The estimated adjustment for the indirect costs of medical education, as determined by Pricer based upon the Federal portion of the total prospective payment, and;

o A per diem payment for items that are reimbursed on a reasonable cost basis. See §2405.2 of HCFA Pub. 15-1 for cost elements to be included in the payment. Divided estimated reimbursable costs for the current year by estimated Medicare days to compute a per diem rate by the number of days in the stay for which benefits are payable. Since the basic prospective payment is payable if a beneficiary has at least one covered day in the stay, payable days may exceed covered days if there are nonoutlier days before entitlement or after benefits are exhausted.

2. Determining Amount of Primary Payer Payment That Applies to Medicare Covered Services.--The hospital indicates the primary payer's allocation of its payment between covered and noncovered Medicare services by entering the amount paid by the primary payer toward Medicare covered services in value codes (Items 46-49). Where the hospital cannot determine the services covered by the primary payment, it applies a ratio of Medicare covered charges to total charges for the stay to the primary payment amount to determine the portion attributable to Medicare covered services and enters this amount in value codes (Items 46-49). Treat all services (other than those for which the beneficiary may be charged, such as a private room that is not medically necessary) furnished on any day for which benefits are payable as covered.

If a benefit exhausted case is also a day outlier, Medicare covered charges cannot be determined until the impact of the primary payment on utilization is determined. See 4 below for determining covered charges in this situation.

3. Effect of Primary Payment on Part A Utilization and Coinsurance.—If the primary payer's payment is less than the Medicare payment rate, the beneficiary will be charged with utilization and coinsurance as follows:

- If the primary payer is an EGHP and it pays an amount for Medicare covered services that is equal to or less than the deductible and coinsurance that would apply if Medicare was primary payer, utilization is not reduced. Therefore, coinsurance is determined in the usual manner.

- If the primary payer is an EGHP and it pays an amount for Medicare covered services that is more than the deductible and coinsurance that would apply if Medicare was the primary payer, follow the procedures below for determining utilization chargeable. Coinsurance is calculated on the basis of the adjusted utilization.

- If the primary payer is WC, automobile medical or no-fault insurer, follow the procedures below for determining utilization chargeable. Coinsurance is calculated on the basis of the adjusted utilization.

Charge utilization as follows for EGHPs:

- Subtract the EGHP payment that applies to Medicare covered services as determined in subsection 2 from the Medicare payment rate (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

- Divide this amount by the amount Medicare would have paid as primary payer (the Medicare payment rate reduced by deductible and coinsurance).

- Multiply this percentage by the number of payable days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more. Where the number of payable days in the stay exceed the number of days for which benefits are available (e.g., benefits are exhausted during the nonoutlier portion of the stay), the number of utilization days charged may not exceed the actual days available. If regular benefit days are exhausted during the basic portion of the stay and lifetime days are used for the outlier portion of the stay, separately compute the chargeable days for each portion of the stay. See 4 to determine the impact of the primary payment on utilization days in benefits exhausted situations involving a day outlier case.

EXAMPLE 1:

A beneficiary enters the hospital with two lifetime reserve days remaining and elects to use them. The beneficiary is discharged after 15 days, before the outlier threshold is reached. The Medicare payment rate is \$5,000. The primary payer amount for Medicare covered services is \$3,000. The applicable coinsurance amount is \$492 (2 LTR days at \$246 a day). Medicare would have paid \$4,508 as primary payer (\$5,000 -\$492).

Medicare secondary liability = \$5,000 - \$3,000 = \$2,000

$$\text{Utilization days potentially chargeable} = \frac{\$2,000}{\$4,508} \times 15 \text{ days} = 7 \text{ days}$$

In this case, only the actual days of coverage in the stay, or two days, are charged for utilization purposes.

EXAMPLE 2:

A beneficiary enters the hospital with two regular coinsurance days remaining and is discharged after 15 days. The outlier threshold is 10 days and the beneficiary elects to use lifetime reserve days for the outlier portion of the stay. The primary payer amount for Medicare covered services (i.e., the entire stay) was $3,000. The Medicare payment rate is $5,000. The applicable coinsurance amount is $1,476 (2 coinsurance days at $123 a day and 5 LTR days at $246 a day). Medicare would have paid $3,524 as primary payer ($5,000 - $1,476).

Medicare secondary liability = $5,000 - $3,000 = $2,000

Regular benefit days chargeable =

$$\frac{\$2{,}000}{\$3{,}524} \text{ X 10 days in basic portion of stay} = 6 \text{ days}$$

The beneficiary would be charged 2 coinsurance days, since only 2 days were available.

Lifetime reserve days chargeable =

$$\frac{\$2{,}000}{\$3{,}524} \text{ X 5 days in outlier portion of stay} = 3 \text{ days}$$

The beneficiary would be charged for 3 lifetime reserve days and coinsurance will be determined on this basis.

EXAMPLE 3:

Same facts as Example 2 except that the beneficiary enters the hospital with 7 regular coinsurance days remaining. Six regular coinsurance days would be chargeable for the basic portion of the stay. For the outlier portion of the stay, one coinsurance day and two lifetime reserve days would be chargeable.

NOTE: For additional utilization examples see §§3681C3 and 3682C3. These examples apply to cost reimbursement providers, not PPS hospitals. Therefore, when utilizing them insert the term "Medicare payment rate" in place of the term "current Medicare interim reimbursement for the stay" wherever it appears.

Charge utilization as follows for WC, automobile medical or no-fault insurer.

o Subtract the primary payer's payment (WC, automobile medical or no-fault insurance) that applies to Medicare covered services as determined in subsection 2 and any applicable deductible and coinsurance amounts from the Medicare payment rate (unreduced by deductible and coinsurance). This yields the Medicare secondary payment.

o Divide this amount by the amount Medicare would have paid as primary payer (i.e., the Medicare payment rate reduced by deductible and coinsurance).

o Multiply this percentage by the number of payable days in the stay.

A partial day resulting from this calculation is not charged as a full day if it is less than .5 of a day. It is charged as a full day if it is .5 or more. Where the number of payable days in the stay exceed the number of days for which benefits are available (e.g., benefits are exhausted during the nonoutlier portion of the stay), the number of utilization days charged may not exceed the actual days available. If regular benefit days are exhausted during the basic portion of the stay and lifetime days are used for the outlier portion of the stay, separately compute the chargeable days for each portion of the stay. See subsection 4 to determine the impact of the primary payment on utilization days in benefits exhausted situations involving a day outlier case.

EXAMPLE 1:

A beneficiary enters the hospital with two lifetime reserve days remaining and elects to use them. The beneficiary is discharged after 15 days, before the outlier threshold is reached. The Medicare payment rate is $5,000. The primary payer amount for Medicare covered services is $3,000. The applicable coinsurance amount is $492 (2 LTR days at $246 a day). Medicare would have paid $4,508 as primary payer ($5,000 -$492).

Medicare secondary liability = $5,000 - $3,000 - $492 = $1,508

Utilization days potentially chargeable = $\frac{\$1,508}{\$4,508}$ X 15 days = 5 days

In this case, only the actual days of coverage in the stay, or two days, are charged for utilization purposes.

EXAMPLE 2:

A beneficiary enters the hospital with two regular coinsurance days remaining and is discharged after 15 days. The outlier threshold is 10 days, and the beneficiary elects to use lifetime reserve days for the outlier portion of the stay. The primary payer amount for Medicare covered services (i.e., the entire stay) was $3,000. The Medicare payment rate is $5,000. The applicable coinsurance amount is $1,476 (2 coinsurance days at $123 a day and 5 LTR days at $246 a day). Medicare would have paid $3,524 as primary payer ($5,000 - $1,476).

Medicare secondary liability = $5,000 - $3,000 - $1,476 = $1,524

Regular benefit days chargeable =

$\frac{\$1,524}{\$3,524}$ X 10 days in basic portion of stay = 4 days

The beneficiary is charged 2 coinsurance days, since only 2 days were available.

Lifetime reserve days chargeable =

$\frac{\$1,524}{\$3,524}$ X 5 days in outlier portion of stay = 2 days

The beneficiary is charged for 2 lifetime reserve days and coinsurance is determined on this basis.

EXAMPLE 3:

Same facts as Example 2 except that the beneficiary enters the hospital with 5 regular coinsurance days remaining. Four regular coinsurance days are chargeable for the basic portion of the stay. For the outlier portion of the stay, one regular coinsurance day and one lifetime reserve day is chargeable.

NOTE: For additional utilization examples see SS3679C3 and 3680C3. These examples apply to cost reimbursement providers, not PPS hospitals. Therefore, when utilizing them, insert the term "Medicare payment rate" in place of the term "current Medicare interim reimbursement for the stay" wherever it appears.

4. Benefits Exhausted Situations Involving a Day Outlier.--If Medicare has secondary liability for an inpatient stay, outlier days that would otherwise not be covered because the beneficiary had exhausted benefits may be covered after the impact of the primary payment on utilization is determined. In these situations, the primary payment effects Medicare covered charges. Since the primary payment is allocated to Medicare based on a ratio of Medicare covered charges to total charges, the primary payment's effect on Medicare covered charges must be taken into account before allocating the primary payment.

To determine Medicare covered charges in benefits exhausted situations involving a day outlier, proceed as in the following example:

EXAMPLE

Facts:	Total Charges	$5,000
	Medicare Covered Charges (without regard to benefits exhausted)	$4,500
	Medicare Covered Charges for Days 1-7	$3,000
	Primary Payment (unallocated)	$3,000
	Remaining Benefit Days	3
	Covered Medicare Days (without regard to benefits exhausted)	10
	Outlier Threshold	5
	Medicare Payment Rate (without regard to benefits exhausted)	$4,800
	Medicare Payment Rate Days 1-7	$4,000

STEPS: 1. Determine what the Medicare payment rate would be if benefits were not exhausted (and no primary payments were involved).

EXAMPLE: $4,800

2. Determine the amount of the primary payment that would apply to Medicare covered services if benefits were not exhausted.

If the primary payer's allocation can be determined, use it.

EXAMPLE: Not applicable

If the primary payer's allocation cannot be determined, apply a ratio of Medicare covered charges (without regard to benefits exhausted) to total charges for the stay to the total primary payment to determine the portion that would be attributable to Medicare.

EXAMPLE: $\frac{\$4,500}{\$5,000} \times 3000 = \$2,700$

3. Determine the Medicare secondary payment that would be made in the absence of benefits exhausted (without regard to deductible or coinsurance) by subtracting Step 2 from Step 1.

EXAMPLE: $4,800 - 2,700 = $2,100

4. Determine the benefit days that would be chargeable absent benefits exhausted by applying a ratio of Step 3 to Step 1 to the number of Medicare covered days without regard to benefits exhaustion.

EXAMPLE: $\frac{\$2,100}{\$4,800} \times 10 = 4.375$ days

5. Determine the number of days for which benefits are available.

EXAMPLE: 3 days

6. If the number of days in Step 5 is greater than the number of days in Step 4, the primary payment extends Medicare coverage over the entire stay. The case no longer involves benefits exhaustion. All otherwise covered days and charges are reported as covered for statistical and reimbursement purposes. The amount in Step 3 is the Medicare secondary payment (without regard to deductible or coinsurance) and the number of days determined in Step 4 are charged to the beneficiary's Medicare utilization record.

EXAMPLE: Not applicable since Step 5 is less than Step 4.

7. If the number of days in Step 5 is less than the number of days in Step 4, the beneficiary, does not have sufficient benefit days available to cover the entire stay. Proceed as follows:

- Charge the days in Step 5 to the beneficiary's Medicare utilization record.

EXAMPLE: 3 days

Multiply the number of Medicare covered days without regard to benefits exhausted by the ratio of the number of days in Step 5 to the number of days in Step 4.

The number of days and related charges recorded as covered for statistical and reimbursement purposes will be the greater of the number of days computed in this step or the number of days in the nonoutlier portion of the stay.

EXAMPLE: $\frac{3}{4.375}$ X 10 = 6.86 = 7 days

If the outlier threshold was fewer than 7 days, charges for days 1-7 would be recorded as covered. If the outlier threshold was 7 days, or more, charges for the nonoutlier portion of the stay would be recorded as covered. Since the outlier threshold is 5 days in this example, 7 days would be considered covered and the charges for days 1-7 would be reported as covered for statistical and reimbursement purposes.

Redetermine the allocation of the primary payer's payment for covered services based on the revised Medicare covered charges.

EXAMPLE: $\frac{\$3,000}{\$5,000}$ X \$3,000 = \$1,800

Determine Medicare payment rate for days recorded as covered for statistical purposes.

EXAMPLE: \$4,000

Determine Medicare's secondary payment.

EXAMPLE: \$4,000 - \$1,800 = \$2,200

B. Primary Payer Pays in Full.—No Medicare payment will be made if the payment by the primary payer for Medicare covered services (as determined by the formula in A2 above) equals or exceeds the hospital's charges for those services or the hospital accepts, or is obligated to accept, the payment as payment in full for the services.

If WC, automobile medical or no-fault insurance primary to Medicare precludes any Medicare payment, the hospital submits a no-payment bill. Process the bill in accordance with SS3679B or 3680B as appropriate. If an EGHP primary to Medicare precludes any Medicare payment, the hospital submits a no-payment bill. Process the bill in accordance with S3681B or S3682B as appropriate.

C. Primary Payer Pays Less Than Full.--If the primary payment for Medicare covered services (as determined by the formula in subsection A2) is less than the hospital's full charges for those services and the hospital does not accept, and is not obligated to accept, the payment as payment in full, the hospital must identify the primary payer and indicate the amount of the primary payment that is allocated for Medicare covered services. It shows the identifying information in Items 57-75 on the first payer line, and the appropriate value code with the amount paid is shown in value codes (Items 46-49).

Your action in varying situations is described below.

1. Primary Payment Equals or Exceeds Medicare Payment Rate.--If the primary payment equals or exceeds the Medicare payment rate, no payment is due from Medicare. If the primary payer is WC, automobile medical or no-fault insurer, process the bill in accordance with SS3679B or 3680B as appropriate. If the primary payer is an EGHP process the bill in accordance with S3681B or S3682B as appropriate.

2. Primary Payment is Less Than Medicare Payment Rate.--

a. Primary Payer is WC, Automobile Medical or No-Fault Insurance.--If the primary payer is WC, automobile medical or no-fault insurer, Medicare's liability is equal to the Medicare payment rate, less the primary payment amount allocated for Medicare covered services and the applicable deductible and coinsurance amount. See below to apply the primary payment amount and coinsurance and deductibles to Medicare payments. The applicable deductible and coinsurance amount is the lesser of the deductible and coinsurance determined under the usual rules or the Medicare payment rate less the primary payer amount for Medicare covered services. The beneficiary's liability is limited to the applicable deductible and coinsurance amount.

If the primary payer is WC process the bill in accordance with S3679C. If the primary payer is an automobile medical or no-fault insurer, process the bill in accordance with S3680C. For hospitals not on PIP, subtract the primary payment and the applicable deductible and coinsurance amounts from the total prospective payment amount (A.1.a) for the beneficiary's stay. If the primary payment amount and applicable deductible and coinsurance exceed the total prospective payment amount, subtract the excess from prospective payments due the hospital for other discharges. Do not adjust biweekly payments for the indirect costs of medical education (A.1.b) and for Items reimbursed on a reasonable cost basis (A.1.c) as a result of primary payment amounts. Biweekly payment is the method by which the amounts in A.1.b and A.1.c are paid on an interim basis for both PPS-PIP and PPS non-PIP hospitals. (See the Provider Reimbursement Manual, Part I, SS2405.2 and 2405.3.) A primary payment amount in excess of the total prospective payment amount for a particular discharge need not be identified to, and subtracted from, the biweekly payments because the hospitals cost report provides for subtraction of total primary payments from the aggregate of all Medicare payments otherwise due.

For hospitals on PIP (see the Provider Reimbursement Manual, Part I, §2405.1.b), reduce the PIP amount for prospective payments to reflect the primary payment. Any reduction in PIP payments may be accomplished by offsetting against the next payment or by taking estimated reductions into account in establishing the PIP payment level. All adjustments resulting from primary payment amounts are reflected only in the PIP payment level. As with non-PIP hospitals, do not adjust biweekly payments for amounts addressed in A.1.b and A.1.c.

NOTE: No reduction is made to the PIP amount with regard to conditional payments. In these situations payment is made, although conditionally, as if Medicare were fully liable.

b. Primary Payer is an EGHP.—If the primary payer is an EGHP, Medicare's liability is equal to the Medicare payment rate less the greater of: the primary payer payment amount allocated for Medicare covered services or the applicable deductible and coinsurance amounts. In this case see below to apply the primary payment amount or deductibles and coinsurance. The applicable deductible and coinsurance amount is determined under the usual rules.

The beneficiary has no liability for Medicare covered services if the primary payment is greater than the applicable deductible and coinsurance amounts. Otherwise, the beneficiary's liability is limited to the applicable deductible and coinsurance amounts less the primary payment.

Process the bill in accordance with §3681C or §3682C as appropriate. For hospitals not on PIP, subtract the greater of the primary payment or the applicable deductible and coinsurance amount from the total prospective payment amount (A.1.a) for the beneficiary stay. If the applicable deductible and coinsurance or primary payment amount exceeds the total prospective payment amount, subtract the excess from prospective payments due the hospital for other discharges. Do not adjust biweekly payments for the indirect costs of medical education (A.1.b) and for items that are reimbursed on a reasonable cost basis (A.1.c) as a result of primary payment amounts. Biweekly payments is the method by which the amounts in A.1.b and A.1.c are paid on an interim basis for both PPS-PIP and PPS non-PIP hospitals. (See the Provider Reimbursement Manual, Part I, §§2405.2 and 2405.3.) A primary payment amount in excess of the total prospective payment amount for a particular discharge need not be identified to, and subtracted from, the biweekly payments because the hospitals cost report provides for subtraction of total primary payments from the aggregate of all Medicare payments otherwise due.

For hospitals on PIP (see the Provider Reimbursement Manual, Part I, §2405.1.b), reduce the PIP amount for prospective payments to reflect any excess of the primary payment amount over the applicable deductible and coinsurance amount. Any reduction in PIP payments may be accomplished by offsetting against the next payment or by taking estimated reductions into account in establishing the PIP payment level. All adjustments resulting from primary payment amounts are reflected only in the PIP payment level. As with non-PIP hospitals, do not adjust biweekly payments for amounts addressed in A.1.b and A.1.c.

NOTE: No reduction is made to the PIP amount with regard to conditional payments. In these situations payment is made, although conditionally, as if Medicare were fully liable.

3686. DEVELOPMENT OF CLAIMS WHERE THERE MAY BE OTHER PAYER INVOLVEMENT

Where Medicare is indicated as primary payer on the HCFA-1450, assume in the absence of evidence to the contrary, that the provider has correctly determined that there is no other primary coverage and process the claim accordingly. If you have reason to believe that Medicare may be secondary payer, e.g., based upon information from an outside source, information included in your data base obtained from the regional data exchange or a Y trailer code A thru I (See §§3512.8 or 3535.1) received in response to a query, contact the provider with your explanation of why Medicare may be the secondary payer. Ask the provider to determine if there is another payer primary to Medicare. If so, instruct the provider to bill the other payer as primary.

Where condition code 08 is reported in Items 35-39 of the HCFA-1450, develop to determine the proper payer based on information included in your data base obtained from the regional data exchange or other internal source. If you are still unable to determine the proper payer after checking your data base, contact the beneficiary and take the following actions:

o Where the beneficiary indicates other insurance coverage, request the provider to bill that insurer as primary;

o Where the beneficiary indicates no other insurance coverage, process the claim for payment; or

o Where the beneficiary refuses to provide information, deny the claim and notify the beneficiary accordingly. (See §3722.4 for denial language.)

3687. DEVELOPMENT OF ESRD CLAIMS WHERE BASIS FOR MEDICARE ENTITLEMENT CHANGES

During the 12 month period in which Medicare may be secondary, develop all cases where a beneficiary's basis for Medicare entitlement changes from entitlement based solely upon ESRD (S2 trailer code) to entitlement based upon ESRD and disability (S3 trailer code). Medicare ceases to be secondary payer for ESRD individuals when entitlement changes to disability. However, the S3 trailer code does not provide the month the Medicare entitlement based on disability begins. To prevent erroneous billing, contact your local SSO whenever you receive an S3 trailer code during the 12 month period in which Medicare may be secondary. Ask the SSO to identify the beneficiary's date of entitlement to Medicare based upon disability (usually the 25th month after disability benefits began). Indicate that the information is needed to determine when the period for which the beneficiary is entitled to Medicare solely because of the ESRD provision ends.

3688. DEDUCTIBLE AND/OR COINSURANCE RATES APPLICABLE ON MEDICARE SECONDARY CLAIMS WHEN AN INPATIENT STAY SPANS TWO CALENDAR YEARS

Where Medicare is secondarily liable because another payer primary to Medicare has made payment on an inpatient claim, and the stay spans two calendar years, the provider bills the deductible and/or coinsurance rate applicable to the year in which Medicare utilization is charged. Medicare utilization (calculated in accordance with instructions in §§3679C3, 3680C3, 3681C3, 3682C3, and 3685A3) is charged beginning with the first day of the stay. This rule applies even though the primary payer paid for only a specified number of days of a stay, e.g., the primary payer's plan covers the first 20 days of a 30 day stay.

Where the Medicare utilization involves coinsurance days spanning two calendar years, the provider bills coinsurance for each coinsurance day in accordance with the applicable coinsurance rate for the year in which the day was utilized. The provider uses value codes 09 and 11, form locators 46 through 49, to show specific coinsurance amounts. See §3876 for reporting coinsurance days on UNIBILL.

EXAMPLE 1:

A beneficiary is in a new benefit period and was admitted to the hospital on December 15, 1984, and discharged on January 14, 1985. An EGHP primary to Medicare paid the first 20 days of the stay. The provider enters $356 deductible (the applicable deductible for the first year in which Medicare utilization is charged).

EXAMPLE 2:

A beneficiary was admitted to the hospital on December 15, 1984, and discharged on January 14, 1985. Only coinsurance days were available. An EGHP primary to Medicare paid the first 20 days of the stay. After performing the utilization calculation, the provider determined the beneficiary can be charged with 10 days utilization (December 15 thru December 24). The provider bills 10 days coinsurance at the 1984 rate ($89 x 10 = $890). The coinsurance amount is based upon the inpatient hospital deductible for the year in which days are utilized.

EXAMPLE 3:

A beneficiary was admitted to the hospital on December 25, 1984, and discharged on January 24, 1985. Only coinsurance days were available. An EGHP primary to Medicare paid the first 20 days of the stay. After performing the utilization calculation, the provider determined the beneficiary can be charged with 10 days utilization (December 25, 1984 thru January 3, 1985). The provider bills 7 days coinsurance at the 1984 rate ($89 x 7 = $623) and 3 days coinsurance at the 1985 rate ($100 x 3 = $300). The coinsurance amount is based upon the inpatient hospital deductible for the year in which days are utilized. The data is reported on the HCFA-1450 as follows:

Value code 09 Medicare Coinsurance Amount in First Calendar Year	$623.00
Value Code 11 Medicare Coinsurance Amount in Second Calendar Year	$300.00
Form locator 25 Coinsurance Days	10
Form locator 61 Coinsurance Amount	$923.00

3689. COORDINATION OF OTHER INSURANCE COVERAGE WITH CARRIERS

Coordinate determinations regarding other insurance coverage with carriers in your service areas by providing the carrier with a copy of all hospital inpatient UNIBILL records; and of SNF inpatient and all outpatient UNIBILL records that contain value codes 12, 13, 14, 15, or 16. (See §3770.2.) Carriers will extract data from these records for Medicare secondary payer development and process claims accordingly.

3693. REVIEW PROTOCOL FOR MEDICAL SECONDARY PAYER

Medicare is secondary payer for:

- Claims involving Medicare beneficiaries age 65 or older who are insured by EGHP coverage based upon their own employment or that of their spouses of any age. Amendments extending the working aged provisions beyond age 69 apply to items and services furnished on or after May 1, 1986. (See §3491.);

- Claims during a period of up to 12 months involving beneficiaries entitled to Medicare solely on the basis of ESRD who have EGHP coverage. (See §3490.);

- Claims involving automobile medical or no-fault insurance or any liability insurance. (See §3419.);

- Claims involving WC or BL; and

- Claims involving Medicare beneficiaries under age 65 who are disabled by Social Security definition and are covered by a large group health plan (employers with 100 or more employees) based upon their employment or that of a family member. The amendment applies to items and services furnished on or after January 1, 1987.

The following sections provide a methodology for reviewing certain hospitals' MSP policies and practices which may reflect inconsistencies affecting MSP savings. Review admission and bill processing procedures and hospital billing data.

3693.1 Frequency of Reviews and Selection Criteria.—Each year conduct a review of 10 percent of the hospitals for which you have Medicare responsibility. Considering the variances within each State as to number of hospitals that would be reviewed, review a minimum of 4 and a maximum of 20 hospitals. (For FY 1987, prorate the number of required reviews based on the number of months remaining in the year, retaining as a minimum 4 reviews.) Providers to consider may include hospitals not properly developing MSP claims, not submitting "no payment" bills, not submitting auto medical cases although they may have shock trauma units specializing in emergency admissions, etc.

3693.2 Methodology For Review of Admission and Bill Processing Procedures.—

A. Review of Hospital Payer Policies.—Obtain the following information from the hospital's administration office regarding the facility's policies on identification of other resources primary to Medicare.

What are their policies on identification and billing of working aged and disabled beneficiaries with other insurance?

- Is information obtained on the patient's and the patient's spouse's employer or on the employment of any other family member?

- On the patient's and the spouse's age?

- On the patient's and the spouse's insurance coverage or the insurance coverage of any other family member?

What are the policies on identifying and billing accident and liability cases?

- Are accident cases separately identified?

- Are auto accidents distinguished from other accidents?

- Are WC or BL cases identified?

- Does the provider correctly complete the work-related condition code on the billing form?

What are the policies on identifying cases in which an ESRD beneficiary is in the 12-month coordination period?

- Are ESRD patients' histories tracked?

- If so, how?

- Is this information supplied to the billing department?

B. Implementing Payer Policies.—To determine whether policies are carried out in practice, visit the admitting department (inpatient and emergency) and for Medicare only analyze the admission forms. Determine from the admission forms or through discussions with admitting personnel whether the:

- Facility has a mechanism to identify other payer resources. (Are there line items to disclose other payer resources, e.g., if the patient is not employed, is information on the spouse obtained in relation to employment, age, place of employment and address, insurer's name and policy number?)

- Facility exercises the process to identify other payer resources. Review actual practices, instructional materials. If such line items exist, are they utilized? If there are no specific line items for disclosing other payer resources, is the information obtained by admissions personnel somewhere on the admissions forms, e.g., under "Comments," or is other space provided?

- Admission forms have specific line items to obtain WC (YES/NO) or BL (YES/NO) involvement. If not, is this information obtained somewhere on the form?

- Admission forms obtain information from, or about, the working spouse of the patient, e.g., place of employment, insurance and policy information. Admission forms obtain information about the patient's place of employment, insurance, and policy information.

o Facility codes admission forms for billing purposes in accident cases. Is there, or can there be, added to the admission form a priority for payers, e.g., "Primary," "Secondary," or working aged, ESRD, Aged-auto Accident, Aged Accident - other designations?

o Verify that the admission office is utilizing the admission development chart in §301 of the Hospital Manual as a guideline for identifying other payers at the time of admission.

Check to see if the hospital has on file a copy of the completed admission development chart or its equivalent. This may be in paper, microfilm or microfische. If the hospital has an on-line admission screen in place, the above requirement does not apply as long as it has documented procedures for collecting and reporting other primary payer information.

C. Observing Admissions.—Observe an admissions clerk during a Medicare admission or series of admissions. Are all other payer resources obtained including negative responses? (This is optional if hospital policy generally prohibits outsiders observing the admission process.)

D. MSP Information from Billing.—Obtain from the billing department the following:

o Is the information pertaining to a resource primary to Medicare and which is contained on the admission forms supplied in its entirety to the billing department? (The billing department will have to be made aware of a payer primary to Medicare, e.g., working aged, ESRD, auto accident.)

o Do circumstances arise where the billing department obtains information from the patient? If so, how complete is it? How is it obtained? For example, when an unconscious patient arrives at the hospital, who obtains the admission information and from what source? Is the regular admissions form used to obtain the information?

o Where the patient's condition on admission precludes his assisting in identifying other payer resources, are members of the patient's family contacted?

o Does the hospital search its records in accordance with Hospital Manual §263.7 to identify prior working aged claims? Is there a specific line item (YES/NO) to record this and an explanation of why records were not searched?

o Where there is a possiblity of WC liability, does the hospital bill WC directly rather than Medicare, bill both WC and Medicare, or only Medicare?

o Does the provider bill the Department of Labor first where the services are covered by the Federal BL program.

- o Does the facility have the ability to track WC cases on succeeding visits to the facility or the outpatient department? (Many times individuals may have to return to the hospital for additional medical services as a result of a WC occurrence.) Does the hospital correctly bill for the succeeding visits?

- o Does the facility bill more than one insurer simultaneously (Medicare/Private Insurer)? If so, what is the disposition of duplicative reimbursements?

- o Review the hospital's patient financial accounts to identify Medicare patients that may have credit balances due to payments received from both Medicare and another insurer. Where such credit balances are identified, recover the Medicare overpayment through the adjustment bill process.

- o In auto/accident injury, are reimbursement checks from an insurer made payable to the beneficiary and/or the facility? If so, what is the policy as to dispostion of these checks?

- o How does the facility bill in the following ESRD situations? (Does the hospital track and follow-up on patients' ESRD history and is it available to the bill department?)

  - — 12-month coordination period (3-month waiting period where applicable, 9 or 12-month secondary payer).
  - — Kidney transplant (exception to the 3-month waiting period).
  - — Self-Dialysis (exception to the 3-month waiting period).

Where the patient is in the ESRD coordination period and an employer has paid in part, or should pay, for the services, does the provider show the name and group number of the insurer, value code 13, and amount (as appropriate) on the bill?

3693.3 Methodology for Review of Hospital Billing Data.—Determine the sample period; recommended is one (1) month's submissions or the following sampling size:

Universe Size	Sample Size
60	all
61 - 120	40
121 - 300	50
301 or more	60

The universe to consider is the hospital's annual inpatient claims.

Review copies of the hospital's inpatient and emergency room (ER) Medicare beneficiary admission forms and complete the "Analysis of Forms" chart (Exhibit 1) and "Other Payer Utilization Data" form (Exhibit 2 or Exhibit 3).

Have hospital personnel provide all inpatient admission forms and all ER admission forms for all Medicare beneficiaries and all admissions over age 64 for the sample period.

Examine every form. Use the following analysis sequence:

- o Is the patient a Medicare beneficiary? (If not, select another admission form. If yes continue the analysis).

- o Is this an ESRD case within the first 12 months of treatment? (If not, continue analysis. If yes, complete Survey Sheet I (Exhibit 4).)

- o Is the beneficiary considered a "Working Aged" beneficiary or a disabled beneficiary with large group health plan coverage? (If not, continue analysis. If yes, complete Survey Sheet II (Exhibit 5).)

- o Is this a WC or BL case? (If not, continue analysis. If yes, complete Survey Sheet III (Exhibit 6).)

- o Is this an auto accident or other liability case? (If not, go to next admission form. If yes, complete Survey Sheet III (Exhibit 6).)

Obtain the HCFA-1450 for all cases involving other payers and determine the amount billed to Medicare for each case; record on the appropriate survey sheets.

Review the Form HCFA-1450 for the following MSP data. (Section 3670 defines these items in detail.)

Items 28 thru 32 - Occurrence Codes and Dates.—Occurrence codes should be completed to show the type and date of the accident.

01-Auto accident
02-Auto accident with no-fault insurance
03-Accident involving civil court process
04-Employment related accident
05-Other accident not described above
  This code is used to report that the hospital has developed for other casualty related payers and have determined that there are none.
24-Date insurance denied

When occurrence codes 01 thru 04 and 24 are entered, they must be accompanied by the entry of the appropriate value code in Items 46-49 if there is another payer involved.

Items 35 thru 39 - Condition Codes.—Condition codes should be completed with condition code 02 if the condition is employment related.

Items 46 thru 49 - Value Codes and Amounts.—Value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services.

12-Working aged/beneficiary/spouse with EGHP
13-ESRD beneficiary in 12-month period with EGHP
14-Automobile, no-fault or any liability insurance

15-WC
16-PHS, other Federal agency
41-BL
42-VA
43-Disabled beneficiary with LGHP coverage.

Where the provider is requesting conditional payment, zeros should be entered beside the appropriate value code in this item.

Item 57A - Payer Identification.—Payer Identification should be completed to show the identity of the other payer primary to Medicare. All additional entries across line A (Items 58-64) supply information needed by the payer named in Item 57A.

Item 57 B, C - Payer Identification.—Payer Identification should be completed to show Medicare when Medicare is the secondary or tertiary payer.

Item 65A - Insured's Name.—Where Medicare is not the primary payer, the insured's name should be completed to show the name of the individual in whose name the insurance is carried.

In Item 65B, the provider should have entered the patient's name as shown on the HI card or other Medicare notice.

Item 67 - Patient's Relationship to the Insured.—This item indicates the relationship of the patient to the identified insured.

Item 68A, B, C - Certification/SSN/HICN.—On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown in Items 57-63, the provider should have entered the patient's Medicare HICN. If the provider is reporting any other insurance coverage higher in priority than Medicare (e.g., employer coverage for the patient or the spouse or during the first year of ESRD entitlement), the involved claim number for that coverage should be shown on the appropriate line.

Items 69 thru 75 - Employment Information Data.—These items are completed when the provider is claiming a payment and there is WC or/and EGHP involvement.

3693.4 Assessment of Hospital Review.—Prepare a narrative summary for each provider. Include selection criteria for the provider and your findings along with suggested recommendations, if appropriate. Include any discrepancies between the hospital's MSP policies and practices, as well as what provider innovations have been/are being devised to determine third party resources. Send a copy within 30 days of your survey to your RO:

HCFA
__________ Regional Office
Division of Program Operations
Attention: MSP Coordinator

Send the hospital a copy. Followup every 30 days until appropriate corrective action is taken. Report continued problems after three months to the RO MSP Coordinator.

3693.5 Exhibits

Exhibit 1	Analysis of Forms	6-582
Exhibit 2	Other Payer Utilization Data (Inpatient Data)	6-583
Exhibit 3	Other Payer Utilization Data (Outpatient Data)	6-584
Exhibit 4	Medicare Secondary Payer - ESRD	6-585
Exhibit 5	Medicare Secondary Payer - Working Aged/Disabled	6-586
Exhibit 6	Medicare Secondary Payer - Other	6-587

Exhibit 1

ANALYSIS OF FORMS

HOSPITAL

1. Type of form
   a. Inpatient Admission
   b. ER Admission

2. Is data system:
   a. Manual
   b. Computerized

3. Answers to the following questions are to be recorded in the corresponding columns in the chart below, (Answers to Question A., will be recorded in Column A, etc.)

   A. Does the form specifically request this data?

   *B. If not, is this information obtained and recorded in comments, etc.?

   *C. Is this information always completed, i.e., are negative responses recorded?

   *To be answered after review of completed forms.

	A	B	C
Patient's Employer			
Primary Insurance			
Secondary or Other Insurance			
Workers' Compensation/On the Job Injury			
Accident			
Location of Accident			
Spouse's Employer			
Spouse's SSN			
Spouse's Age			
ESRD Beneficiary in 12-month Period			

Exhibit 2

OTHER PAYER UTILIZATION DATA
(INPATIENT DATA)

1. Month Reviewed - Inpatient Admissions ______________________
2. Total Inpatient Admissions ______________________
3. Medicare Admissions ______________________
4. Percentage Medicare Utilization (#3/#2) ______________________
5. Working Aged Identified ______________________
6. Percentage of Working Aged (#5/#3) ______________________
7. ESRD Patients in 12-month Period ______________________
8. Percentage of ESRD (#7/#3) ______________________
9. Auto Accident Cases Identified ______________________
10. Percentage of Auto Cases (#9/#3) ______________________
11. Other Liability Cases Identified ______________________
12. Percentage of Other Liability Cases (#12/#3) ______________________
13. Workers' Comp/Black Lung Cases Identified ______________________
14. Percentage of Workers' Comp/Black Lung Cases (#14/#3) ______________________

Exhibit 3

OTHER PAYER UTILIZATION DATA
(OUTPATIENT DATA)

1. Month Reviewed - ER ____________________
2. Total ER Admissions ____________________
3. Medicare ER Admissions ____________________
4. Percentage ER Medicare Utilization (#3/#2) ____________________
5. Working Aged Identified ____________________
6. Percentage of Working Aged (#5/#3) ____________________
7. ESRD Patients in 12-month Period ____________________
8. Percentage of ESRD (#7/#3) ____________________
9. Auto Accident Cases Identified ____________________
10. Percentage of Auto Cases (#9/#3) ____________________
11. Other Liability Cases Identified ____________________
12. Percentage of Other Liability Cases (#11/#3) ____________________
13. Workers' Comp/Black Lung Cases Identified ____________________
14. Percentage of Workers' Comp/Black Lung Cases (#13/#3) ____________________

Exhibit 4

— ESRD HOSPITAL: PAGE OF

TRTMT. START/ SERVICE DATES	BENEFICIARY: NAME, ADDRESS PHONE	PATIENT ACCOUNT NUMBER	AMOUNT BILLED TO MEDICARE	EXCEPTIONS		EMPLOYER		INSURANCE		SSN BENEFICIARY SPOUSE
				TRNS PLANT	SELF TRNG	BENEFICIARY	SPOUSE	PRIMARY	SECONDARY	

Exhibit 5

II —WORKING AGED/DISABLED HOSPITAL: PAGE OF

DATE OF SERVICE	BENEFICIARY: NAME, ADDRESS PHONE	PATIENT ACCOUNT NUMBER	AMOUNT BILLED TO MEDICARE	AGE		EMPLOYER		INSURANCE		SSN BENEFICIARY SPOUSE
				BENE.	SPOUSE	BENEFICIARY	SPOUSE	PRIMARY	SECONDARY	

Exhibit 6

III — OTHER HOSPITAL: PAGE OF

DATE OF SERVICE	BENEFICIARY: NAME, ADDRESS PHONE	PATIENT ACCOUNT NUMBER	AMOUNT BILLED TO: MEDICARE	AMOUNT BILLED TO: OTHERS	SSN BENEFICIARY AND SPOUSE	ACCIDENT (EXPLAIN)	OTHER LIABILITY (EXPLAIN)	WORKERS' COMPENSATION	BLACK LUNG	COMMENTS: ATTORNEY INVOLVEMENT, ETC.

Request for Information From the Public

3694. REQUEST FOR INFORMATION REQUIRED IN THE DEVELOPMENT OF MEDICARE SECONDARY PAYER CLAIMS

The items of information listed below have been approved by the Office of Management and Budget (OMB) under approval number 0938-0214 as the information you may request from providers and beneficiaries in the development of Medicare Secondary Payer (MSP) claims. You may not routinely collect information other than that given on these lists. You may have forms printed requesting some, or all, of the information on these lists. However, if you do so, the form must have the OMB approval number printed in the upper right-hand corner of the first page. It should read:

Form Approved
OMB NO. 0938-0214

The items of information (broken out by specific primary payer categories) that you may collect for MSP development are:

A. WC Including B/L

o Name and address of the WC or B/L carrier or State WC agency.

o Was WC payment a lump sum compromise payment? If so, what portion, if any, was allocated to medical and hospital expenses?

o Is the WC claim contested?

o If the WC claim is contested, does the carrier or the WC agency agree to notify you promptly when a final decision is reached?

o Will the WC carrier agree to reimburse Medicare the amount of the conditional payment if full WC benefits are awarded or if the particular services were reimbursed by a lump sum award?

o Is the Medicare beneficiary entitled to black lung medical benefits? If the Department of Labor or the WC carrier was billed before Medicare but not all services were covered, a copy of the explanation of benefit is needed.

o Date of accident which resulted in illness or injury.

o Brief description of accident or other cause of illness or injury.

o Request beneficiary's permission to contact the employer or the WC carrier for information concerning WC claim.

B. Automobile Medical, No-Fault, or Liability Insurance

o Was the treatment for an illness or injury which resulted from an automobile accident or other accident for which another party could be held responsible?

- Was it an automobile or nonautomobile accident?
- Date of accident which resulted in illness or injury.
- Brief description of accident or other cause illness or injury.
- Is the injury or illness covered by the individual's uninsured motorist coverage or by a State's uninsured motorist fund?
- Name, address, and telephone number of the party responsible for illness or injury.
- Name and address of the attorney, if one is involved.
- Liability carrier's claim file number.
- Has a request been received for medical records or bill from an attorney or insurance company?
- How much did it cost the beneficiary or attorney to obtain a liability insurance payment?

C. End State Renal Disease (ESRD) Beneficiaries Covered by Employer Group Health Plans (EGHP)

- Is patient entitled to Medicare based solely on the basis of ESRD?
- Date regular course of dialysis was initiated.
- Did the patient start self-dialysis training? If so, when?
- Did the patient receive a kidney transplant? If so, when?
- What was the first month of the patient's 12-month coordination period?
- Is patient covered by an EGHP?
- Did the provider check its records to ascertain if Medicare paid primary benefits for other services rendered during the 12-month coordination period for which there was EGHP coverage.

D. Working Aged Beneficiaries Covered by EGHP

- Is the patient or spouse working? If not, when did he/she stop?
- Does patient/spouse have EGHP coverage by reason of current employment?

- Spouse's date of birth.

- Is spouse entitled to Part A benefits?

- Does the employer employ 20 or more employees?

- If the working individual or the spouse is covered by a multiemployer group health plan which has at least one employer with 20 or more employees, has the multiemployer plan identified the individual as an employee of an employer of fewer than 20 employees?

- If the worker is disabled, was he/she determined disabled by SSA prior to age 65 or does his/her employer pay him/her sick or disability pay covered by the Federal Insurance Contribution Act?

- Request the EGHP to designate to whom to give any "excess" EGHP refund.

- To recover Medicare overpayment, request a transfer of funds from your private side where you are the EGHP.

- Request refund from the beneficiary if the beneficiary received direct payment from the EGHP.

E. Veterans Administration (VA)

Has the VA issued an authorization (i.e., a fee basis ID card) for benefits under its program?

- If a beneficiary was issued a fee basis ID card, what services were billed to the VA?

F. Other Exclusions

- Were services paid for by another governmental program such as under a research grant?

G. Any MSP Situation

- Has a claim been filed or does the beneficiary intend to file a claim with the other payer? If not, explain.

- Name. address, and telephone number of other insurer which may be responsible for payment of medical expenses.

- Has a claim been denied by the other insurer? If so, why?

- Request a copy of the other insurer's decision, i.e., the explanation of benefits or denial.

- o Request claims information not contained in the insurer's explanation of benefits or a denial from the insurer or the beneficiary.
- o Amount paid by the other insurer for Medicare covered services.
- o Date payment was received from other payer.
- o Policy, claim or group number.
- o Name and telephone number of individual at other payer assigned to handle claim.
- o Request completion of repayment agreement.
- o Justification for requesting conditional payment.
- o Request permission from the beneficiary to release Medicare payment information to other insurer.
- o Request a primary insurer to refund excess Medicare payment.

Limit the information collected for MSP development to these items. A distinction is drawn between information which is sought routinely and that which is sought nonroutinely. The distinction is based upon a requirement in the Paperwork Reductio Act that OMB approval be obtained when the identical question is posed to 10 or mo members of the public in a given year. Since the items above are OMB approved, you may ask for this information whenever necessary. OMB approval is not required when information for a specific application is requested annually from fewer than 10 members of the public. You may use this exemption to seek additional information to resolve an MSP issue on an exception basis, i.e., the information requested is not sought on a routine basis.

MSP Outpatient Claims Involving Lab Charges

3695. CALCULATION OF DEDUCTIBLE AND COINSURANCE FOR MSP OUTPATIENT CLAIMS INVOLVING LAB CHARGES PAID BY FEE SCHEDULE

A. General.—The following procedure describes how to calculate deductible and coinsurance for MSP outpatient claims which include charges for clinical diagnostic lab services (reimbursed on the basis of 100 percent of a fee schedule) and charges for nonlab services (subject to the regular deductible and coinsurance requirement) when a primary payer pays in part for the services, without designating how much of its payment is for each type of service.

B. Prorating Primary Payments.—Prorate the undesignated primary payer's payment for Medicare covered services by applying a ratio of this payment between lab and nonlab charges on the bill to determine what portion of the primary payer's payment is attributable to the nonlab charges.

NOTE: This ratio is based upon Medicare billed charges, not Medicare's payment under the fee schedule.

C. Calculation of Deductible and Coinsurance.—Deductible and coinsurance are calculated in the usual manner after applying the primary payer's payment allocated for nonlab services (as derived in subsection B above). Follow the guidelines in §§3679F4, 3680F4, and 3685C2a for determining the applicable deductible amount when the primary payer is WC, automobile medical, no-fault, or a liability insurer. See examples below for calculation of coinsurance.

EXAMPLE I - DEDUCTIBLE PREVIOUSLY MET

Outpatient services were furnished to a Medicare beneficiary for which the provider billed $100 for lab services and $200 for emergency room services. The lab fee schedule amount for the $100 lab services is $70. The beneficiary's Part B deductible was previously met. The primary payer paid $150 for Medicare covered services without designating what portion of its payment was for each type of service. Since the ratio of lab charges to nonlab charges is $100/$200, divide the primary payer's payment of $150 into two amounts based upon the same ratio: $100/$200 = $50/$100. Apply $50 of the primary payer's payment to the $70 lab fee schedule amount and the remaining $100 to the $200 in nonlab charges (emergency room services). Calculate the coinsurance in the usual manner based upon the $200 nonlab charges as follows:

o If the primary payer is automobile medical, no-fault, liability, or W/C insurer, the coinsurance for the nonlab charges is computed as follows: $200 (nonlab charges) minus $100 (primary payment allocated to nonlab charges) = $100 X .20 = $20. The applicable coinsurance amount charged is $20.

o If the primary payer is an EGHP, no coinsurance is charged since the primary payment of $100 allocated to nonlab charges is greater than the $40 regular coinsurance on the $200 in nonlab charges. (For the PS&R, record $40 coinsurance and $60 primary payment.)

EXAMPLE II - DEDUCTIBLE NOT MET

Outpatient services were furnished to a Medicare beneficiary for which the provider billed $100 for lab services and $200 for emergency room services. The lab fee schedule amount for the $100 lab services is $70. No part of the beneficiary's Part B deductible of $75 had been met previously. The primary payer paid $150 for Medicare covered services without designating what portion of its payment was for each type of service. Since the ratio of lab charges to nonlab charges is $100/$200, divide the primary payer's payment of $150 into two amounts based upon the same ratio: $100/$200 = $50/$100. Apply $50 of the primary payer's payment to the $70 lab fee schedule amount and the remaining $100 to the $200 in nonlab charges (emergency room services). Calculate the deductible and coinsurance in the usual manner based upon the $200 nonlab charges as follows:

o If the primary payer is automobile medical, no-fault, liability, or W/C insurer, the coinsurance for the nonlab charges is computed as follows: $200 (nonlab charges) minus $100 (primary payment allocated to nonlab charges) minus $75 (deductible) = $25 X .20 = $5. The applicable deductible amount charged is $75 and the applicable coinsurance amount charged is $5.

o If the primary payer is an EGHP, no deductible and coinsurance are charged since the primary payment of $100 allocated to nonlab charges is equal to the the $25 regular coinsurance and $75 deductible on the $200 in nonlab charges. (For the PS&R, record $75 deductible and $25 coinsurance.)

3696. MEDICARE SECONDARY PAYER (MSP) DATA EXCHANGE

A. Introduction.—HCFA initiatives have made available information pertinent to the identification of MSP beneficiaries. For example, selected contractors sent letters to aged beneficiaries advising them of the working aged provisions. Beneficiaries responded providing detailed information on working aged status. It is important that this information, as well as information on all other MSP situations known to you be made available to, and shared by, the entire contractor community. In order to facilitate and standardize the exchange of this information, a MSP Regional Data Exchange System (RDES) has been designed.

This exchange expands the lines of communication among contractors and reduces the duplication of effort to identify MSP sources. A timely exchange of MSP related information assures efficient and consistent development and recovery action.

Information on MSP situations is valid only as long as it is current. It is important to identify new MSP situations, update information on existing situations and revise the RDES. For example, contractors receiving data transfers from State Workers Compensation Commissions or other State Agencies are expected to include that information into the RDES. It is important to identify new working aged/spouse beneficiaries and disabled beneficiaries who may be entitled to compensation from other insurance to which Medicare plays a secondary role.

B. Tape Exchanges.—MSP data bases have been established in each region. Send prepared tapes as described in §§3696.1 and 3696.2 to the designated Regional Data Exchange Manager (RDEM) (Exhibit 1). The RDEM edits and merges all tapes received and returns a tape to you containing information on all identified beneficiaries in your region. Update your MSP data base with that information. You have the option of loading the entire regional file or selecting only your processing State(s) data. Specialty contractors; e.g., HHA or PEN load information from all areas they service. The RDEMs retain tape files from all other regions which you may request.

Maintain a current MSP data set containing the data elements listed in §3696.2 for all MSP situations for each beneficiary where Medicare has been determined not to be the primary payer. Where a data set is nonexistent, extract MSP data from independent sources (history or other files), thereby creating the necessary data set. Each situation has two options:

o Maintain your current MSP file when creating the data exchange tape and receive the RDEM updated exchange tape to update your current MSP file; or

o Convert your current MSP file to VSAM KSDS format and create your exchange tape. Use Prudential prepared programs to update your converted VSAM KSDS data set. This becomes your current MSP file.

Programs will be made available to you to update the converted VSAM KSDS data set you receive from the RDEM—the converted VSAM KSDS data set then becomes your current MSP file. However, if you select the first option, write a conversion program that takes your current MSP data set and creates the data exchange tape in the national standard format. (See §3696.1 for data transmission.)

C. Subsequent Tape Exchange.—Incorporate newly identified MSP situations and updates of existing situations into the RDES through subsequent tape exchanges.

o. Update Information to be Included by All Contractors.Incorporate all newly identified MSP situations or changes into the RDES. Regional/State tapes modified to reflect newly identified MSP situations to the prior tape submission will be exchanged on a quarterly basis — December, March, June and September. All tapes must be received by the RDEM servicing your region no later than the 10th day of the month following the end of each quarter. The RDEM will return the update tape no later than the 15th day of the following month. (See §3696.1 for data transmission.)

3696.1 MSP Data Exchange Tape Format.—All items described in the MSP Data Exchange Tape Record Layout in §3696.2 are "Required" if possessed by you in any format or file; i.e., place the information on the tape for the exchange. The following items are "MANDATORY":

- Health Insurance Claim Number (HICN);
- Beneficiary Last Name;
- Beneficiary First Name;
- Beneficiary State Code;
- Beneficiary Date of Birth;
- Beneficiary Sex Code;
- MSP Code;
- Intermediary/Carrier Code; and
- Maintenance Date.

When all "MANDATORY" items are not present, DO NOT INCLUDE that particular MSP situation for the beneficiary. "MANDATORY" means if a field is missing the entire record will reject.

A. Tape Characteristics.—

1. Label : NL**
2. Record Length : 650
3. Blocking Factor : 13,000
4. Track : 9
5. Density : 6250
6. Record Format : FB

**Designate on the external label whether a "complete file" or "processing State(s) only" is being sent to the RDEM.

B. MSP Data Exchange Tape Transmittal Shipment Sheet.—Use this form (Exhibit 3) for the exchange of MSP tapes. It serves as a control mechanism at both the sending and receiving contractor's site. It is self explanatory. Complete it in its entirety.

C. External Tape Label.—In addition to the tape transmittal shipment sheet, tape labels are required on tapes sent to and from the RDEM. The label must include the following information:

- Medicare MSP Regional Data Exchange;
- Region #____________;
- Contractor Name and ID Number;
- Data Set Name, Volume, Serial Number;
- Create Date; and
- Reel ______ of ______

D. Magnetic Tapes.—All magnetic tapes become the property of the receiver.

EXAMPLE 1: Tapes sent to RDEM become property of RDEM.

EXAMPLE 2: Tapes sent to contractor become property of contractor.

Therefore, the exact tape sent will not necessarily be returned.

3696.2 MSP Data Exchange Tape Record Layout.—

FIELD NAME	REC LEN	REC POS	DESCRIPTION
1. HICN	12	1-12	Beneficiary's HICN/RRB Number MANDATORY
2. XREF HICN	12	13-24	Cross Referred Beneficiary HICN DEFAULT SPACES
3. BENE LAST NAME	20	25-44	Beneficiary Last Name MANDATORY
4. BENE FIRST NAME	10	45-54	Beneficiary First Name MANDATORY
5. BENE MID INIT	1	55	Beneficiary Middle Initial DEFAULT SPACE
6. BENE ADDR 1	18	56-73	Beneficiary Address Line 1 DEFAULT SPACES
7. BENE ADDR 2	18	74-91	Beneficiary Address Line 2 DEFAULT SPACES
8. BENE CITY	15	92-106	Beneficiary City DEFAULT SPACES
9. BENE STATE CODE	2	107-108	Beneficiary State Code MANDATORY See Exhibit 4 for valid State Code
10.a. BENE ZIP CODE	5	109-113	Beneficiary ZIP Code MANDATORY Must be numeric and greater than zero
10.b. PLUS 4 ZIP	4	114-117	DEFAULT SPACES
11. BENE DATE OF BIRTH	6	118-123	Beneficiary Date of Birth Format:YYMMDD MANDATORY
12. BENE SEX	1	124	Beneficiary Sex Code F=Female M=Male DEFAULT SPACE

FIELD NAME	REC LEN	REC POS	DESCRIPTION
13. MSP CODE	2	125-126	MSP Coverage Type MANDATORY 12=Working Aged 13=ESRD 14=Auto/Liability 15=WC 16=Federal (Public Health) 41=Black Lung 42=VA 43=Disability
14. INTERMEDIARY/CARRIER CODE	5	127-131	HCFA assigned contractor number/code identifying contractor sending the record MANDATORY
15. INITIAL SOURCE CODE	2	132-133	Source of Initial MSP Information NOTE: Show updates to original information in CURRENT SOURCE. 10=Mass Mailing (ages 65-69) 20=Claim Processing 30=Y Trailer 40=Other 50=COBRA Mailing (ages 70-79) DEFAULT SPACES
16. CURRENT SOURCE CODE	2	134-135	Source of Most Current Information NOTE: Source of most recent current information on this record. 10=Mass Mailing (ages 65-69) 20=Claim Processing 30=Y Trailer 40=Other 50=COBRA Mailing (ages 70-79) DEFAULT SPACES
17. INSURER TYPE	1	136	Type of Primary Insurer A=Administrator U=Underwriter DEFAULT SPACES
18. DIAGNOSIS CODE	5	137-141	Diagnosis Code NOTE: Use ICD-9-CM. DEFAULT SPACES

FIELD NAME	REC LEN	REC POS	DESCRIPTION
19. INSURER NAME	32	142-173	Primary Insurer Name DEFAULT SPACES
20. INSURER ADDR 1	32	174-205	Primary Insurer Address Line 1 DEFAULT SPACES
21. INSURER ADDR 2	32	206-237	Primary Insurer Address Line 2 DEFAULT SPACES
22. INSURER CITY	15	238-252	Primary Insurer City DEFAULT SPACES
23. INSURER STATE	2	253-254	Primary Insurer State Code DEFAULT SPACES
24. INSURER ZIP CODE	9	255-263	Primary Insurer ZIP Code DEFAULT SPACES
25. POLICY NUMBER	17	264-280	Primary Insurance Policy Number DEFAULT SPACES
*26.MSP EFFECTIVE DATE	6	281-286	Effective Date of MSP Coverage Format:YYMMDD MANDATORY
*27.MSP TERMINATION DATE	6	287-292	Termination Date of MSP Coverage Format:YYMMDD DEFAULT ZEROS
28. PATIENT RELATIONSHIP	2	293-294	Relationship of Patient to Insured 01=Patient is Insured 02=Spouse 03=Natural Child/Insured has Financial Responsibility 04=Natural Child/Insured does not have Financial Responsibility 05=Step Child 06=Foster Child 07=Ward of the Court 08=Employee 09=Unknown

*See page 6-619 for the instruction for this field.

FIELD NAME	REC LEN	REC POS	DESCRIPTION
			10=Handicapped Dependent 11=Organ Donor 12=Cadaver Donor 13=Grandchild 14=Niece/Nephew 15=Injured Plaintiff 16=Sponsored Dependent 17=Minor Dependent of a Minor Dependent 18=Parent 19=Grandparent DEFAULT ZEROS
29. VALIDITY INDICATOR	1	295	Validity of MSP Coverage Y=Confirmed—beneficiary HAS MSP coverage N=Confirmed—beneficiary HAS NO MSP coverage U=Under development
30. MEDICARE A INDICATOR	1	296	Medicare A Indicator Y=Beneficiary has Medicare A N=Beneficiary does not have Medicare A DEFAULT SPACES
31. MEDICARE A EFFECTIVE DATE	6	297-302	Medicare A Effective Date Format: YYMMDD DEFAULT ZEROS
32. MEDICARE B INDICATOR	1	303	Medicare B Indicator Y=Beneficiary has Medicare B N=Beneficiary does not have Medicare B DEFAULT SPACES
33. MEDICARE B EFFECTIVE DATE	6	304-309	Medicare B Effective Date Format:YYMMDD DEFAULT ZEROS
34. SUBSCRIBER NAME	25	310-334	Name of Policyholder DEFAULT SPACES
35. SUBSCRIBER DOB	6	335-340	Policyholder Date of Birth Format:YYMMDD DEFAULT ZEROS

FIELD NAME	REC LEN	REC POS	DESCRIPTION
36. REMARK LINE 1	73	341-413	General Comments DEFAULT SPACES
37 REMARK LINE 2	73	414-486	General Comments DEFAULT SPACES
38. EMPLOYEE ID #	12	487-498	Employee ID Number Assigned by Employer DEFAULT SPACES
39. EMPLOYEE STATUS CODE	1	499	Employment Status 1=Full Time 2=Part Time 3=Not Employed 4=Self Employed 5=Retired 6=Active MilitaryDuty 7=Reserved Code 8=Reserved Code 9=Unknown DEFAULT SPACE
40. EMPLOYEE INFORMATION DATA	1	500	To Whom the Employment Data Applies P=Patient S=Spouse M=Mother F=Father DEFAULT SPACE
41. EMPLOYER NAME	24	501-524	Employer Providing Coverage DEFAULT SPACES
42. EMPLOYER ADDRESS	18	525-542	Employer Street Address DEFAULT SPACES
43. EMPLOYER CITY	15	543-557	Employer City DEFAULT SPACES
44. EMPLOYER STATE	2	558-559	State Code of Employer DEFAULT SPACES
45. EMPLOYER ZIP CODE	9	560-568	ZIP Code of Employer DEFAULT SPACES

46. INSURANCE GROUP NUMBER	20	569-588	Insurance Group Number Assigned by Primary Payer DEFAULT SPACES
47. INSURANCE GROUP	17	589-605	Name of Group Plan DEFAULT SPACES
48. MAINTENANCE DATE	6	606-611	Date Record Last Updated Format:YYMMDD MANDATORY NOTE: Do not use tape creation or transmission dates.
49. FILLER	37	612-648	Reserved for Field Expansion

NOTE: The following fields (50 & 51) for RDEM internal use only—transfer not required.

50. MAINTENANCE CODE	1	649	Maintenance Code A=Add U=Update D=Delete
51. MAINTENANCE RECORD	1	650	Maintenance Record Type B=Beneficiary I=Insurer 2=Both Beneficiary & Insurer

** CRITERIA FOR MSP ISSUES - Item 26 — "Effective Date" And Item 27 — "Termination Date"

"WORKING AGED"

"EFFECTIVE DATE":

- Should not be prior to January 1, 1983.
- The Medicare beneficiary's 65th birthday. (First day of month).
- The date the Medicare beneficiary becomes eligible on the Employer Group Health Plan (EGHP) if it is after his/her birthday.
- The date the Medicare beneficiary becomes entitled to Medicare if it is after his/her 65th birthday.

"TERMINATION DATE":

- The last day of the month in which the Medicare beneficiary retires.
- The day the Medicare beneficiary is terminated from the EGHP.
- The beneficiary's date of death.

"END STAGE RENAL DISEASE (ESRD)"

"EFFECTIVE DATE":

- Effective for all persons whose 12-month period began on or after October 1, 1981.
- The day the Medicare beneficiary became entitled to Medicare (kidney transplant).
- The day the Medicare beneficiary became entitled to Medicare (start of Home Dialysis treatment).
- The day the Medicare beneficiary became entitled to Medicare (Renal Dialysis treatment).

"TERMINATION DATE":

- 12 months from the Medicare effective date if the beneficiary had a self training dialysis course or kidney transplant.
- 9 months from the Medicare effective date if the beneficiary had a dialysis treatment.
- First day of the month in which the beneficiary becomes 65.

- The day the Medicare beneficiary is terminated from the EGHP.
- The beneficiary's date of death.

"AUTOMOBILE/NO-FAULT/OTHER LIABILITY"

"EFFECTIVE DATE":

- The date of the Medicare beneficiary's illness or accident (not prior to December 5, 1980).

"TERMINATION DATE":

- The date the case was settled with the liability insurance.
- The beneficiary's date of death.

"WORKERS' COMPENSATION

"EFFECTIVE DATE":

- Should not be prior July 1, 1966.
- The date of the job related illness or injury.
- The date Medicare became effective.

"TERMINATION DATE":

- The date of the Workers' Compensation.
- No termination date if insurer is responsible for medicals related to that injury or illness for life.
- The beneficiary's date of death.

"BLACK LUNG"

"EFFECTIVE DATE":

- Should not be prior to July 1, 1973.
- The date of the black lung related illness.
- The date Medicare became effective.

"TERMINATION DATE":

- The date of Department of Labor (DOL) settlement.

- No termination date if insurer is responsible for medicals related to that illness for life.
- The beneficiary's date of death.

"VETERANS ADMINISTRATION (VA)"

"EFFECTIVE DATE":

- Should not be prior to July 1, 1966.
- The first date of VA benefits.

"TERMINATION DATE":

- The date Medicare terminates.
- The date the VA is released from issuing benefits for the service related condition.
- The beneficiary's date of death.

FEDERAL PROGRAMS (PUBLIC HEALTH)

"EFFECTIVE DATE":

- Should not be prior to July 1, 1966.
- The first date of Federal Program (FP) benefits.

"TERMINATION DATE":

- The date Medicare terminates.
- The date the FP is released from issuing benefits.
- The beneficiary's date of death.

"SPOUSE WORKING AGED"

"EFFECTIVE DATE":

- Should not be prior to May 1, 1986.
- The Medicare beneficiary's 65th birthday. (First day of month).

- The date the Medicare beneficiary becomes eligible on his/her spouse's EGHP if it is on/or after his/her 65th birthday.

"TERMINATION DATE":

- The last day of the month in which the Medicare beneficiary's spouse retires.
- The day the Medicare beneficiary's spouse is terminated from the EGHP.
- The beneficiary's date of death.

"DISABLED PROVISION"

"EFFECTIVE DATE":

- Should not be prior to January 1, 1987.
- The date the disabled beneficiary became entitled to Medicare benefits.
- The date the Medicare beneficiary becomes eligible on the EGHP, if it is after the date he/she becomes entitled to Medicare.

"TERMINATION DATE":

- The day the disabled Medicare beneficiary is terminated from the EGHP.
- When the disabled beneficiary becomes entitled to aged benefits, terminate as disabled and classify as Working Aged.
- The beneficiary's date of death.

Exhibit 1 Regional Data Exchange Manager (RDEM).—The contractors listed below are the RDEMs' for the region specified.

REGION	CONTRACTOR/NAME/ADDRESS
I	Blue Cross/Blue Shield of Massachusetts 178 Forbes Rd. Suite 119 Braintree, MA 02184 617-849-4649
II	The Prudential Insurance Company of America High & Sharp Streets Millville, NJ 08332 609-293-2249
III	Blue Cross/Blue Shield of Virginia 2015 Staples Mill Rd. Richmond, VA 23279 804-287-2187
IV	Blue Cross/Blue Shield of South Carolina I-20 at Alpine Rd. Columbia, SC 29219-0001 803-788-3860 Ext. 1916
V	Community Mutual Insurance Company 801A West Eighth St. (Randall Bldg.) Cincinnati, OH 45202 513-852-4337
VI	Blue Cross/Blue Shield of Oklahoma 1215 South Boulder Tulsa, OK 74129 918-560-2133
VII	Blue Cross/Blue Shield of Missouri 4444 Forrest Park Blvd. St. Louis, MO 63108 314-658-4543
VIII	Blue Cross/Blue Shield of Utah 2455 Parley's Way Salt Lake City, UT 84130-0270 801-481-6583

REGION	CONTRACTOR/NAME/ADDRESS
IX	Blue Cross of California 21555 Oxnard St., 4th Floor Woodland Hills, CA 91367 818-703-3665
X	Blue Cross/Blue Shield of Oregon 100 S.W. Market St., 4th Floor Portland, OR 97207 503-225-5304

Exhibit 2 Regional Data Exchange Manager (RDEM) Service Areas.—Listing showing RDEM service area.

Region	RDEM	State
I	Blue Cross/Blue Shield of Massachusetts	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont
II	Prudential Insurance Company of America (New Jersey)	New Jersey New York Puerto Rico Virgin Islands
III	Blue Cross/Blue Shield of Virginia	Delaware Maryland Pennsylvania Virginia Washington D.C. West Virginia
IV	Blue Cross/Blue Shield of South Carolina	Alabama Florida Georgia Kentucky Mississippi North Carolina South Carolina Tennessee
V	Community Mutual Insurance Company (Ohio)	Illinois Indiana Michigan Minnesota Ohio Wisconsin
VI	Blue Cross/Blue Shield of Oklahoma	Arkansas Louisiana New Mexico Oklahoma Texas

Region	RDEM	State
VII	Blue Cross/Blue Shield Health Services of Missouri	Iowa Kansas Missouri Nebraska
VIII	Blue Cross/Blue Shield of Utah	Colorado Montana North Dakota South Dakota Utah Wyoming
IX	Blue Cross of California	Arizona California Hawaii Nevada
X	Blue Cross/Blue Shield of Oregon	Alaska Idaho Oregon Washington

Exhibit 3 MSP Data Exchange Tape Shipment Sheet

Date: ___________

Date of Shipment: ____________________

From ___________

Contractor Name: ________________
Address: ________________________
____
____

Total Number Reels Shipped: ________________

Distribution Instructions For Shipper

1. Send 2 copies with Shipment to:

Contractor Name: ________________
Address: ________________________
____
____

2. Retain 1 copy for file

Person to Be Notified ________________________

Phone Number:

Indicate below complete copy of state code(s)

____

Carrier/Intermediary Number ________

Tape Data Set Name (File ID)	Volume Serial Number	Density	Label Type	Record Format	Logical Record Length	Block Size

Date Received: ________________

Remarks:
____
____

Exhibit 4 Two Letter State Abbreviations.--Valid beneficiary State code (pos. 107-108) of MSP data exchange tape record layout.

Alabama................	AL	Missouri......................	MO
Alaska.................	AK	Montana.......................	MT
Arizona................	AZ	Nebraska......................	NE
Arkansas...............	AR	Nevada........................	NV
American Samoa.........	AS	New Hampshire.................	NH
California.............	CA	New Jersey....................	NJ
Canal Zone.............	CZ	New Mexico....................	NM
Colorado...............	CO	New York......................	NY
Connecticut............	CT	North Carolina................	NC
Delaware...............	DE	North Dakota..................	ND
District of Columbia....	DC	Ohio..........................	OH
Florida................	FL	Oklahoma......................	OK
Foreign Country.........	FC	Oregon........................	OR
Georgia................	GA	Pennsylvania..................	PA
Guam...................	GU	Puerto Rico...................	PR
Hawaii.................	HI	Rhode Island..................	RI
Idaho..................	ID	South Carolina................	SC
Illinois...............	IL	South Dakota..................	SD
Indiana................	IN	Tennessee.....................	TN
Iowa...................	IA	Trust Territories.............	TT
Kansas.................	KS	Texas.........................	TX
Kentucky...............	KY	Utah..........................	UT
Louisiana..............	LA	Vermont.......................	VT
Maine..................	MA	Virginia......................	VA
Maryland...............	MD	Virgin Islands................	VI
Massachusetts..........	MA	Washington....................	WA
Michigan...............	MI	West Virginia.................	WV
Minnesota..............	MN	Wisconsin.....................	WI
Mississippi............	MS	Wyoming.......................	WY

3697. COMPUTER PROGRAMS SUPPLIED BY HCFA TO SUPPORT MSP

A. Introduction.—MSP modules have been developed in an effort to standardize the processing of MSP claims. Updates to these modules will be furnished, as appropriate. The processes related to MSP have been identified below.

1. Review of Primary Claims (MSPPRIM).—Compares a claim for which Medicare is indicated as the primary payer, i.e., item 57 of the HCFA-1450 indicates Medicare as the primary payer on line A, against Medicare secondary data for the insured. If there is evidence of other insurance coverage for this claim, an indicator is set.

2. Review of Secondary Claims (MSPSEC).—Edits a claim for which Medicare is indicated as the secondary payer, i.e., item 57 of the HCFA-1450 indicates Medicare as the secondary payer on line B and another insurer as primary payer on line A. The situations involved are: EGHP, ESRD with EGHP, DIB with LGHP, auto medical/no-fault, liability, WC, and other federal agencies.

3. Payment Calculation for MSP Claims (MSPPAY).—Performs the following payment calculation processes for valid MSP claims:

- Computes the secondary payer payment amount, applicable deductible and coinsurance amounts;
- Reduces benefit utilization (if applicable); and
- Computes MSP savings.

B. Implementation.—Implementation of the MSPPRIM and MSPSEC modules are required. However, if you establish that you have systems in place which perform the same edits on all inputed claims on a prepayment basis and use the same data elements as MSPPRIM and MSPSEC, implementation of either one or both may be waived. Submit appropriate documentation to the RO for its review and determination.

To ensure uniformity of MSP calculations, implementation of the MSPPAY module by you is required. However, if you have a similar MSP calculation package you may apply for a temporary implementation delay due to other major system updates which may be needed to interface with MSPPAY. If you wish a temporary exemption from implementing MSPPAY submit documentation to your RO showing that your system generates the same output.

3697.1 Review of Primary Claims (MSPPRIM)

A. Introduction.—MSPPRIM is an MSP edit module that examines all inputed primary claims against beneficiary historical data searching for evidence of other insurance coverage. MSPPRIM performs the following functions:

- Receives appropriate data of the Medicare primary claim from the calling program.

- Obtains previously processed MSP data by calling a user module containing individual MSP beneficiary data obtained from prior claims.

- Returns to the calling module one of the following conditions after previously processed data for the beneficiary has been examined:

  - No previously processed MSP data for the beneficiary;

  - Other insurance coverage present during the period covered by the claim; or

  - Other insurance coverage present prior to, or after, the period covered by the claim.

B. Requisite MSPPRIM Data Elements and Return Codes.—The calling program must send the following data elements to MSPPRIM:

Field Name/Definition	Source
User Data	User specified
Test switch	User specified T = exhibit sending/returning data Space = do no exhibit
HICN	HCFA-1450, item 68A
Covers from date - Beginning service date of the period included on the claim (YYMMDD).	HCFA-1450, item 22
Covers thru date - Ending service date of the period included on the claim (YYMMDD).	HCFA-1450, item 22

MSPPRIM issues a return code indicating the result of processing the primary claim through this module. Return Code Table A contained in the Medicare Secondary Payment Technical Manual defines the specific return codes. Along with a return code, MSPPRIM also returns the data which caused the specific return code.

C. Proposed Claims Flow.—Take the following actions when you receive a claim from a provider for Medicare primary benefits:

- o Perform front-end edits;
- o Enter the claim into your processing system;
- o Control the claim;
- o Call MSPPRIM;
- o Receive return code from MSPPRIM; and
- o Process accordingly, i.e., suspend to develop or process to payment.

D. Installation.—You have received the MSP software on tape along with the Medicare Secondary Payment Technical Manual documenting and describing installation and execution of the MSP modules. The input and output data elements required of MSPPRIM are specifically referenced. You are responsible for installing, modifying, testing, and verifying the accurancy of the MSPPRIM module.

E. Processing Requirements.—The following requirements apply:

o Process all bills where Medicare is shown on line 57A of the HCFA-1450 as primary payer through the MSPPRIM module;

o MSPPRIM must interface with a user "MSP Control File," the definition of which is your responsibility. The "MSP Control File" is a generic term to indicate a file housing previously processed MSP data by beneficiary. The "MSP Control File" must contain all data elements required of MSPPRIM and MSPSEC but need not be limited solely to them;

o If MSPPRIM returns a code indicating another insurer, suspend, develop, and process the claim accordingly. If another insurer is not indicated, process the claim to payment;

o Resolve all error conditions and invalid MSP situations unveiled by MSPPRIM. Refer to the Medicare Secondary Payment Technical Manual for a list of return codes; and

o Update your "MSP Control File" after new and pertinent MSP claim information is received.

3697.2 Review of Secondary Claims (MSPSEC)

A. Introduction.—MSPSEC is an MSP edit module that reviews claim data for a valid MSP situation. The calling module sends to MSPSEC pertinent data from a claim in which Medicare has been determined to be a secondary payer. MSPSEC then performs the following functions:

o It reviews the claim for a valid MSP situation, e.g., age check, ESRD coordination period check, relationship check;

o If a valid MSP situation is found, the user's "MSP Control File" is automatically updated; or

o If an invalid MSP situation is found, MSPSEC returns to the calling module a code indicating the nature of the violation.

B. Requisite MSPSEC Data Elements and Return Codes.—The calling program must send the following elements, which are elaborated upon in the Medicare Secondary Payment Technical Manual, to MSPSEC:

Field Name/Definition	Source
User data	User specified
Test switch	User specified T = exhibit sending/returning data Space = do not exhibit data
HICN	HCFA-1450, item 68 (the Medicare line)
Patient's birth date - Beneficiary's date of birth in format (CCYYMMDD).	HCFA-1450, item 12
Entitlement date - Beneficiary's date of Medicare A/Medicare B eligibility.	Query/Reply from HCFA
Covers from date - Beginning service date of the period included on the claim.	HCFA-1450, item 22 (YYMMD
Covers thru date - Ending service date of the period included on the claim.	HCFA-1450, item 22 (YYMMDD)
Number other payers - Number of other payers that are primary to Medicare.	Determined by the calling program
Other payer data - The following information through "employer location" can occur twice, i.e., information about two insurers can be accepted by MSPSEC.	
Conditional payment - Denotes whether conditional payment has been requested. (Y = claim is conditional payment; N = claim is not conditional payment).	HCFA-1450, items 46-49 (zero amount with appropriate value code indicates conditional payment)
MSP code - Code identifying the other payer.	HCFA-1450, items 46-49 (value codes 12-16 and 41-43)

Field Name/Definition	Source
Payer identification number - Number identifying the organization from which the provider might expect some payment for the bill.	From your own system, if available
Other payer ID - Insured's unique identification number assigned by the payer.	HCFA-1450, item 68
Payer name - Name identifying the payer organization from which the provider might expect some payment for the bill.	HCFA-1450, item 57
Insured's name - Full name of the insured.	HCFA-1450, item 65
Insured's sex - Code indicating the sex of the insured.	HCFA-1450, item 66
Patient relationship - Code indicating the relationship of the patient to the insured.	HCFA-1450, item 67
Group name - Name of the group or plan through which the insurance is provided.	HCFA-1450, item 69
Insurance group number - Identification number, control number, or code assigned by the health insurance carrier to identify the group under which the individual is covered.	HCFA-1450, item 70
Employment information data - Code indicating whether the employment information given in the related areas applies to an insured, the patient or the patient's spouse.	HCFA-1450, item 71
Employment status code - Code used to define the employment status of the individual.	HCFA-1450, item 72
Employer name - Name of the employer that provides health care coverage for the individual.	HCFA-1450, item 73
Employee identification number - Identification number assigned by the employer to the individual.	HCFA-1450, item 74
Employer location - Address of the employer of the insured individual.	HCFA-1450, item 75

Document control number - A unique patient control number or document control number used by the provider or intermediary to distinguish each specific claim.	From a nonrequired item on the HCFA-1450 or from your system, if available.

MSPSEC can return up to two return codes, one for payer 1 and the other for payer 2. The return code indicates the result of processing the secondary claim through the MSP edit module. Return Code Table B in the Medicare Secondary Payment Technical Manual defines the specific return codes.

C. Proposed Claims Flow.—Take the following actions when you receive a claim from a provider or beneficiary for MSP benefits:

- o Perform front-end edits;
- o Enter the claim into your processing system;
- o Control the claim;
- o Call MSPSEC;
- o Receive return code from MSPSEC; and
- o Process accordingly, i.e., suspend for development or process to payment.

D. Installation.—You have received the MSP software on tape along with the Medicare Secondary Payment Technical Manual documenting and describing installation and execution of the MSP modules. The input and output data elements required of MSPSEC are referenced in the Medicare Secondary Payment Technical Manual. You are responsible for installing, modifying, testing, and verifying the accuracy of the MSPSEC module.

E. Processing Requirements.—The following requirements apply:

o Process all bills where Medicare is shown on line 57B of the HCFA-1450 as secondary payer through the MSPSEC module;

o MSPSEC must interface with a user "MSP Control File," the definition of which is your responsibility. The "MSP Control File" is a generic term to indicate a file housing previously processed MSP data by beneficiary. The "MSP Control File" must contain all data elements required of MSPPRIM and MSPSEC but need not be limited solely to them;

o Resolve all error conditions and invalid MSP situations unveiled by MSPSEC. Refer to the Medicare Secondary Payment Technical Manual for a list of return codes; and

o If MSPSEC returns a code indicating a match with an existing record, allow the claim to continue through your system to payment. If a match does not occur, MSPSEC creates a new record automatically for the "MSP Control File." Writing the new record ensures that any future claims on that beneficiary will be flagged as having other insurance. Continue to process the claim.

3697.3 Payment Calculation for MSP Claims (MSPPAY)

A. Introduction.—MSPPAY accepts data from the user's system and performs the following:

- Computes the MSP payment, applicable deductibles and coinsurance amounts;
- Reduces benefit utilization days and amounts using the amount paid by the other payer;
- Computes the MSP savings amount depending upon the type of other payer and whether the claim is fully or partially paid; and
- Returns status codes along with the MSP payment computation and savings data to the calling module.

Once MSPPAY passes back information to your claims processing system, you can retrieve it in any format desired, e.g., savings reports, management tools, EOMB generation. The reports can be tailored to your specific needs.

B. Requisite MSPPAY Input Data Elements.—The calling program must send the following data elements to MSPPAY:

Field Name/Definition	Source
Test switch	User specified T = exhibit sending/returning Space = do not exhibit data
Type of bill - Code indicating the type of bill (inpatient, outpatient, etc.).	Positions 1-2 = Type of claim: Medicare A (PA), Home Health (HH), Outpatient (OP) Position 3 = frequency code: HCFA-1450. A zero indicates a fully paid claim.
Number of other payers	Determined by calling program as the number of other payers that have made primary payments
Other payer data - MSP Code and MSP Amount comprise Other Payer Data which can occur 10 times.	

Field Name/Definition	Source
MSP Code - Code identifying the other payer	HCFA-1450, items 46-49 (value codes 12-16 and 41-43)
MSP Amount - Amount paid by the other payer	HCFA-1450, items 46-49 (value amount)
Total covered charges - Total charges covered by Medicare.	Computed by the calling program
Blood deductible - Total cash blood deductible.	As determined in your system after query
Cash deductible - Medicare cash deductible.	As determined in your system after query
Regular coinsurance days 1st yr - Medicare coinsurance days charged in in the year of admission.	Computed by calling program
Regular coinsurance rate 1st yr - Medicare coinsurance rate charged in year of admission	Determined by calling program
Regular coinsurance amount 1st yr - Medicare coinsurance days charged in the year of admission.	As determined in your system after query
Regular coinsurance days and yr - Medicare coinsurance days charged in the year of discharge where the bill spans two calendar years.	Computed by calling program
Regular rate 2nd yr - Medicare coinsurance charged in the year of discharge where the bill spans two calendar years.	Determined by calling program
Regular coinsurance amount 2nd yr - Medicare coinsurance amount charged in the year of discharge where the bill spans two calendar years.	As determined in your system after query
Lifetime reserve coinsurance days 1st yr - Medicare lifetime reserve days charged in the year of admission.	Computed by the calling program

Field Name/Definition	Source
Lifetime reserve coinsurance rate 1st yr - Medicare lifetime reserve amount charged in the year of admission.	As determined in your system after query
Lifetime reserve coinsurance amount 1st yr - Medicare lifetime reserve days charged in the year of discharge where the bill spans two calendar years.	Computed by calling program
Lifetime reserve coinsurance rate 2nd yr - Medicare lifetime reserve rate charged in the year of discharge where the bill spans two calendar years.	Determined by calling program
Lifetime reserve coinsurance amount 2nd yr - Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.	As determined in your system after query
Total coinsurance amount - Total coinsurance amount chargeable to the beneficiary.	Computed by the calling program
Full days - The inpatient Medicare days occurring in the first 60 days in a single spell of illness.	Computed by the calling program
Covered days	HCFA-1450, item 23
PPS indicator	Determined by the calling program
DRG amount - Total prospective payment amount including any other payment.	Computed by PRICER
Indirect teaching - Estimated adjustment for the indirect cost of medical education.	Computed by PRICER
Pass thru per diem - Payment for those items that are reimbursed on a reasonable costs basis.	Determined by calling program
Medicare reimbursement amount - Amount paid to the provider and patient by Medicare.	Computed by the calling program

Field Name/Definition	Source
Provider Payment Amount - Reimbursement made to the provider.	Computed by the calling program
Payment to Patient - Reimbursement paid to the patient.	Computed by the calling program.
Gramm-Rudman-Hollings Percent - A percentage used to reduce Medicare payment.	Determined by the calling program.
Charges Not Subject to Deductible and Coinsurance - Charges reimbursed at 100 percent.	Determined by the calling program.

C. Requisite MSPPAY Output Data Elements.—MSPPAY will return the following data to the calling program. Refer to §3697.3B for field definitions not reflected below.

Field Name/Definition	Source
Return code	Determined by MSPPAY and indicates the results of processing this secondary claim (see Return-Code Table C in the Medicare Secondary Payment Technical Manual)
Blood deductible	The source of all of the following is the calling program, possibly modified by MSPPAY.
Cash deductible	
Regular coinsurance days 1st day yr	
Regular coinsurance rate 1st day yr	
Regular coinsurance amount 1st yr	
Regular coinsurance days 2nd yr	
Regular coinsurance rate 2nd yr	
Regular coinsurance amount 2nd yr	
Lifetime reserve coinsurance days 1st yr	

Field Name/Definition	Source
Lifetime reserve coinsurance rate 1st yr	
Lifetime reserve coinsurance amount 1st yr	
Lifetime reserve coinsurance days 2nd yr	
Lifetime reserve coinsurance rate 2nd yr	
Lifetime reserve coinsurance amount 2nd yr	
Medicare A regular coinsurance days - Total Medicare coinsurance days chargeable to the beneficiary.	
Medicare A lifetime reserve coinsurance days - Total Medicare lifetime reserve days chargeable to the beneficiary.	
Medicare A coinsurance days - Total Medicare coinsurance and lifetime reserve days chargeable to the beneficiary.	
Total coinsurance amount	
Full days	
Utilized days - Days of care chargeable to Medicare.	
Cost report days - Days credited to provider's PS&R report as Medicare days.	
Medicare reimbursement amount	
Provider payment amount	
Payment to patient	
MSP blood deductible - Offset to the cash blood deductible due from the beneficiary.	
MSP cash deductible - Offset to the cash deductible due from the beneficiary.	
MSP total coinsurance amount - Offset to the coinsurance due from the beneficiary.	

best copy available

Field Name/Definition	Source
MSP covered days - Days covered by the primary payer.	
Medicare interim reimbursement - Medicare interim reimbursement without reduction of deductible and coinsurance.	
Savings MSP Code 12 - Amount saved by Medicare when EGHP has made a payment for a WA beneficiary.	
Savings MSP Code 13 - Amount saved by Medicare when EGHP has made a payment for an ESRD beneficiary.	
Savings MSP Code 14 - Amount saved by Medicare when another insurer has made payment in an auto, no-fault, or liability claim.	
Savings MSP Code 15 - Amount saved by Medicare when WC payment has been made.	
Savings MSP Code 16 - Amount saved by Medicare when PHS or other Federal agency made payment.	
Savings MSP Code 41 - Amount saved by Medicare when BL payment has been made by DOL.	
Savings MSP Code 42 - Amount saved by Medicare when payment has been made by VA.	
Savings MSP Code 43 - Amount saved by Medicare when LGHP has made a payment for a DIB beneficiary.	
Savings total - Total amount saved by Medicare when Medicare is the secondary payer and the primary payer has made a payment (for MSP value codes 12, 13, 14, 15, 16, 41, 42, and 43).	

MSP EGHP Payment Subject to Deductible and Coinsurance - Amount excluding "MSP cash deductible," "MSP blood deductible," and "MSP total coinsurance amount" paid by an EGHP or LGHP to be reflected on the PS&R report. This amount, when added to the "MSP cash deductible," "MSP blood deductible," and the "MSP total coinsurance amount," reflects the total primary payer amount. The primary payer amount designated to lab charges reimbursed at 100 percent is not reflected in this figure.

MSP Non-EGHP Payment Subject to Deductible and Coinsurance - Amount paid by a non-EGHP to be reflected on the PS&R report. The primary payer amount designated to lab charges reimbursed at 100 percent is not reflected in this figure.

D. Installation.—You have received the MSP software on tape along with the Medicare Secondary Payment Technical Manual documenting and describing installation and execution of the MSPPAY Module. The input data elements and output data elements required of MSPPAY are referenced in the Medicare Secondary Payment Technical Manual. You are responsible for installing, modifying, testing, and verifying the accuracy of MSPPAY module.

E. Processing Requirements.—The following processing requirements apply:

o Process all MSP inpatient hospital and SNF, HHA and all outpatient claims through MSPPAY to determine MSP payment amount, deductible, coinsurance and savings;

o Claims to be processed by MSPPAY must be in ready-to-pay status, e.g., the amount that Medicare would have paid as the primary payer, the type of MSP situation, the amount of other insurer payment, information regarding outstanding deductible and coinsurance must be available to MSPPAY;

o All data elements required by MSPPAY must be passed to it. Section 3697.3B lists these data elements. The Medicare Secondary Payment Technical Manual also contains more extensive information about them.

o You are responsible for resolving error conditions reflected as return codes. These return codes are detailed in Return Code Table C of the Medicare Secondary Payment Technical Manual.

3698. SERVICES RENDERED IN NONPARTICIPATING PROVIDERS

A. Services in Nonparticipating Domestic Hospital.—Payment may be made for certain Part A inpatient and Part B outpatient hospital services provided in a nonparticipating U.S. hospital where they are necessary to prevent the death or serious impairment of the health of the individual. Because of the threat to the life or health of the individual, the use of the most accessible hospital equipped to furnish such services is necessary. Items and services furnished in a domestic nonparticipating hospital may be reimbursed if the following apply:

- o The hospital meets the definition of an emergency hospital. (See §3698.2.)
- o The services meet the definition of emergency services. (See §3698.1.)
- o The hospital is substantially more accessible from the site of the emergency than is the nearest participating hospital. (See §3698.12.)

B. Beneficiary Services in Canada and Mexico.—Items and services furnished outside the United States are excluded from coverage except for the following Canadian and Mexican services:

- o Emergency inpatient hospital services where the emergency occurred:
  - — While the beneficiary was physically present in the U.S. (§3698.4(d)(1)).
  - — In Canada while the beneficiary was traveling without unreasonable delay by the most direct route, between Alaska and another State. (See §3698.4(d)(2).)
- o Emergency or nonemergency inpatient hospital services furnished in a Canadian or Mexican hospital closer to, or substantially more accessible from the beneficiary's U.S. residence than the nearest participating U.S. hospital which was adequately equipped to deal with and available to provide treatment of the illness or injury. (See §§3698.5 and 3698.13.)
- o Physician and ambulance services furnished in connection with, and during a period of, covered foreign hospitalization. Program payment may not be made for any other Part B Medical and Other Health Services, including outpatient services furnished outside the U.S. (See §3698.6.)
- o Christian Science services furnished under specified conditions in a Christian Science sanatorium. (See §3698.8.)

NOTE: The term "United States" means the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, Northern Mariana Islands, American Samoa and, for purposes of services rendered on a ship, the territorial waters adjoining the land areas of the U.S.

For Medicare purposes, services rendered aboard a ship in an American port or on the same day the ship arrived at, or departed from, that port are considered to have been rendered in American waters. Services not furnished in port or on the day of arrival or departure are considered to have been furnished outside the U.S. territorial waters.

3698.1 Establishing an Emergency.—Claims for emergency services must be accompanied by a physician's statement describing the nature of the emergency and stating that the services were necessary to prevent the death, or the serious impairment of, the beneficiary. A statement that an emergency existed is not sufficient. In addition, when inpatient services are involved, the statement must include the date when, in the physicians' judgment, the emergency ceased.

The finding of whether the patient's condition required emergency diagnosis or treatment is ordinarily based upon the physician's evaluation of the patient's condition immediately upon the beneficiary's arrival at the hospital.

However, the emergency nature of the situation may have been assessed by a physician who attended the patient where the incident resulting in hospitalization occurred (for example, a heart attack or an automobile accident). In these cases, the attending physician who ordered the hospitalization may substantiate the claim that emergency hospitalization was necessary.

Most emergencies are of relatively short duration so that only one bill is submitted. Generally, only one physician's statement is necessary. However, in the rare situation where an emergency continued over an extended period, subsequent requests for payment must be accompanied by a physician's statement containing sufficient information to indicate clearly that the emergency situation still existed. A statement that the emergency continued to exist is not acceptable.

Request additional information to support a finding that the services were emergency services from the physician, the hospital, and others (e.g., the police department at the scene of an accident).

Medical necessity can be documented by the physician on a HCFA-1771, Attending Physician's Statement and Documentation of Medicare Emergency (see §3699.5) or by the beneficiary's medical records.

3698.2 Qualifications of an Emergency Services Hospital.—An emergency services hospital is a nonparticipating hospital which meets the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. (See §3010D and F.) (A Federal hospital need not be licensed under State or local licensing laws to meet this definition.) In addition, the hospital must be primarily engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type that §3010 describes in defining the term hospital.

It must not be primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care. (See requirement "a" of the definition of a SNF in §3020.) Psychiatric hospitals can qualify as emergency hospitals.

3698.3 Claims From Hospital-Leased Laboratories Not Meeting Conditions of Participation.—Services furnished by a laboratory that does not meet the hospital laboratory conditions of participation and is operated under a lease arrangement in a domestic emergency hospital are covered only if they are emergency inpatient services reimbursable under Part A.

A carrier may send you a claim from such a laboratory and identify it as an "Emergency Lead." Check your files to see if a claim for emergency services was filed and if so, determine whether the laboratory services were furnished during the period of emergency. If the emergency claim was forwarded to the appropriate intermediary for processing, enter the date received on the laboratory claim.

If no emergency claim was filed, or laboratory services were not furnished in the period covered by the emergency claim, develop the claim as a possible emergency. Include the laboratory claim with any subsequent claim.

If no emergency is alleged, record on the claim that no emergency existed and disallow it.

3698.4 Coverage Requirements for Emergency Hospital Services Furnished in Canada or Mexico.—The following requirements must be met for payment to be made for emergency services received by Medicare beneficiaries in Canadian or Mexican hospitals:

- The hospital furnishing must meet the definition of an emergency hospital. (See §3698.2.) It must be licensed under Canadian or Mexican law.
- The services meet the criteria of emergency services. (See §3698.14.)

Secure a statement from the beneficiary or representative that indicates:

- The point of entry into Canada from the U.S;
- The intended point of departure from Canada;
- The route traveled at the time of the emergency;
- An explanation of any apparent deviation from the intended route; and
- An explanation of any nonroutine stopover.
- The foreign hospital must be closer to or substantially more accessible from the site of the emergency than the nearest U.S. hospital which was adequately equipped and available to treat the illness or injury. (See §3698.13.)
- The conditions in either (1) or (2) below must be met.

1. Emergency Occurred in the U.S.—If the individual was physically present in the U.S. at the time the emergency occurred, the individual's reason for departure from the U.S. must have been specifically to obtain treatment at the foreign hospital. Services are not covered where the person's departure from the U.S. is part of a trip abroad and the Candian or Mexican hospital is more accessible simply because he was in the process of travel. For example, the airplane on which he was traveling could not readily return to permit the person's removal.

2. Emergency Occurred in Canada.—If the emergency occurred in Canada, the beneficiary must have been traveling without unreasonable delay by the most direct route, between Alaska and another State. Benefits are not payable if the emergency occurred while a beneficiary was vacationing. The requirement of travel without unreasonable delay by the most direct route will be considered met if the emergency occurred while the beneficiary was enroute betwen Alaska and another State by the shortest practicable route, or while making a necessary stopover in connection with such travel.

NOTE: An emergency occurring within the Canadian inland waterway between the States of Washington and Alaska is considered to have occurred in Canada.

Ordinarily, the "shortest practicable route" is the one that results in the least amount of travel in Canada, consistent with the mode of travel used between the point of entry into Canada and the intended point of departure. The amount of travel in the U.S., prior to entering Canada is not pertinent. A route involving greater travel within Canada may be considered the "shortest practicable route" if the additional travel resulted in a saving of time or was necessary because of such factors as road or weather conditions, the age, health, or physical condition of the traveler, the need to make suitable travel arrangements, or obtain acceptable accommodations.

However, the individual would be considered to have deviated from the "shortest practicable route" if the detour was unrelated to the purpose of reaching his destination (e.g., for the principal purpose of sightseeing or vacationing).

The term "necessary stopover" means a routine stopover for rest, food, or servicing of the vehicle, and a nonroutine stopover (even though of significant duration) caused by such factors as unsuitable road or weather conditions, the age, health, or physical condition of the traveler, the need to make suitable travel arrangements, or to obtain acceptable accommodations.

3698.5 Services Furnished in a Foreign Hospital Nearest to Beneficiary's U.S. Residence.--Coverage is provided for inpatient hospital services furnished in a Canadian/Mexican hospital which is closer to, or substantially more accessible from, the beneficiary's U.S. residence than the nearest available participating U.S. hospital which is adequately equipped to deal with the illness or injury, whether or not an emergency existed and without regard to where the illness or injury occurred.

"Residence" means the beneficiary's fixed and permanent home to which he intends to return whenever he is away or a dwelling where the beneficiary periodically spends some time (e.g., a summer home).

The Canadian or Mexican hospital must meet accreditation requirements equivalent to JCAH standards. The Canadian Council on Hospital Accreditation (CCHA) has equivalent requirements. Thus, Canadian hospitals accredited by the CCHA meet the qualifying requirements. In the case of Mexican hospitals, the determination is made by the Dallas or San Francisco RO, depending upon the hospital's location.

See §3698.12B for discussion of accessibility criteria.

Some claims for services furnished in a foreign hospital nearest to the beneficiary's U.S. residence will not be "emergency." In these nonemergency situations, it may be necessary to deny payment in whole or part, (even though it has been approved with regard to accessibility) because the services are not medically reasonable and necessary or involve custodial care (i.e., exclusions under §1862(a)(1) or (9)).

Where a denial is made in a nonemergency foreign claim for reasons other than accessibility (e.g., cosmetic surgery benefits exhausted), the usual beneficiary denial notice procedures in §3717 apply. However, in the case of denials under the medical necessity and custodial care exclusions, apply the waiver of liability considerations under §1879 before issuing the denial notice.

Examine claims involving medical necessity or custodial care denials to determine if there is any evidence that the beneficiary (or the person acting on behalf of the beneficiary) was aware that he/she did not require, or no longer required, a covered level of care. The foreign hospital, since it is not participating, is not under any obligation to furnish a written notice of noncoverage to a beneficiary in order to protect itself from being held liable under the §1879 waiver of liability provision. However, there may be instances where the medical records of the denied foreign claim show that the beneficiary was advised that he/she did not require, or no longer required, Medicare covered services, (e.g., written notice of noncoverage from the hospital's staff or a prior HCFA denial notice). It will probably be rare where a finding is made that the beneficiary had knowledge of noncoverage, so that, generally, payments are made under the waiver of liability provision. Use appropriate denial paragraphs in §§3722.5ff. for determinations involving the waiver of liability provision.

3698.6 Coverage of Physician and Ambulance Services Furnished Outside U.S.--Physician and ambulance services which meet the coverage requirements of the Act and which are furnished in connection with inpatient services meeting the requirements of §§3698.4 or 3698.5 are covered under Part B. When they are met, Part B payment is possible even though there may be no Part A payment because Part A benefits are exhausted or there is no Part A entitlement.

Where inpatient services in a Canadian or Mexican hospital are covered, make payment for:

- Physicians' services rendered to the beneficiary while an inpatient.
- Physicians' services rendered to the beneficiary outside the hospital on the day of admission as an inpatient, provided the services were for the same condition for which the beneficiary was hospitalized.
- Services of a Canadian ship's physician who furnished emergency services in Canadian waters on the day the beneficiary is admitted to a Canadian hospital for a covered emergency stay.

- Ambulance services, where necessary, for the trip to the hospital in conjunction with the beneficiary's admission. Return ambulance trips from a foreign hospital are not covered.

In cases involving foreign ambulance services, the general requirements in §3647 are applicable, subject to the following special rule: If the foreign hospitalization was covered as emergency services, the necessity and the destination requirements are met.

The definition of "physician," for purposes of coverage of services furnished outside the U.S., includes a foreign practitioner, provided the practitioner is legally licensed to practice in the country in which the services were rendered.

Only the beneficiary may file for Part B benefits; the assignment method may not be used. However, where the enrollee is deceased, the rule for settling Part B underpayments are applicable: reimbursement may be made to the foreign physician or ambulance company on the basis of an unpaid bill, provided the physician or ambulance company accepts the carrier's reasonable charge determination as the full charge.

The regular deductible and coinsurance requirements apply to physicians' and ambulance services.

3698.7 Claims for Services Furnished in Canada and Mexico to Qualified Railroad Retirement Beneficiaries.—

A. Canadian Claims.—Under the Railroad Retirement Act, payment is made to QRRBs by the RRB for covered hospital services furnished in Canadian hospitals as well as in the U.S. Physician and ambulance services are not covered by the Railroad Retirement Act; however, under an agreement between HCFA and RRB, if the QRRB claims payment for Part B services in connection with Canadian hospitalization, RRB processes the Part B claim. In such cases the RRB determines:

- Whether the requirements in §§3698B and 3698.6 are met in regard to the inpatient services; and
- Whether the physician and/or ambulance services were furnished in connection with the services.

If either is not met, RRB denies the claim and notifies the beneficiary. If met, it refers the claim to Travelers to determine if the coverage critieria for physician and/or ambulance services are met.

Forward all claims for services furnished QRRBs in Canada to:

Railroad Retirement Board
844 Rush Street
Chicago, IL 60611

If a QRRB is a resident of Canada, Medicare payments are reduced by the amount of payment made for the same services by a Canadian Provincial Health Insurance Plan.

B. Mexican Claims.--The RRB does not pay for health care services furnished in Mexico. Forward all claims for inpatient hospital services and/or related physician or ambulance services furnished in Mexico to QRRBs to either the Dallas or San Francisco RO (whichever services the hospital that provided the inpatient services).

3698.8 Nonemergency Part B Medical and Other Health Services.--

A. Coverage.--Nonemergency services may be paid for when furnished Medicare beneficiaries if the coverage requirements for the services are met, and if such services are not covered as Part A emergency inpatient services.

Program payment may be made for the following Part B medical and other health services furnished by a U.S. nonparticipating hospital on a nonemergency basis:

- Diagnostic x-ray tests, diagnostic laboratory tests and other diagnostic tests. (The hospital must meet the applicable conditions of participation for the services.)
- X-ray, radium, and radioative isotope therapy, including materials and services of technicians. (The hospital must meet the applicable conditions of participation for these services.)
- Services of residents and interns, nurses, therapists, etc., which are directly related to the provision of x-ray or laboratory or other diagnostic test, or the provisions of x-ray or radium therapy.
- Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the functions of a permanently inoperative or malfunctioning internal body organ, including replacement of such devices.
- Leg, arm, back, and neck braces, trusses and artificial legs, arms, and eyes, including replacement, if required, because of a change in the patient's physical condition.

B. Distinction Between Emergency and Nonemergency Medical and Other Health Services.--Emergency coverage, particularly Part B emergency outpatient coverage, is broader than the nonemergency Part B Medical and Other Health Services coverage provisions. When the emergency requirements are met, program payment may be made to an emergency hospital for the full range of outpatient hospital services. In addition to the nonemergency coverage list, emergency coverage includes hospital services (including drugs and biologicals--blood is a biological--which cannot be self-administered), "incident to physicians' services rendered to outpatients," and outpatient physical therapy and speech pathology. The latter two services are not covered under the nonemergency provisions. Payment for "incident to" services must be under the emergency rather than the nonemergency provisions.

Whether Part B payment is made under the emergency or nonemergency provisions, such payment may only be made for diagnostic laboratory tests furnished by an emergency hospital if the hospital meets the conditions of participation relating to hospital laboratories, and such payment may only be made for radiology services furnished by an emergency hospital if the hospital meets the conditions of participation relating to radiology departments. Part B payment may be made for diagnostic laboratory tests furnished by a nonparticipating hospital which is not an emergency hospital only if the hospital laboratory meets the conditions of coverage of independent laboratories and for radiology services furnished by such a hospital only if the hospital meets the conditions of participation relating to radiology departments.

C. Claims Processing.—The annotation "nonemergency-hospital accepts assignments" should be entered in Remarks by the hospital. If the patient filed, enter in Remarks "nonemergency patient filed." If it is determined that some or all of the services are not covered under the nonemergency provisions, return the claim to the hospital (if hospital-filed) or to the beneficiary (if patient-filed) to determine whether the services might be covered as emergency services.

3698.9 Canadian or Mexican Christian Science Services Claims.—

A. Coverage.—Payment may be made for otherwise covered Christian Science services furnished in a Canadian/Mexican Christian Science Sanatorium under the same requirements of §§3698B and 3698.6, provided that the foreign sanatorium is closer to or more accessible from the beneficiary's residence in the U.S., (or, if applicable, the site of the emergency) than the nearest U.S. Christian Science Sanatorium. This is true even where there is a closer or more accessible general hospital. For accreditation, it is sufficient that the Christian Science Sanatorium be certified by the First Church of Christ, Scientist, in Boston, MA.

B. Claims Processing.—Send claims for services in a Christian Science Sanatorium to Aetna Life and Casualty for accessbility and/or emergency determination and processing. (See §3699.3.) If these requirements are not met Aetna denies the claim.

3698.10 Elections to Bill for Services Rendered in Nonparticipating Hospitals.—

A. Nonparticipating U.S. Hospitals.—Nonparticipating U.S. hospitals meeting emergency requirements have the option to bill the program during a calendar year by filing an election with you. If an election is filed, the hospital submits claims for the following services furnished all Medicare beneficiaries throughout the year:

- Emergency inpatient services.
- Emergency outpatient services.

In addition, the hospital may not bill any beneficiary beyond deductibles, coinsurance, and noncovered services in that calendar year. It must also agree to refund any monies incorrectly collected. The hospital may not file an election for the calendar year if it has already charged any beneficiary for covered services furnished in that year.

If the hospital does not file a billing election, the beneficiary can file for those services. The beneficiary may request information from you or the provider as appropriate.

During November of each year, send a letter to nonparticipating domestic hospitals that elected to bill for the current year and wish to continue. (See Exhibit 1.) Also, during November of each year, send a letter to each domestic hospital giving it an opportunity to elect to bill Medicare. (See Exhibit 2.)

For hospitals that request, during the year, to bill the program, send the model letter in Exhibit 3.

B. Billing for Services Furnished Prior to Certification.—The following rules apply if a bill is received for services rendered before and after the provider certification (participation) date:

- Pay PPS hospitals the DRG, if the date of discharge is after the certification date.
- Pay other hospitals for services rendered after the certification date. However, include services before certification date on the cost report.

C. Canadian/Mexican Hospitals.—Canadian and Mexican hospitals may submit a statement to the appropriate intermediary stating that they will bill for all claims. If they do not, the beneficiary may claim the payment. When you are aware that a Canadian or Mexican hospital is willing to bill the program for all covered services, solicit the hospital's agreement to:

- Bill for all covered services for the calendar year (except for deductible and coinsurance amounts);
- Not to bill the beneficiary for any amounts other than for deductible and coinsurance and charges for noncovered services; and
- Refund to the beneficiary any monies incorrectly collected.

The hospital may not file an election for a calendar year if it has already charged any beneficiary for covered services furnished during that year.

3698.11 Submitting Claims.—The beneficiary or a hospital which has elected to bill the program submits emergency claims for payment to the appropriate intermediary for evaluation of accessibility or emergency factors.

NOTE: See §3699.3 Processing Claims - For designated intermediaries.

If you receive a claim from a U.S. hospital that has not filed an election to bill the program, contact the hospital to determine if it is qualified and wishes to elect to bill the program. If the hospital declines, deny the hospital's claim and secure a claim from the beneficiary.

Similarly, whenever you receive a beneficiary-filed claim, ascertain if the hospital has filed a billing election. If it has, deny the beneficiary's claim and contact the hospital to secure the claim.

3698.12 Processing Claims.—All claims are subject to development to determine whether the Medicare secondary payer provisions apply. (See §§3407ff., 3419, 3489, 3490, and 3491.) Follow procedures in §§3686ff.

A. Nonparticipating Hospitals.—The processing intermediary is responsible for making accessibility and medical emergency determinations for any physician and ambulance services.

1. Claims Subject to Technical Denials.—The following claims are subject to technical denial:

- Foreign nonemergency services claims if:
  - The residence requirement is not met. (See §3698.5.)
  - The hospital rendering the service does not meet JCAH or equivalent accreditation requirements set by a hospital approval program of the country in which the hospital is located.
  - The accessibility requirements are not met. (See §3698.5.)
- Canadian travel claims when the requirements in §3698.4 are not met.
- Emergency services claims in which the hospital rendering the service does not meet the definition of an emergency hospital.
- Claims for which the query response shows the beneficiary is not entitled to benefits.
- Any foreign claim when Part A benefits are exhausted and no Part B physician or ambulance claim is involved.

2. Either the Accessibility or Medical Emergency Requirements are Not Met.—Deny the claim, but retain the claim in case of appeal.

NOTE: Even though Part A or Part B emergency services furnished by nonparticipating U.S. hospitals are denied, Part B payment may be possible for Medical and Other Health Services specified in §3110. Retain the claim in case of appeal.

3. Emergency Services Partially Denied.—When the medical emergency is approved but not for the entire period, process and make payment for the covered period.

B. Canadian and Mexican Part B Physician and Ambulance Claims.—Attach any Part B claim for foreign physician and ambulance services to the corresponding Part A claim. If it is not attached:

- Associate the Part B claim with any corresponding Part A claim previously filed.
- Process the Part A claim, but hold the Part B claim until completing action on the Part A claim.

If you determine that the inpatient services were covered, send the physician and/or independent ambulance claim to the designated carrier for processing and payment. (See §3699.4.)

If the Part A claim is denied on the basis of accessibility of medical emergency, deny the Part B claim, and send a denial letter to the claimant. Retain copies in case of appeal.

NOTE: Even though Part A benefits are totally or partially exhausted, payment may be made by the carrier for physician and independent ambulance services rendered if all coverage requirements are met.

If a Part A claim was partially denied because the emergency terminated, make a decision on the claim and any provider-based ambulance claim. Send copies to the appropriate carrier for processing.

3698.13 Accessibility Criteria.—

A. Emergency Claims.—Use the same critieria in domestic and foreign emergency claims. This includes services in a foreign Christian Science Sanatorium (see §3698.8) and Canadian Travel claims. (See §3698.4.)

The regulations state that your determination must take into account such matters as relative distances of a participating hospital, road conditions. Consider whether the nature of the emergency required immediate transportation to the nearest available hospital (i.e., the nonparticipating hospital) or, without hazard to the patient, would have permitted the additional transportation time to take the patient to a more distant participating hospital in the same general area .

Do not consider in your determination such factors involving selection of a hospital which reflect the personal preferences of the individual or physician, (e.g., physician does not have staff privileges at the participating hospital) nearness to beneficiary's residence, presence of previous medical records at the nonparticipating hospital, cost, or type of accommodations available.

The following sections discuss documentation of the accessibility requirement and provide guidelines for making a determination where the participating hospital is:

- Closer to the site of the emergency than is the admitting nonparticipating hospital;
- Fifteen or fewer miles farther from the site of the emergency than is the nonparticipating hospital; or
- Sixteen or more miles farther from the site of the emergency than is the admitting nonparticipating hospital.

In urban and suburban areas, where both participating and nonparticipating hospitals are similarly available, it is presumed, in the absence of clear and convincing evidence to the contrary, that the services could have been provided in the participating hospital.

1. Participating Hospital Closer to Site of Emergency.—If there is an adequately equipped participating hospital with available beds closer to the site of the emergency than the nonparticipating hospital, accessibility is not met. Deny the claim unless extenuating circumstances were present that necessitated admission to the nonparticipating hospital, e.g., because of road or traffic conditions additional travel time would have been needed to get to the participating hospital.

2. Participating Hospital 15 or Fewer Miles Farther From the Location of the Emergency Than the Admitting Nonparticipating Hospital.—In this situation the accessibility is provisionally not met. Review the claim to determine if the nature of the emergency required the immediate transportation to the nonparticipating hospital. If the review indicates that the nature of the emergency would have allowed the additional transportation time needed to take the patient to the participating hospital without undue hazard, the accessibility requirement is not met. Deny the claim.

3. Participating Hospital More than 15 Miles Farther From the Location of the Emergency Than the Admitting Nonparticipating Hospital.—In this situation the accessibility requirement is deemed met.

B. Foreign Nonemergency Claims.—Apply the following presumptions to the relative accessibility of the nearest participating U.S. and foreign hospitals.

1. Admitting Foreign Hospital is Closer to the Beneficiary's Residence Than the Nearest Participating U.S. Hospital.—The accessibility requirement is met.

2. Admitting Foreign Hospital is Farther from the Beneficiary's Residence Than the Nearest Participating U.S. Hospital.—The accessibility requirement is not met unless evidence establishes the practical necessity for the beneficiary's admission to the foreign hospital. This requirement is met if the use of a closer participating U.S. hospital was impractical, e.g., nonavailability of beds, needed equipment or personnel, or transportation not available.

In determining whether a foreign hospital is more accessible than a participating hospital do not consider the personal preference of the beneficiary, physician, or others in the selection of a hospital, the type of accommodations available, or the nonavailability of staff privileges to the attending physician.

C. Documenting Accessibility for Emergency Claims.—Use form HCFA-2628, Foreign HI Claim or Emergency Services Accessbility Documentation and Determination to document the accessibility in emergency claims. (See §3699.6.) This form can be obtained from:

Office of Program Operations
Division of Provider Procedures
6325 Security Boulevard
1-H-3 Meadows East Building
Baltimore, MD 21207

Check the "met" block for claims that fall in the category described in §3698.12(3), or that are described in §3698.12(2) and there are special circumstances of a nature not requiring medical judgment (e.g., Part I, Section C, Items 1, 2, and 5: bed unavailability, lack of transportation).

Check the "not met" block for claims that fall in the category described in §3698.12(1) and there are no special circumstances.

Check the "not met-medical factors" for claims that fall in the category described in §3698.12(1) and there are special circumstances requiring medical judgment (i.e., Part I, Section C, Items 4 and 6 unusual medical circumstances or nonavailability of needed equipment or personnel in the participating hospital).

3698.14 Medical Necessity.—

A. Emergency Services.—Reimbursement for emergency inpatient hospital services is permitted only for those periods during which the patient's state of injury or disease is such that a health or life-endangering emergency existed and continued to exist, requiring immediate care which could only be provided in a hospital. The allegation that an emergency existed must be substantiated by sufficient medical information from the physician or hospital. If the physician's statement does not provide it, or is not supplemented by adequate clinical corroboration of this allegation, it does not constitute sufficient evidence.

Death of the patient does not necessarily establish the existence of a medical emergency, since in some chronic, terminal illnesses, time is available to plan admission to a participating hospital. The lack of adequate care at home or lack of transportation to a participating hospital does not constitute a reason for emergency hospital admission, without an immediate threat to the life and health of the patient. Since the existence of medical necessity for emergency services is based upon the physician's assessment of the patient prior to admission, serious medical conditions developing after a nonemergency admission are not "emergencies" under the emergency services provisions of the Act.

The emergency ceases when it becomes safe, from a medical standpoint, to move the individual to a participating hospital, another institution, or to discharge him.

B. Criteria.—Since the decision that a medical emergency existed can be a matter of subjective medical judgment involving the entire gamut of disease and accident situations, it is impossible to provide arbitrary guidelines.

1. Diagnosis is Considered "Usually an Emergency".—An emergency condition is an unanticipated deterioration of a beneficiary's health which requires the immediate provision of inpatient hospital services because the patient's chances of survival, or regaining prior health status, depends upon the speed with which medical or surgical procedures are, or can be, applied. While many diagnoses (e.g., myocardial infarction, acute appendicitis) are normally considered emergencies, check medical documentation for internal consistencies (e.g, signs and symptoms upon admission, notations concerning changes in a preexisting condition, results of diagnostic tests).

EXAMPLE: If the diagnosis is given as "coronary," the physician's statement is "coronary," without further explanatory remarks, and the statement of services rendered gives no indication that an electrocardiogram was taken, or that the patient required intensive care, etc., further information is required. On the other hand, if the diagnosis is one which ordinarily indicates a medical and/or surgical emergency, and the treatment, diagnostic procedures, and period of hospitalization are consistent with the diagnosis, further documentation may be unnecessary. An example is: admitting diagnosis—appendicitis; discharge diagnosis—appendicitis; surgical procedures—appendectomy; period of inpatient stay—7 days.

2. Patient Dies During Hospitalization.—If you determine that an emergency did exist at the time of admission and the patient subsequently expires, allow the claim for emergency services if the period of coverage is reasonable. However, death of the patient is not *prima facie* evidence that an emergency existed; e.g., death can occur as a result of elective surgery or in the case of a chronically ill patient who has a long terminal hospitalization. Deny such claims.

3. Patient's Physician Does Not Have Staff Privileges at a Participating Hospital.—The fact that the beneficiary's attending physician does not have staff privileges at a participating hospital has no bearing on the emergency services determination. If the lack of staff privileges in an accessible participating hospital is the governing factor in the decision to admit the beneficiary to an "emergency hospital," deny the claim irrespective of the seriousness of the medical situation.

4. Beneficiary Chooses to be Admitted to a Nonparticipating Hospital.—Deny the claim if the beneficiary chooses to be admitted to a nonparticipating hospital as a personal preference (e.g., participating hospital is on the other side of town) when a bed for the required service is available in an accessible, participating, hospital.

5. Beneficiary Cannot be Cared for Adequately at Home.—The patient who cannot be cared for adequately at home does not necessarily require emergency services. Deny the claim in the absence of an injury, the appearance of a disease or disorder, or an acute change in a pre-existing disease state which poses an immediate threat to the life or health of the individual and which necessitates the use of the most accessible hospital equipped to furnish emergency services.

6. Lack of Suitable Transportation to a Participating Hospital.—Lack of transportation to a participating hospital does not, in and of itself, constitute a reason for emergency services. The availability of suitable transportation can only be considered when the beneficiary's medical condition contra-indicates taking the time to arrange transportation to a participating hospital. However, deny the claim if there is no immediate threat to the life or health of the individual, and time could have been taken to arrange transportation to a participating hospital.

7. "Emergency Condition" Develops Subsequent to a Nonemergency Admission to a Nonparticipating Hospital.—Program payment cannot be made for emergency services furnished by nonparticipating hospitals when the emergency condition arises *after* a nonemergency admission. An example: treatment of postoperative complications following an elective surgical procedure or treatment of a myocardial infarction which occurred during a hospitalization for an elective surgical procedure. The existence of medical necessity for emergency services is based upon the physician's initial assessment of the apparent condition of the patient at the time of his arrival at the hospital, i.e., prior to admission.

8. Additional "Emergency Condition" Develops Subsequent to an Emergency Admission to a Nonparticipating Hospital.—If the patient enters a nonparticipating hospital under an emergency situation and subsequently has other injuries, diseases or disorders, or acute changes in preexisting disease conditions, related or unrelated to the condition for which he entered the hospital, which pose an immediate threat to his life or health, emergency services coverage continues. Emergency services coverage ends when it becomes safe from a medical standpoint to move the patient to an available bed in a participating institution or to discharge him, whichever occurs first.

3698.15 Documenting Medical Necessity.—

A. Physician's Supporting Statement.—Claims for emergency services by a nonparticipating hospital generally are accompanied by an Attending Physician's Statement and Documentation of Medicare Emergency, Form HCFA-1771. This form describes the nature of the emergency, furnishing relevant clinical information about the patient, and certifying that the services rendered were required as emergency services. However, a copy of the patient's hospital records may be submitted instead. It should include history, physical, and admission notes, the medical record admission sheet, nurses' notes, doctors' orders, discharge summary, and all progress notes. A statement that an emergency existed, or the listing of diagnoses, without supporting information, is not sufficient. In addition, the statement must include the date in the physician's judgment, the emergency ceased. The statement concerning emergency services is made by the physician who attended the patient at the hospital. Only in exceptional situations, with appropriate justification, may another physician having full knowledge of the case, make the certification.

B. Beneficiary's Statement in Canadian Travel Claims.—In Canadian travel claims, consider the beneficiary's statement in making a determination regarding medical necessity for emergency services; i.e., whether an emergency occurred while a beneficiary was traveling between Alaska and another State by the most direct route without unreasonable delay. (See §3698.4.)

3698.16 Time Limitation on Claims.—The time limit on requests and claims for payment for emergency hospital services and hospital services outside the U.S., for physician and ambulance services furnished in connection with foreign hospitalization, and for nonemergency services furnished by a domestic nonpaticipating hospital, are set forth in §§3310 and 3312.

A. Beneficiary Denial Notices.—Send denial notices to the hospital and/or beneficiary, as appropriate, whenever a domestic emergency or foreign claim is fully or partially denied. (See §3725.)

B. Termination of Emergency Services.—No payment can be made for inpatient or outpatient emergency services rendered after a reasonable period of medical care in relation to the emergency condition in question. Some services may be covered in a domestic nonparticipating hospital as Part B Medical and Other Health Services. (See §3110.) If, based upon all information the total period claimed for emergency services coverage does not exceed the time required for a reasonable period of emergency medical care, the entire inpatient stay is covered. The fact that a medical record or other information states that the patient showed definite improvement several days prior to discharge is not necessarily an indication that emergency services ceased as of that date.

The concept of a reasonable period of emergency medical care is most easily applied when relatively short-term medical care is followed by the patient's progressive improvement. There are situations or conditions in which the determination of the end of covered emergency services may be more difficult because the patient's impairment is prolonged, there is no progressive improvement, or the patient's course may be progressively downhill, even though the condition is not critical. The stroke patient may be in this category. In such cases the need for emergency medical care usually ceases before the need for medical care in an institutional setting (i.e., hospital or SNF) ceases. Thus, the reasonable period of emergency care does not include the entire hospital stay if the stay were prolonged beyond the point when major diagnostic evaluation and treatment were carried out.

Make the determination based upon all the information available. As a general rule, if the period claimed for emergency services exceeds by more than 3 to 5 days the date on which the record definitely indicates that there was substantial improvement in the patient's condition so that he possibly could have been moved to a participating facility or discharged without damage to his health, deny the period beyond the 3 to 5 days. If the total period claimed for emergency services exceeds by no more than 3 to 5 days the date on which the record indicates substantial improvement in the patient's condition, allow the entire period.

The rule is intended to screen out short stay emergency hospitalization cases in which the patient was either discharged or transferred to a participating provider within a reasonable time after the medical record definitely indicated substantial improvement in the patient's condition.

The reasonable period of emergency care is that period required to provide relief of acute symptoms or for initial management of the condition while arrangements are made for definitive treatment. Two examples of this category: (1) prostatic hypertrophy which results in acute urinary retention; and (2) mental illness with suicidal and/or homicidal tendencies. In acute urinary retention, the reasonable period of emergency medical care includes the period required for catheterization and stabilization of the patient. The patient could then be transferred to a participating hospital for surgery or other required treatment. For the suicidal or homicidal patient a reasonable period of emergency medical care includes the time required for initial management of the case while arrangements are made for transfer (by commitment or otherwise) to a participating hospital. A period of 24 to 48 hours of emergency care is usually sufficient in both cases.

3698.17 Appeals.—

A. Reconsiderations.—Where a request is received, conduct the reconsideration and notify the claimant of the decision. Follow guidelines in SS3782ff. Review the initial determination of the claim, including all documentation, in accordance with the guidelines in S3780.

Prepare the necessary beneficiary notification and retain the file for 6 months after the month of the final determination. Any decision on an initial emergency claim or a reconsideration constitutes a final determination.

NOTE: The RRB conducts reconsideratons for hospital services under the Railroad Retirement Act for services rendered in Canada.

B. Review.—(Part B Appeals).—Where a request for review of an initial determination is received, the review is conducted and the determination sent by the intermediary or the carrier, whichever made the initial determination.

C. Appeal of Reconsideration or Review Determination.—All Part B hearing requests on claims for physician and independent ambulance services furnished in Canada or Mexico are within the jurisidiction of a HO of the carrier regardless of who made the review determination. However, a hearing request on an intermediary determination is normally in connection with the Part A claim and considered and processed as such. If the enrollee had a Part A hearing and then requests a hearing on the same issue for the Part B claim, forward all pertinent information regarding the initial and reconsideration determinations and the hearing request to the carrier. Notify the beneficiary of the transfer.

3699. REIMBURSEMENT FOR SERVICES RECEIVED IN NONPARTICIPATING PROVIDERS

3699.1 Reimbursement for Services of Nonparticipating Domestic Hospitals.—The HCFA-1450 must be used.

A. Hospital Filed Claims

1. Inpatient Services.—The reimbursement rate for hospital filed inpatient claims is the lower of: 90 percent of the hospital's average inpatient per diem cost for all patients, or 85 percent of the hospital's regular charge for the services rendered. Determine the hospital's average per diem cost from the most recent calculation of the average per diem cost by a non-Governmental third-party payer.

Adjust the cost of the services by any applicable deductible and coinsurance amounts for which the beneficiary is responsible.

2. Outpatient Services.—Obtain the amount reimbursed by Medicare for hospital-filed emergency outpatient claims as follows:

Eighty-five percent of the total covered charges is the estimated cost figure. Subtract the applicable Part B deductible. Apply the 80 percent reimbursement rate to the remainder.

Obtain the patient's coinsurance amount by subtracting the deductible from the total charges and applying the 20 percent coinsurance rate to the remainder.

3. Part B Medical and Other Health Services.—Part B Medical and Other Health Services, including provider-based ambulance services whether provider or beneficiary filed, may be covered and reimbursed on a "nonemergency" basis. To calculate the amount reimbursed by Medicare, subtract the Part B deductible from the total covered charges and apply the 80 percent reimbursement rate.

4. Special Letters for Partially or Totally Denied (Hospital-Filed) Claims for Emergency Inpatient Services.—The patient receives a HCFA-1533 from HCFA covering the emergency payment of a partially denied claim. Prepare a letter using the model denial letter A or B, as appropriate, in Exhibits 4 or 5 and a Part B provider explanation of benefits. Show your address on these letters.

B. Beneficiary Filed Claims

1. Emergency Inpatient Claims.—The reimbursement computation follows:

- o Subtract any noncovered accommodation charge from the total accommodation charges. Subtract the amount of the inpatient deductible or coinsurance met on this bill. Multiply any remainder by 60 percent.
- o Subtract the total noncovered ancillary charge from the total ancillary charge. Subtract any inpatient deductible or coinsurance that may be remaining. Multiply the remainder by 80 percent.

- Add the benefit amounts obtained.

If the hospital is an all-inclusive rate hospital, subtract the noncovered charges from the covered charges, apply any deductible and coinsurance, and multiply the remainder by 66 2/3 percent.

EXAMPLE: The total charge in an all-inclusive rate hospital is $966.46, the deductible is $492. The remainder of $474.46 is figured at 66 2/3 percent reimbursement, or a benefit amount of $316.32.

2. Emergency Outpatient Services.--To calculate the amount reimbursed by Medicare, subtract the Part B deductible from the total covered charges and apply the 80 percent reimbursement rate.

3. Part B Medical and Other Health Services.--Part B Medical and Health Services furnished by nonparticipating providers, including provider-based ambulance services, may be covered and reimbursed on a "nonemergency" basis.

To calculate the amount reimbursed by Medicare, subtract the Part B deductible from the total covered charges and apply an 80 percent reimbursement rate.

4. Special Letters for Patient-Filed Claims for Emergency Inpatient Services.--For emergency admissions to nonparticipating hospitals where direct payment is made to the patient, send to the beneficiary one of the letters described below, as appropriate.

The letter explains the Part A payments made and/or the Part B payments made for ancillary services not covered by Part A. (See §3110.) This letter also explains the beneficiary's right of appeal.

Retain a duplicate of all notices sent for documentation in any appeals process. Enter the date the notice is released on both copies of all notices.

Sample paragraphs:

- Enclosed is a check for $ _____, which is the amount Medicare can pay for the inpatient hospital services you received from (date of admission) to (date of discharge) in (hospital).

- Medicare is able to pay 60 percent of the charges for your room and board plus 80 percent of the charges for all other covered services during the period (date emergency began) to (date payment ended).

- Medicare is able to pay 60 percent of the charges for your room and board, 80 percent of the charges for other separately identified charges, and 66 2/3 percent of the other charges which were not separately identified on the hospital bill.

- Medicare does not pay (the first $ ____ of charges) (the first three pints of blood) ($ ____ a day after the 60th day) in a benefit period. (Select one or more, if applicable.)

If lifetime reserve days are used, all $ ___ a day from ________ to _________.

- If you believe your Medicare hospital insurance should have covered all or more, of your expenses, you may get in touch with us at the address shown on this letter.
- If you believe that the determination is not correct, you may request a reconsideration for hospital insurance (or a review for medical insurance). You may make the request by mail to the address shown on this letter. If you come in person, please bring this notice with you.
- This check includes a medical insurance payment for 80 percent of the charges for certain nonroutine hospital services which you received from _______ through _______. These services are listed on the enclosed form.
- If a hospital bill is not itemized, Medicare can pay 66 2/3 percent of the total covered charges. Payment is being made at this rate for charges from (date emergency began) to (date payment ended).
- We are enclosing a check for $ ______. This is your payment under medical insurance for 80 percent of the charges for the services which you received from (admission date) through (discharge date) while in (name of hospital). These services are listed on the enclosed form.

When payment cannot be made under hospital insurance, medical insurance covers some, but not all, of the hospital services. Room and board and certain other services are not covered by medical insurance.

3699.2 Reimbursement for Services of Canadian/Mexican Hospital.—

A. Hospital Filed Claim.—A Canadian or Mexican hospital that elects to bill the Medicare program receives 100 percent of its customary charges, subject to applicable deductible and coinsurance amounts. The hospital establishes its customary charges for the services by submitting an itemized bill with each claim. This eliminates the need for it to file a cost report.

Regardles of the billing form used, you must:

- Recode the bill using revenue codes for the HCFA-1450.
- Prepare a UNIBILL.

The Canadian or Mexican hospital must file a statement of election for each calendar year to receive direct payment from Medicare for all claims filed that year.

Payment to the hospital is subject to the official exchange rate on the date the patient is discharged.

B. Beneficiary Filed Claim.—**Follow §3699.1B for inpatient hospital services.**

To calculate the amount reimbursed by Medicare for Part B Provider-Based Ambulance Claims, subtract the unmet Part B deductible from the total covered charges and apply the 80 percent reimbursement rate.

Payment to the beneficiary is subject to the official exchange rate on the date of discharge.

3699.3. Designated Intermediaries.—Claims for services provided in Mexican or Canadian hospitals are processed by the designated fiscal intermediary. Forward these claims and any subsequent appeals directly to the designated intermediary.

Canada

New Brunswick Newfoundland Nova Scotia Quebec Prince Edward Island	Associated Hospital Services 110 Free Street Portland, ME 04010
Ontario	Blue Cross/Blue Shield of Michigan Mediare Adjudication #1513 600 Lafayette East Detroit, MI 48226
Alberta Manitoba Saskatchewan	Blue Cross of Montana 3360 10th Avenue, South Post Office Box 5017 Great Falls, MO 59403
British Columbia Northwest Territories Vancouver Yukon Territories	Blue Cross of Washington/Alaska, Inc. Post Office Box 2847, M/S 814 Seattle, WA 98111

Mexico

Western Mexico (Sonora and the Bajas)	Blue Cross of California Post Office Box 70000 Van Nuys, CA 91704
Eastern Mexico (Chihuahua, Coahuila, Nuevo Leon, Tamaulipas, etc.)	Blue Cross and Blue Shield of Texas Medicare Part A 901 South Central Expressway Richardson, TX 75080

Send claims for services provided in countries other than Canada or Mexico to:

Health Care Financing Administration
Division of Accounting, OMB
P.O. Box 17255
Baltimore, MD 21203-7255.

Domestic Emergency Claims

Region I - Associated Hospital Services

Region III - Blue Cross of Western Pennsylvania

Region IV - Blue Cross and Blue Shield of Florida

Region VI - Blue Cross and Blue Shield of Texas

Region VII - Blue Cross and Blue Shield of Nebraska

Region IX - Blue Cross of California

Regions II, V, VIII, and X have no designated intermediary.

Send claims for services provided in a Christian Science Sanatorium (domestic and foreign) to:

Aetna Life and Casualty
Medicare Benefits Administration
The Exchange
P.O. Box 329
Farmington, CT 06032

3699.4 Designated Carriers.—The following carriers have been designated to process claims for physicians' and ambulance services rendered in connection with covered hospitalization in Canada and Mexico.

Canadian Claims

Boston Region - Blue Shield of Massachusetts, Inc., Portland, Maine
New York Region - Blue Shield of Western New York, Binghamton, N.Y.
Chicago Region - Blue Shield of Michigan, Detroit, Michigan
Denver Region - Montana Physicians' Service, Helena, Montana
Seattle Region - Washington Physicians' Service, Seattle, Washington

Mexican Claims

Dallas Region - Texas Blue Shield, Dallas, Texas
San Francisco Region - Occidental Life Insurance Company of California, Los Angeles, California

Submit other claims to your servicing carriers.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0023

ATTENDING PHYSICIAN'S STATEMENT AND DOCUMENTATION OF MEDICARE EMERGENCY

SECTION A

1. PATIENT'S NAME	2. HI CLAIM NUMBER

SECTION B *(To be completed by attending physician)*

IMPORTANT: Please supply all information requested in order that the reviewing physician may promptly process the claim. A copy of the patient's chart including a minimum of admission history and physical, admission nurse's notes, all physician's orders, progress notes, and discharge summary may be submitted in addition to or in lieu of this form if it covers all information requested below.

1. Date and approximate hour when emergency occurred which resulted in hospital admission..

MO	DAY	YR.	APPROXIMATE HOUR	
			A.M.	P.M.

2. When and where was the patient first seen by you or another physician in connection with the emergency PRIOR TO ADMISSION TO THE HOSPITAL?

MONTH	DAY	YEAR	APPROXIMATE HOUR		
			A.M.	P.M.	☐ Home ☐ Physician's Office ☐ Emergency Room ☐ Accident Site Other: *(Specify)*

3. Date and hour of admission	Admitting diagnosis(es):

4. Emergency services are defined in the Medicare program for purposes of payment as inpatient and outpatient hospital services which are necessary to prevent the death or serious impairment of the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available which is equipped to furnish such services

In your opinion was this an emergency as defined under Medicare? ☐ Yes ☐ No

5. List special equipment or special personnel available at the admitting hospital if such special equipment or personnel was a factor in necessitating admission there rather than to a hospital which participates in the Medicare program.

6. Indicate specific signs and symptoms of the patient at the time of initial examination which will help to justify this case as a Medicare emergency. *(If the patient was admitted because of a change in a chronic condition or a condition which existed for several days prior to admission, please indicate the ACUTE changes):*

6.a. Other findings on hospital admission:

☐ Ambulatory ☐ Conscious ☐ Unconscious
☐ Non-ambulatory ☐ Semi-conscious ☐ Pain – Yes ☐ No Location of Pain ______

Temperature	Blood Pressure	Pulse /min.	Respirations /min.

Pertinent laboratory findings at that time:

7. List specific emergency services and care including surgery and other procedures (i.e., cystoscopy, bronchoscopy, X-rays, etc.) provided during the hospital admission.

EMERGENCY SERVICE (Do not list elective procedures or surgery)	DATE(S)	RATIONALE OR REASON FOR SERVICE

Blood transfusion ☐ Yes ☐ No

[illegible] HCFA-1771 [illegible]

8. List the clinical and laboratory findings, complications, or need for special services which justified the patients remaining on "emergency case" for the entire period claimed and which precluded an earlier transfer to a participating hospital, or discharge.

FINDINGS, COMPLICATIONS, OR SERVICES	DATE

	MONTH	DAY	YEAR
9. Give the earliest date on which it was permissible, from a medical standpoint, to either transfer the patient to a participating hospital or extended care facility, or to discharge the patient.			

10. Discharge diagnosis(es) *(Show only diagnosis(es) that were related to the alleged emergency)*

10a. Other contributing conditions:

11. Please include (or attach) any additional information which you believe may be helpful in reaching a decision on this case.

SIGNATURE	☐ M.D. ☐ D.O.	DATE
ADDRESS		PHONE NUMBER

DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION

FOREIGN HI CLAIM OR EMERGENCY SERVICES ACCESSIBILITY DOCUMENTATION AND DETERMINATION

1. PATIENT'S NAME	2. HI CLAIM NUMBER
3. PATIENT'S RESIDENCE ADDRESS	
4. ADMITTING HOSPITAL'S NAME AND ADDRESS	5. Hospital's Emergency Number (Domestic only)

PART I — ACCESSIBILITY DOCUMENTATION—COMPLETE ALL SECTIONS

SECTION A - Location of Beneficiary When Emergency Occurred (Answer 1-2 for Domestic, 3-6 for foreign hospital)

Beneficiary was considered to require emergency services when 1. ☐ Emergency was "Self-evident" (e.g. sudden change in state of consciousness, sudden onset of severe pain or bleeding, etc.) 2. ☐ The physician, by seeing beneficiary or by telephone contact, first decided emergency services were required.	**Address and/or Site of Checked Location**

3. Distance from Beneficiary's Resident to admitting hospital	4. Name and address of nearest paticipating U.S. hospital to beneficiary's residence	5. Distance of Participating Hospital from Beneficiary's Residence

6. Check either a or b

a. ☐ The foreign hospital is not more than 15 miles farther from the beneficiary's residence than the nearest participating U.S. hospital

b. ☐ The foreign hospital is more than 15 miles farther from the beneficiary's residence than the nearest participating U.S. hospital

SECTION B - Alternative Hospitals (Answer either 1 or 2; always answer 3)—Domestic Emergency Claims Only

1. ☐ Participating hospital 15 or fewer miles farther from the location of the emergency than is the admitting non-participating hospital (as determined in Section A) — *(Answer a, b and c.)*

A. Distance to Admitting Hospital from Location of Emergency	b. Distance to Participating Hospital Closer to Location of Emergency	C. Name and Address of Participating Hospital Closest to Location of Emergency

2. ☐ Participating hospital more than 15 miles farther from the location of the emergency than is the admitting non-participating hospital (as determined in Section A) *(If checked omit Section C.)*

3. List the participating hospital closest to the admitting hospital:

A. Name and Address	b. Distance Between Two Hospitals

SECTION C-Special Circumstances (Domestic Claims—Do NOT complete this section if Section B, Item 2 is checked)(Foreign Claims—Include an explanation in "Remarks" or an attachment for each item checked.)

1 ☐ Bed unavailable in nearest participating hospital

2 ☐ Nearest participating hospital would not accept patient

3 ☐ Geographic difficulties

4 ☐ Needed equipment or personnel unavailable in nearest participating hospital

5 ☐ Other factors

6 ☐ Unusual medical circumstances indicated, e.g., shock loss of blood, etc. (domestic claims only)

REMARKS

PART II — DETERMINATION

SECTION A — Accessibility

☐ MET ☐ NOT MET ☐ NOT MET MEDICAL FACTORS	INTERMEDIARY SIGNATURE	DATE

Form HCFA-2628 (5-86)

Exhibits	Page
Exhibit 1 - Model letter to nonparticipating hospital that elected to bill for current year	3-331
Exhibit 2 - Model letter to nonparticipating hospital that did not elect to bill for current year	3-332
Exhibit 3 - Model letter to nonparticipating hospital that requests during the year to bill the program	3-333
Exhibit 4 - Model Denial Notice A	3-335
Exhibit 5 - Model Denial Notice B	3-336

Exhibit 1 - Model Letter to Nonparticipating Hospital That Elected to Bill For Current Year

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REFER TO:

Identification Number:
____

Dear ________________:

Your election to bill the Medicare program for emergency services furnished to Medicare beneficiaries will expire on December 31. Payment for emergency services can be made to a nonparticipating hospital only if the hospital elects to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year.

If you elect to bill the program, please return to us in the enclosed self-addressed envelope a statement signed by an authorized official of your hospital stating that you elect to claim payment under the Medicare program. An election to bill cannot be withdrawn during the year. If a statement is not received by December 31, we will assume that you do not wish to continue to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to him.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting the intermediary serving nonparticipating hospitals in your State. If a hospital does not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

Please contact us if you need any further information. In addition, if at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely yours,

Exhibit 2 - Model Letter to Nonparticipating Hospital That Did Not Elect to Bill For Current Year

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REFER TO:

Identification Number:

____

Dear ____________________:

Under the Medicare program, hospital benefits ordinarily can be paid only for care furnished to patients of hospitals that are participating in the program. However, the program can also pay for hospital services furnished to a beneficiary who is admitted to a nonparticipating hospital in an emergency. To receive payments for emergency services, a nonparticipating hospital must meet certain conditions specified in the law. We have determined that your hospital meets these conditions.

Payment for emergency services can be made to a nonparticipating hospital only if the hospital elects to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year. Although your hospital did not elect to bill the program for the current calendar year, you may wish to bill for the coming year. If you so choose, please have an authorized official of your hospital sign a statement to this effect and return in the enclosed self-addressed envelope. Retain a copy for your records. An election to bill cannot be withdrawn during the year.

If we have not received a statement from you by December 31, we will assume that you do not wish to bill the program at this time. However, you still retain the right to elect to bill the program at any time during the coming year if, when you make your election, you have not yet charged any Medicare beneficiary in that year for emergency hospital services rendered to him.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting us. If a hospital does not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

If at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely yours,

Exhibit 3 - Model Letter to Nonparticipating Hospital That Requests During the Year to Bill the Program

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REFER TO:

Identification Number:

____

Dear ____________________:

This refers to your inquiry concerning payment for emergency hospital services rendered to a Medicare beneficiary in a hospital which is not participating in the Medicare program. Under the Medicare program, hospital benefits ordinarily can be paid only for care furnished to patients of hospitals that are participating in the program. However, the program can also pay for hospital services furnished to a beneficiary who is admitted to a nonparticipating hospital in an emergency. To receive payments for emergency services, a nonparticipating hospital must meet certain conditions specified in the law. We have determined that your hospital meets these conditions.

Payment for emergency services can be made to a participating hospital only if the hospital elects to receive reimbursement from Medicare for all emergency services furnished to Medicare beneficiaries in a calendar year. Your hospital may now choose to bill the program for all emergency services furnished to Medicare beneficiaries during the current calendar year, if you have not yet charged any Medicare beneficiary this year for emergency hospital services rendered to him.

If you so choose, please have an authorized official of your hospital sign a statement to this effect and return in the enclosed self-addressed envelope. Retain a copy for your records. An election to bill cannot be withdrawn during the year.

Hospitals electing to bill the program for emergency services may obtain information on reimbursement by contacting us. If a hospital does not elect to bill, the beneficiary may apply for reimbursement by submitting an itemized bill.

If at any time you decide to request full participation as a provider of hospital services under the Medicare program, please contact your Medicare intermediary for complete particulars.

Sincerely yours,

MODEL DENIAL NOTICE A

Exhibit 4 - (Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim)

(INTERMEDIARY'S NAME AND ADDRESS)

Date:______________________

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: ______________________ Claim Number: _______________

We are sorry but payment cannot be made for your stay from ______ through ______ at (hospital). This is because the (hospital) does not participate in the Medicare program and it has been determined that your treatment there does not qualify as emergency care.

Under the law, payment for services received in a nonparticipating hospital can only be made if you go, or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. Care which is necessary to prevent the death or serious impairment of the health of the individual and

b. which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) which has a bed available and is equipped to handle the emergency.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that, although it was necessary for you to be hospitalized, a medical emergency did not exist. There would have been time for you to have been admitted to a hospital participating in Medicare.

If you have questions about this notice, or if you believe the determination is not correct, you may request a reconsideration for hospital insurance. You must file your request within 6 months from the date of this notice. You may make the request through us.

EMERGENCY AND FOREIGN HOSPITAL SERVICES

MODEL DENIAL NOTICE B

Exhibit 5 - (Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim)

(INTERMEDIARY NAME AND ADDRESS)

Date: ____________________

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: ____________________ Claim Number: ____________

This refers to your request for reimbursement under Medicare for the services received while a patient at (hospital), from ______ through ______.

Payment can be made under the hospital insurance part of medicare only for the costs of your hospitalization from ________ to ________.

The (hospital) does not participate in the Medicare program. Under the law, payment for services received in a nonparticipating hospital can only be made if you go, or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. care which is necessary to prevent the death or serious impairment of the health of the individual and

b. which, because of threat to life or health of the individual, requires the use of the nearest hospital (in miles or travel time) which has a bed available and is equipped to handle the emergency.

Payment for emergency services stops when the emergency ends and it is permissible, from a medical standpoint, either to transfer the patient to a participating hospital or to discharge him.

The medical facts of your hospital admission and stay have been carefully reviewed. Based upon this review, we have found that an emergency condition existed when you were admitted. However, the medical information indicates that this emergency condition ended on ______. At that time your condition had improved to the extent that you could have been transferred to a hospital participating in the Medicare program.

If you have questions about this notice, or you believe the determination is not correct, you may request a reconsideration. You must file your request within 6 months from the date of this notice. You may make the request through us.

ADDENDUM A - PROVIDER ELECTRONIC BILLING FILE AND RECORD FORMATS

	Section	Page
Recommended Physical File Specifications - Magnetic Tape	1	A-2
File Specifications - Media Other Than Magnetic Tape	2	A-3
File Logic Flowchart	3	A-4
File Logic Specifications	4	A-5
Key to Records	5	A-6
Record Layouts	6	A-7

1. Recommended Physical File Specifications - Magnetic Tape.—Tape Characteristics -9 Track, 8 1/2" to 10 1/2" reels with silver mylar reflector (standard reels) with write ring removed.

Parity - Odd

Recording Density - 1600 bytes per inch.

Recording Code - Extended Binary Coded Decimal.

File Label - None. The tape must have an end of file mark. The first data record on the file will identify the submitter and the receiver, and will serve the function of a file label.

Physical Record Length - 192 characters.

Block Size: 1920 characters; i.e., a blocking factor of 10.

Unfilled Final Block - Fill with spaces.

The external label on the reel must appear as follows:

From ___a___ To ___b___
Reel Number ___c___ Claim Types ___d___
Billing Date ___e___
f. ☐ Medicare ☐ Medicaid ☐ Other
Recording Density 1600 BPI

(a) Identification of submitter
(b) Identification of intended recipient
(c) Unique number by which tape is identified in submitter's tape library
(d) Types of claims on the tape; e.g., inpatient hospital, inpatient SNF, outpatient hospital, etc.
(e) Date tape created (MMDDYY)
(f) Check one: Medicare, Medicaid, or Other

2. File Specifications - Media Other Than Magnetic Tape.—

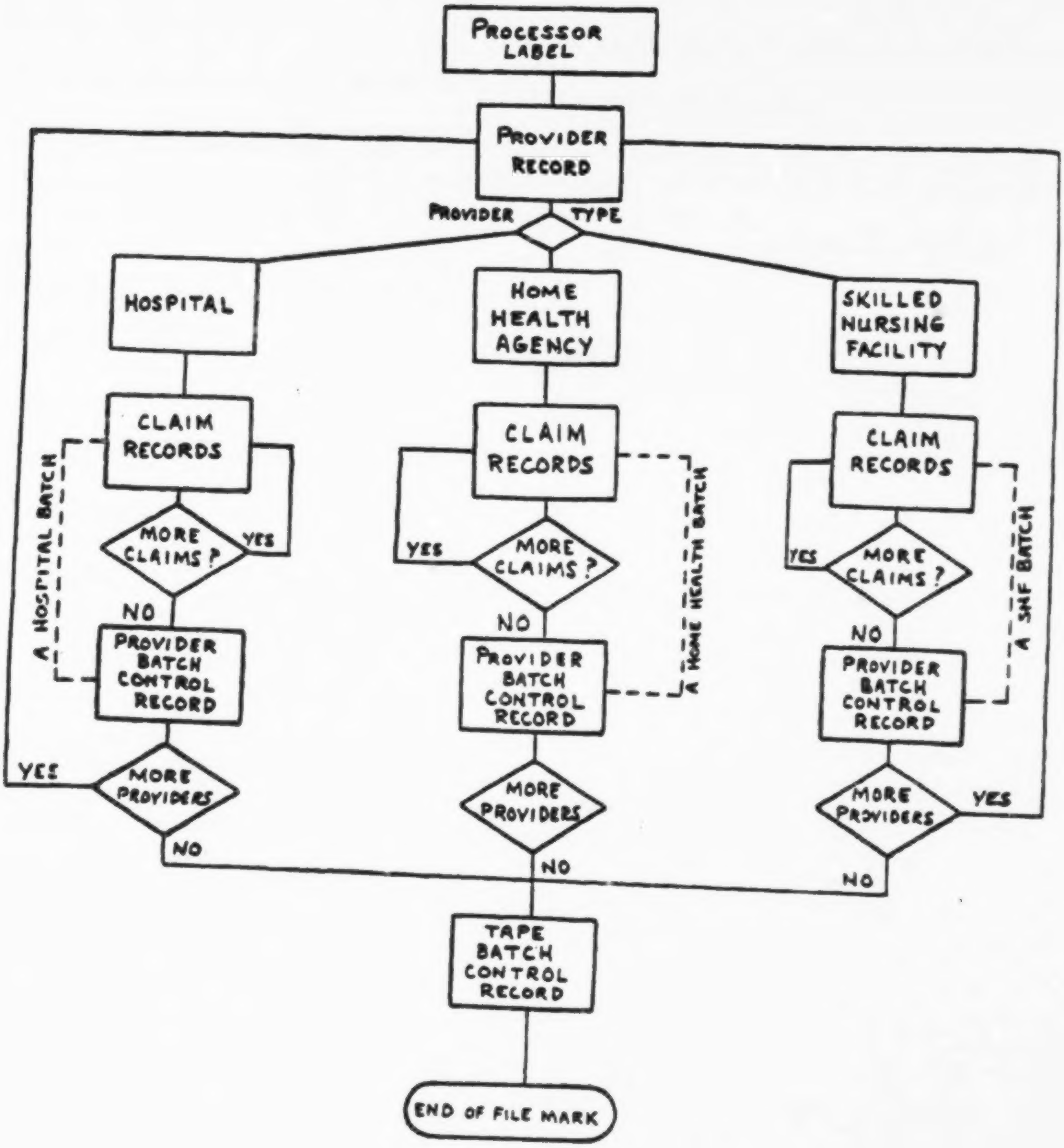
File Label - None

Physical Record Length - 192 characters

External Label - Same as magnetic tape, a thru f

Other specifications will be agreed upon between provider and intermediary with the concurrence of the appropriate Regional Administrator.

3. File Logic - Flowchart.—


PROCESSOR LABEL
PROVIDER RECORD
PROVIDER TYPE
HOSPITAL
HOME HEALTH AGENCY
SKILLED NURSING FACILITY
CLAIM RECORDS
CLAIM RECORDS
CLAIM RECORDS
MORE CLAIMS ?
MORE CLAIMS ?
MORE CLAIMS ?
YES
YES
YES
NO
NO
NO
A HOSPITAL BATCH
A HOME HEALTH BATCH
A SNF BATCH
PROVIDER BATCH CONTROL RECORD
PROVIDER BATCH CONTROL RECORD
PROVIDER BATCH CONTROL RECORD
MORE PROVIDERS
MORE PROVIDERS
MORE PROVIDERS
YES
YES
NO
NO
NO
TAPE BATCH CONTROL RECORD
END OF FILE MARK

4. Record Specifications.—The logical claim record is made up of a series of 192 character physical records. The physical records for each claim are divided into logical subsets as follows:

Subset 1 - Patient Data - Record Codes 20-29
Subset 2 - Third Party Data - Record Codes 30-39
Subset 3 - Claim Data - Record Codes 40-49
Subset 4 - Inpatient Accommodations Data - Record Codes 50-59
Subset 5 - Ancillary Services Data - Record Codes 60-69
Subset 6 - Medical Data - Record Codes 70-79
Subset 7 - Physician Data - Record Codes 80-89

A. The record layouts that follow will provide the following data:

1. Record Name: The name of this data record.
2. Record Type: Code indicating the type of record.
3. Record Size: Physical length of record. Constant 192.
4. Field Number
5. Field Name
6. Picture: this will be the COBOL picture. Pic X will be initialized to blanks, and Pic 9 will be initialized to zeroes. All money fields and date fields will be Pic 9. All code fields that have a legitimate value of zero will be Pic X. This will make it possible to detect whether the field has been omitted.
7. Field Specification: This simply indicates how the data field is justified. L = Left justification, and R = Right justification.
8. Position
   From = Leftmost position in the record (high order).
   Thru = Rightmost position in the record (low order).

5. Key to Records.

Record Name	Record Type Code
Processor Data	01
Reserved for National Assignment	02-04
Local Use	05-09
Provider Data	10
Reserved for National Assignment	11-14
Local Use	15-19
Patient Data	20
Non-insured Employment	21
Reserved for National Assignment	22-24
Local Use	25-29
Third Party Insurer Data	30-31
Reserved for National Assignment	32-34
Local Use	35-39
Claim Data	40
Reserved for National Assignment	41-44
Local Use	45-49
Accommodations Data	50
Reserved for National Assignment	51-54
Local Use	55-59
Ancillary Data	60
Procedure Data	61
Reserved for National Assignment	62-64
Local Use	65-69
Medical Data	70
Reserved for National Assignment	71-74
Local Use	75-79
Physician Data	80
Reserved for National Assignment	81-84
Local Use	85-89
Screen	90
Reserved for National Assignment	91-94
Batch Control	95
Local Use	96-98
Tape Control	99

6. Record Layouts

RECORD TYPE 01 - PROCESSOR DATA

- Must be first record on tape
- Must be followed by RT 10.

NOTE:

1) Tapes will be formatted so that this is a data record, not a conventional label. From a system standpoint this will be a 'labelless' tape.

2) The processor data record will be the first record on each reel.

3) This record indicates, in fields 5 thru 7, the class of and identification of the organization designated to receive this tape or transmission. If the code in field 5 is a "Z," the file contains records for multiple primary payers. In this case, the employer identification number (EIN), also known as the tax identification number (TIN), identifies the organization designated to receive this tape or transmission. Otherwise, the code in field five designates the types of primary payer, field 6 contains the receiver/primary payer identification (NAIC number for commercials, Blue Cross number for PLANS, as indicated by each State agency for Medicaid, as assigned by CHAMPUS where applicable, etc.). For commercial insurers, Field 7 contains the specific office within the insurance carrier designated to receive this tape or transmission. For Blue Cross plans this field will be used as designated by the Plan receiving the file.

4) It is recommended that billers and intermediaries establish a protocol limiting a file to a single reel of tape, single disk, cassette, etc. In the event a file exceeds that limit, the reel, disk, etc. must end in a batch control (record type 95).

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Processor Data	01	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '01'	XX	L	1	2
2	Submitter EIN	9(9)	L	3	11
3	Multiple Provider Billing Tape Indicator	9		12	12
4	Filler	X(18)	L	13	30
5	Receiver Type Code	X		31	31
6	Receiver Identification	9(5)	L	32	36
7	Receiver Sub-Identification	X(4)	L	37	40
8	Processing Date ("Date Bill Submitted" on HCFA-1450)	9(6)	L	41	46
9	Submitter Name	X(21)	L	47	67
	Submitter Address (Fields 10-13)				
10	Address	X(18)	L	68	85
11	City	X(15)	L	86	100
12	State	XX	L	101	102
13	Zip	X(9)	L	103	111
14	Submitter Telephone Number	X(10)	L	112	121
15	Reel Sequence Number	9		122	122
16	Reel Serial Number	X(6)	L	123	128
17	Filler (Reserved for National use)	X(32)		129	160
18	Filler (reserved for local use)	X(29)		161	189
* 19	Version Code	XXX	L	190	192

VERSION 002

RECORD TYPE 10 - PROVIDER

- Must follow either RT 01 or 95.
- Must be followed by RT 20.

NOTE: THIS RECORD MUST BE PRESENT FOR EACH PROVIDER, BATCH COMBINATION.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Provider	10	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record type '10'	XX	L	1	2
2	Type of Batch	XXX	L	3	5
3	Batch Number	99	R	6	7
4	Federal Tax Number	9(9)	L	8	16
5	Filler	X(6)	L	17	22
6	Medicare Provider Number	X(8)	L	23	30
7	Reserved for Medicare	X(2)	L	31	32
8	Medicaid provider number	X(12)	L	33	44
9	Reserved for Medicaid	X(4)	L	45	48
10	Blue Cross/Blue Shield Provider Number	X(13)	L	49	61
11	Filler	X(9)	L	62	70
12	Provider Telephone Number	X(10)	L	71	80
13	Provider Name	X(18)	L	81	98
	Provider Address (Fields 14-17)				
14	Address	X(18)	L	99	116
15	City	X(15)	L	117	131
16	State	XX	L	132	133
17	Zip	X(9)	L	134	142
18	Procedure Coding Method Used	9		143	143
19	Filler (reserved for national use)	X(25)		144	168
20	Filler (reserved for local use)	X(24)		169	192

RECORD TYPES 20-2N - Patient

- Must follow either RT 10 or RT 90.
- May be followed by RT 21-2N or 30.
- All records following to RT 90 must have the same patient control number.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Patient	20	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION	
				FROM	THRU
1	Record type '20'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
	Patient Name (Fields 4-6)				
4	Last Name	X(20)	L	22	41
5	First Name	X(10)	L	42	51
6	Middle Initial	X		52	52
7	Patient Sex	X		53	53
8	Patient Birthdate (MMDDYYYY)	9(8)	L	54	61
9	Patient Marital Status	X		62	62
10	Type of Admission	X		63	63
11	Source of Admission	X		64	64
12	Accident Hour	XX	R	65	66
	Patient Address (Fields 13-17)				
13	Address - Line 1	X(18)	L	67	84
14	Address - Line 2	X(18)	L	85	102
15	City	X(15)	L	103	117
16	State	XX	L	118	119
17	Zip	X(9)	L	120	128
18	Admission Date	9(6)	L	129	134
19	Admission Hour	XX	R	135	136
	Statement Covers Period				
20	From (MMDDYY)	9(6)	L	137	142
21	Thru (MMDDYY)	9(6)	L	143	148
22	Patient Status	99	R	149	150
23	Discharge Hour	XX	R	151	152
24	Patient Has Paid	9(5)V99	R	153	159
25	Medical Record Number	X(18)	L	160	177
26	Filler (Local Use)	X(18)		178	192

RECORD TYPE 21 - Non-insured Employment Information

- Must follow RT 20.
- May be followed by RT 21-2N or 30.
- This record contains employment information pertaining to individuals not claiming insurance but who may have some insurance coverage through their employer from which the patient may be eligible for benefits.
- There are four different individuals to whom this may apply: the patient, the patient's spouse, the patient's father, and the patient's mother. If more than two of these individuals are involved in this claim, a second record type 21 is to be used to submit the relevant employment data for the third, and if applicable, the fourth party involved. The sequence number (field 2) of the second Type 21 record would be shown as "2".

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Non-insured employment	21	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '21'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	EMPLOYMENT INFORMATION PACKET ONE				
4	Employer Name	X(18)	L	22	39
	Employer Location (Fields 5 - 8)				
5	Employer Address	X(18)	L	40	57
6	Employer City	X(15)	L	58	72
7	Employer State	XX	L	73	74
8	Employer Zip	X(9)	L	75	83
9	Employee ID Number	X(12)	R	84	95
10	Employment Information Data (P,S,M, or F only)	X		96	96
11	Employment Status Code	9		97	97
	EMPLOYMENT INFORMATION PACKET TWO				
12	Employer Name	X(18)	L	98	115
	Employer Location (Fields 5 - 8)				
13	Employer Address	X(18)	L	116	133
14	Employer City	X(15)	L	134	148
15	Employer State	XX	L	149	150
16	Employer Zip	X(9)	L	151	159
17	Employee ID Number	X(12)	R	160	171
18	Employment Information Data (P,S,M, or F only)	X		172	172
19	Employment Status Code	9		173	173
20	Filler	X(19)		174	192

RECORD TYPES 30-3N - Third Party Payer

One third party payer record packet (record types 30-3N) will appear in the bill record for each payer involved in the bill. Each third party payer packet must contain a record type 30. However, each record type 30 may or may not have an associated record type 31, etc. depending on the specific third party payer data required by the particular payer.

Example: Medicare is primary, and the secondary payer requires the insured's address:

	Record Type Code	Sequence Number
Medicare	30	01
Secondary Payer	30	02
	31	02

Note that the sequence number of the type 31 record for the secondary payer matches the sequence number of the secondary payer's type 30 record, serving as a matching criterion for the specific third party payer record packet.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Third Party Payer	30	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record type '30'	XX	L	1	2
2	Sequence Number	99	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Source of Payment Code	X		22	22
5	Payer Identification	9(5)	L	23	27
6	Payer Sub-Identification	X(4)	L	28	31
7	Certificate/Social Security Number/ Health Insurance Claim/ Identification Number	X(17)	L	32	48
8	Payer Name	X(16)	L	49	64
9	Primary Payer Code	X		65	65
10	Insurance Group Number	X(20)	L	66	85
11	Insured Group Name	X(17)	L	86	102
	Insured's Name (Fields 11-13)				
12	Last Name	X(20)	L	103	122
13	First Name	X(10)	L	123	132
14	Middle Initial	X		133	133
15	Insured's Sex	X		134	134
16	Release of information Certification Indicator	X		135	135
17	Assignment of Benefits Certification Indicator	X		136	136
18	Patient's Relationship to Insured	99	L	137	138
19	Employment Status Code	9		139	139
20	Covered Days	999	R	140	142
21	Non-Covered Days	9999	R	143	146
22	Coinsurance Days	999	R	147	149
23	Lifetime Reserve Days	99	R	150	151
24	Deductible	9(6)V99	R	152	159
25	Co-Insurance	9(6)V99	R	160	167
26	Estimated Amount Due	9(6)V99	R	168	175
27	Estimated Responsibility	9(6)V99	R	176	183
28	Prior Payments	9(6)V99	R	184	191
29	Filler	X		192	192

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Third Party Payer	31	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record type '31'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Insured's Address (Fields 4-8)				
4	Address - Line 1	X(18)	L	22	39
5	Address - Line 2	X(18)	L	40	57
6	City	X(15)	L	58	72
7	State	XX	L	73	74
8	Zip	X(9)	L	75	83
9	Employer Name	X(18)	L	84	101
	Employer Location (Fields 10 - 13)				
10	Employer Address	X(18)	L	102	119
11	Employer City	X(15)	L	120	134
12	Employer State	XX	L	135	136
13	Employer Zip	X(9)	L	137	145
14	Employee ID Number	X(12)	R	146	157
15	Special Program Indicator	99	R	158	159
16	Filler (reserved for national use)	X(10)		160	169
17	Filler (reserved for local use)	X(23)		170	192

RECORD TYPE 40 - 4N - CLAIM

Generally, a claim contains a single type 40 record. However, if the single record is not sufficient to contain all iterations of a particular coding structure, e.g. more than 6 value codes are required, additional iterations of record type 40 could be submitted to convey the additional codes.

For Record Type 40, sequence numbers 02 or higher, all fields except the field or fields required to convey the additional code or codes that could not be contained on the sequence 01 record would be initialized to zeroes or blanks as appropriate, with the exception of the Patient Control Number and the Record Type fields.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Claim = '40'	40	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '40'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
4	Type of Bill	999	R	22	24
5	PSRO/PRO Approval Indicator	9		25	25
	PSRO/PRO Approved Stay Dates				
6	FROM (MMDDYY)	9(6)	L	26	31
7	THRU (MMDDYY)	9(6)	L	32	37
8	Number of Grace Days	X		38	38
9	Treatment Authorization Code	X(10)	L	39	48
10	Blood - Furnished Pints	999	R	49	51
11	Blood - Replaced Pints	999	R	52	54
12	Blood - Unreplaced Pints	999	R	55	57
13	Blood - Deductible Pints	99	R	58	59
14	Occurrence Code - 1	99	R	60	61
15	Occurrence Date - 1(MMDDYY)	9(6)	L	62	67
16	Occurrence Code - 2	99	R	68	69
17	Occurrence Date - 2 (MMDDYY)	9(6)	L	70	75
18	Occurrence Code - 3	99	R	76	77
19	Occurrence Date - 3 (MMDDYY)	9(6)	L	78	83
20	Occurrence Code - 4	99	R	84	85
21	Occurrence Date - 4 (MMDDYY)	9(6)	L	86	91
22	Occurrence Code - 5	99	R	92	93
23	Occurrence Date - 5 (MMDDYY)	9(6)	L	94	99
24	Occurrence Span Code - 1	99	L	100	101
	Occurrence Span Date - 1 (Fields 25-26)				
25	Occurrence Span FROM DATE - 1(MMDYY)	9(6)	L	102	107
26	Occurrence Span THRU DATE - 1 (MMDDYY)	9(6)	L	108	113

NOTE: IF THE CODE IN THE OCCURRENCE CODE FIELD IS OVER 69 THE TWO DATE FIELDS FOLLOWING THAT CODE ARE ASSOCIATED WITH IT, AND THE FIELD FOLLOWING THE FIRST DATE IS ZERO. IF THE CODE ENCOUNTERED IN THE OCCURRENCE SPAN CODE FIELD IS LESS THAN 70, ONLY THE OCCURRENCE SPAN FROM DATE WILL BE COMPLETED. THE CODE AND DATE WILL BE INTERPRETED AS AN OCCURRENCE CODE.

Claim = 40

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
27	Condition Code - 1	99	R	114	115
28	Condition Code - 2	99	R	116	117
29	Condition Code - 3	99	R	118	119
30	Condition Code - 4	99	R	120	121
31	Condition Code - 5	99	R	122	123
32	Value Code - 1	99	R	124	125
33	Value Amount - 1	9(6)V99	R	126	133
34	Value Code - 2	99	R	134	135
35	Value Amount - 2	9(6)V99	R	136	143
36	Value Code - 3	99	R	144	145
37	Value Amount - 3	9(6)V99	R	146	153
38	Value Code - 4	99	R	154	155
39	Value Amount - 4	9(6)V99	R	156	163
40	Value Code - 5	99	R	164	165
41	Value Amount - 5	9(6)V99	R	166	173
42	Value Code - 6	99	R	174	175
43	Value Amount - 6	9(6)V99	R	176	183
44	Filler	X(9)		184	192

RECORD TYPE 50 - ACCOMMODATION

May be preceded by RT 40 - 4n or 50 - 5n.

May be followed by RT 50 - 5n, 60 or 70.

Accommodations should be entered in the sequence in which they occur (date sequence).

The sequence number for record type 50 can go from 01 to 99, each such physical record containing five accommodations, thus making provision for reporting up to 495 accommodations on a single claim.

ACCOMMODATION REVENUE CODES: 100 THRU 22X

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
IP Accommodations	50	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record type '50'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Accommodations (occurs 5 times)				
	Accommodations - 1	9(33)	L	22	54
4	Accommodations Revenue Code	999	L	22	24
5	Filler	9		25	25
6	Accommodations Rate	9(4)V99	R	26	31
7	Accommodations Days	9(4)	R	32	35
8	Accommodations Total Charges	S9(5)V99	R	36	42
9	Accommodations Non-Covered Charges	S9(5)V99	R	43	49
10	Filler	9(5)	L	50	54
11	Accommodations - 2	9(33)	L	55	87
12	Accommodations - 3	9(33)	L	88	120
13	Accommodations - 4	9(33)	L	121	153
14	Accommodations - 5	9(33)	L	154	186
15	Filler	X(6)	L	187	192

RECORD TYPE 60 - INPATIENT ANCILLARY SERVICES

May be preceded by RT 40, 50 - 5n or 60 - 6n (excluding 61).

May be followed by RT 60 - 6n (excluding 61), 70 or 80.

The sequence number for record type 60 can go from 01 to 99, each such physical record containing five inpatient ancillary service codes, thus making provision for reporting up to 495 inpatient ancillary services on a single claim.

PAYER AND RELATED INFORMATION (codes 001 - 099).

THESE CODES MAY BE REPORTED IN RECORD TYPE 60, BUT THE AMOUNTS ASSOCIATED WITH THEM ARE NOT TO BE INCLUDED IN CONTROL TOTALS FOR ANCILLARIES IN RECORD TYPES 90 THRU 9N.

INPATIENT ANCILLARY SERVICES REVENUE CODES: CODES 220 - 99X.

INPATIENT ANCILLARY CODES SHOULD BE IN CODE NUMBER SEQUENCE

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Inpatient Ancillary Services	60	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '60'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Inpatient Ancillaries (occurs 5 times)				
	Inpatient Ancillaries - 1	9(34)	L	22	53
4	Inpatient Ancillary Revenue Code	9(3)	L	22	24
5	Filler	X(12)	L	25	36
6	Inpatient Ancillary Units of Service	999	R	37	39
7	Inpatient Ancillary Total Charges	S9(6)V99	R	40	47
8	Inpatient Ancillary Non-Covered Charges	S9(6)V99	R	48	55
9	Inpatient Ancillaries - 2	9(34)		56	89
10	Inpatient Ancillaries - 3	9(34)		90	123
11	Inpatient Ancillaries - 4	9(34)		124	157
12	Inpatient Ancillaries - 5	9(34)		158	191
13	Filler	X(1)		192	192

RECORD TYPE 61 - OUTPATIENT SERVICES

Must be preceded by RT 40 - 4n.

May be followed by RT 61 - 6n (excluding 60), or 70.

The sequence number for record type 61 can go from 01 to 99, each such physical record containing three outpatient service codes, thus making provision for reporting up to 297 outpatient service codes on a single claim.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Outpatient Services	61	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record type '61'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
	Revenue Centers (occurs 3 times)				
	Revenue Center - 1	X(57)		22	78
4	Revenue Center Code	999	L	22	24
5	HCPCS Procedure Code	X(5)	L	25	29
6	Modifier 1 (HCPCS & CPT-4)	X(2)	L	30	31
7	Modifier 2 (HCPCS & CPT-4)	X(2)	L	32	33
8	Units	9(4)	R	34	37
9	Date of Service (MMDDYY) (if applicable)	9(6)	L	38	43
10	Charges	9(6)V99	R	44	51
11	Non Covered Charges	9(6)V99	R	52	59
12	Filler	X(19)		60	78
13	Revenue Center - 2	X(57)		79	135
14	Revenue Center - 3	X(57)		136	192

RECORD TYPE 70 - 7N - MEDICAL

May be preceded by RT 50, 60, or 61.

May be followed by RT 7N, 80 or 90.

NOTE: ICD-9-CM CODING IS REQUIRED FOR ALL BILL TYPES. THE ICD-9-CM DIAGNOSIS CODES HAVE BEEN ASSIGNED A COBOL PICTURE OF X. THE ACTUAL CODE WILL BE FORMATTED IN ONE OF FOUR GENERAL WAYS:

1 999.99 MAY INCLUDE ZERO TO TWO DECIMAL PLACES.
2 V99.99 MAY INCLUDE ZERO TO TWO DECIMAL PLACES.
3 E999.9 MAY INCLUDE ZERO TO ONE DECIMAL PLACE.
4 M9999 INCLUDES NO DECIMAL PLACES.

TO DETERMINE THE LOCATION OF THE DECIMAL POSITION AND THE POTENTIAL NUMBER OF DECIMAL POSITIONS IT IS NECESSARY ONLY TO EXAMINE THE HIGH ORDER (LEFTMOST) POSITION IN THE FIELD.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Medical	70	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '70'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
4	Principal Diagnosis Code	X(5)	L	22	26
	Other Diagnosis Codes (fld. 5-8)				
5	Other Diagnosis Code	X(5)	L	27	31
6	Other Diagnosis Code	X(5)	L	32	36
7	Other Diagnosis Code	X(5)	L	37	41
8	Other Diagnosis Code	X(5)	L	42	46
9	Principal Procedure Code	X(5)	L	47	51
10	Filler	X(4)	L	52	55
11	Principal Procedure Date	9(6)	L	56	61
	Other Procedure Codes and Dates (fld. 12 through 17).				
12	Other Procedure Code	X(5)	L	62	66
13	Filler	X(4)	L	67	70
14	Other Procedure Date	9(6)	L	71	76
15	Other Procedure Code	X(5)	L	77	81
16	Filler	X(4)	L	82	85
17	Other Procedure Date	9(6)	L	86	91
18	Admitting Diagnosis Code	9(5)	L	92	96
19	Filler (Local Use)	X(96)		97	192

RECORD TYPES 71-73 - HOME HEALTH DATA ELEMENTS FOR MEDICAL REVIEW OF HOME HEALTH CLAIMS

Must be preceded by RT 70

May be followed by RT 74, 7N, 80 or 90

RECORD TYPE 71 - PLAN OF TREATMENT AND PATIENT INFORMATION (FORMS HCFA-485/486)
RECORD TYPE 72 - SPECIFIC SERVICES AND TREATMENTS (FORM HCFA-486)
RECORD TYPE 73 - PLAN OF TREATMENT/MEDICAL UPDATE NARRATIVE (FORMS HCFA-485/486)

For use by HHAs to submit data from the forms HCFA-485 and 486. Data is required with the initial home health bill and with subsequent bills closest to the recertification dates. Record Types 71, 72 and 73 must be present. However, when submitting data from the HCFA-486 only (i.e., on interim claims) complete only the following fields on Record Type 71: Fields 1-6, 24-26 and 28-31. Zeros are present in numeric fields and blanks in alphanumeric fields which do not contain data.

The HHA should retain signed copies of the forms HCFA-485 and 486 in your files. The Provider Representative Certification must be submitted with the initial batch of claims containing the HCFA-485 and HCFA-486 data elements. Subsequent certifications are to be submitted in accordance with §499.1.

Record Type 74, Patient Information.—This record is used to give patient information when the agency submits HCFA-485/486 data separately from billing records. HCFA-485/486 data (i.e., Record Types 71-73) submitted separately must be preceeded by Record Type 10 -"Provider." Enter in Field 2 - Type of Batch "3M blank" to identify that the batch contains only HCFA-485/486 data.

The agency must receive permission from you prior to submitting separate data. You should advise the agency how to submit these batches.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
PLAN OF TREATMENT AND PATIENT INFORMATION	71	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record Type '71'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Data ID	X		22	22
5	SOC Date (MMDDYY)	9(6)	L	23	28
	Certification Period				
6	From (MMDDYY)	9(6)	L	29	34
7	To (MMDDYY)	9(6)	L	35	40
8	Date of Onset or Exacerbation of Principal Diagnosis (MMDDYY)	9(6)	L	41	46
9	Surgical Procedure Code	X(4)	L	47	50
10	Date Surgical Procedure Performed (MMDDYY)	9(6)	L	51	56
	Dates of Onset/Exacerbation of Secondary Diagnoses (occurs 4 times)				
11	Date Secondary Diagnosis-1	9(6)	L	57	62
12	Date Secondary Diagnosis-2	9(6)	L	63	68
13	Date Secondary Diagnosis-3	9(6)	L	69	74
14	Date Secondary Diagnosis-4	9(6)	L	75	80
15	Functional Limitation Code (occurs 13 times)	X(13)	L	81	93
16	Activities Permitted Code (occurs 13 times)	X(13)	L	94	106
17	Mental Status Code (occurs 8 times)	X(8)	L	107	114
18	Prognosis	X		115	115
19	Verbal SOC Date (MMDDYY)	9(6)	L	116	121

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
PLAN OF TREATMENT PATIENT INFORMATION	71	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
	Physician's Name				
20	Last Name	X(15)	L	122	136
21	First Name	X(10)	L	137	146
22	Initial	X		147	147
23	Physician's ZIP Code	X(9)	L	148	156
24	Medicare Covered	X		157	157
25	Date Physician Last Saw Patient (MMDDYY)	9(6)	L	158	163
26	Date Last Contacted Physician (MMDDYY)	9(6)	L	164	169
27	Patient Receiving Care in 1861J1 Facility	X		170	170
28	Cert/Recert/Mod	X		171	171
29	Admission (MMDDYY)	9(6)	L	172	177
30	Discharge (MMDDYY)	9(6)	L	178	183
31	Type of Facility	X		184	184
32	Filler	X(8)		185	192

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
SPECIFIC SERVICES AND TREATMENTS	72	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFI-CATION	POSITION FROM	POSITION THRU
1	Record Type '72'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
4	Filler	XX		22	23
5	Discipline	XX	L	24	25
6	Visits (This Bill) Related to Prior Certification	99	R	26	27
7	Frequency and Duration (Occurs 12 Times)	X(72)	L	28	99
	Frequency of Visits				
	Frequency Number	9			
	Frequency Period	XX	L		
	Duration	X(3)	L		
8	Treatment Codes (Occurs 25 Times)	X(75)	L	100	174
	Code	X(3)			
9	Total Visits Projected This Cert.	99	R	175	176
10	Filler (National Assignment)	X(5)		177	181
11	Filler (State Assignment)	X(11)		182	192

Record Type 73 - Plan of Treatment/Medical Update Narrative

This record(s) contains narrative information from the forms "Home Health Certification and Plan of Treatment" and "Medical Update and Patient Information." This record is used to provide information requested on the HCFA-485 and 486 forms and to elaborate on any item on the forms. The agency should not provide narrative instead of completing fields on Record Types 71 and 72. A separate 73 Record for each item is completed. As many 73 records as necessary are used. A sequence number is incremented by one for each record present (i.e., 01-99). Listed below are items which may require a narrative record. An "R" is reflected for data which is always required.

Data Element	Data ID Number	Required Element
Medications	48510	R
DME and Supplies	48514	Not required if no DME or supplies will be billed.
Safety Measures	48515	If present.
Nutritional Requirements	48516	R
Allergies	48517	If present.
Orders for Discipline and Treatments	48521	R
Goals/Rehabilitation Potential/Discharge Plans	48522	R
Updated Information	48616	R
Functional Limitations Reason Homebound	48617	R
Supplementary Plan of Treatment	48618	If applicable.
Unusual Home/Social Environment	48619	If applicable.
Times and Reasons Patient Not at Home	48620	If affirmative.
Medical/Nonmedical Reasons Patient Leaves Home	48621	R

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
PLAN OF TREATMENT/ MEDICAL UPDATE NARRATIVE	73	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record Type '73'	XX	L	1	2
2	Sequence Number	99	R	3	4
3	Patient Control Number	X(17)	L	5	21
4	Filler	XX		22	23
5	Data ID Number	X(5)	L	24	28
6	Corresponding Data	X(164)	L	29	192

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
PATIENT INFORMATION	74	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record Type '74'	XX	L	1	2
2	Filler	XX		3	4
3	Patient Control Number	X(17)	L	5	21
4	Filler	XX		22	23
5	HICN	X(17)	L	24	40
6	Medical Record Number	X(18)	L	41	58
	Patient Name				
7	Last Name	X(20)	L	59	78
8	First Name	X(10)	L	79	88
9	Initial	X		89	89
10	Date of Birth (MMDDYY)	X	L	90	95
11	Sex	X		96	96
12	Principal Diagnosis Code	X(5)	L	97	101
13	Secondary Diagnosis Code-1	X(5)	L	102	106
14	Secondary Diagnosis Code-2	X(5)	L	107	111
15	Secondary Diagnosis Code-3	X(5)	L	112	116
16	Secondary Diagnosis Code-4	X(5)	L	117	121
17	Filler	X(71)		122	192

RECORD TYPE 80 - 8N - PHYSICIAN DATA

- May follow RT 50, 60, or 70 - 7N.
- May be followed by RT 8N, or 90.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Physician Data	80	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '80'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Attending Physician Number	X(16)	L	22	37
5	Operating Physician Number	X(16)	L	38	53
6	Other Physician Number	X(16)	L	54	69
7	Other Physician Number	X(16)	L	70	85
8	Attending Physician Name	X(26)	L	86	111
9	Operating Physician Name	X(26)	L	112	137
10	Other Physician Name	X(26)	L	138	163
11	Other Physician Name	X(26)	L	164	189
12	Filler	X(3)	L	190	192

RECORD TYPE 81 - PACEMAKER REGISTRY RECORD

- May be preceded by RT 50 - 5N, 60 - 6N, 70 - 7N, or 80.
- Must be followed by RT 20 or 95.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Pacemaker	81	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '81'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Ordering Physician Number	X(16)	L	22	37
5	Ordering Physician Name	X(13)	L	38	50
6	Operating Physician Number	X(16)	L	51	66
7	Operating Physician Name	X(13)	L	67	79
8	Record Identification Code 1 = Implanted Pulse Generator 2 = Implanted Atrial Lead 3 = Implanted Ventricular Lead 5 = Explanted Pulse Generator 6 = Explanted Atrial Lead 7 = Explanted Ventricular Lead	X	L	80	80
9	Manufacturer Identification	XXX	L	81	83
10	Model Number	X(15)	L	84	98
11	Serial Number	X(20)	L	99	118
12	Warranty Expiration Date MMDDYY	X(6)	L	119	124
13	Implant Date (MMDDYY)	X(6)	L	125	130
14	Leads Left In Patient Y=Yes, N=No	X		131	131
15	Returned to Manufacturer Y=Yes, N=No	X		132	132
16	Filler (National Use)	X(30)	L	133	162
17	Filler (Local Use)	X(30)	L	163	192

RECORD TYPE 90 - CLAIM SCREEN

- May be preceded by RT 50 - 5N, 60 - 6N, 70 - 7N, or 80 - 8N.
- Must be followed by RT 20 or 95.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Screen = '90'	90	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '90'	XX	L	1	2
2	Filler	XX	L	3	4
3	Patient Control Number	X(17)	L	5	21
4	Physical Record Count (Excluding Screen)	999	R	22	24
	Record Type nn Count (Fields 5-11)				
5	Record Type 2n Count	99	R	25	26
6	Record Type 3n Count	99	R	27	28
7	Record Type 4n Count	99	R	29	30
8	Record Type 5n Count	99	R	31	32
9	Record Type 6n Count	99	R	33	34
10	Record Type 7n Count	99	R	35	36
11	Record Type 8n Count	99	R	37	38
12	Total Days/Visits	9(4)	R	39	42
13	Total Accommodation Charges Revenue Centers	S9(7)V99	R	43	51
14	Non-Covered Accommodation Charges - Revenue Centers	S9(7)V99	R	52	60
15	Total Ancillary Charges Revenue Centers	S9(7)V99	R	61	69
16	Non-Covered Ancillary Charges - Revenue Centers	S9(7)V99	R	70	78
17	Remarks	X(114)		79	192

RECORD TYPE 95 - PROVIDER BATCH CONTROL

- Must be preceded by RT 90.
- Must be followed by RT 10 or 99.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Batch Control	95	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION FROM	POSITION THRU
1	Record Type '95'	XX	L	1	2
2	Federal Tax Number	9(9)	L	3	11
3	Receiver Identification	9(5)	L	12	16
4	Receiver Sub-Identification	X(4)	L	17	20
5	Type of Batch	XXX	L	21	23
6	Number of Claims	9(6)	R	24	29
7	Total Days/Visits	9(6)	R	30	35
8	Accommodations Total Charges for the Batch	S9(8)V99	R	36	45
9	Accommodations Non-Covered Charges for the Batch	S9(8)V99	R	46	55
10	Ancillary Total Charges for the Batch	S9(8)V99	R	56	65
11	Ancillary Non-Covered Charges for the Batch	S9(8)V99	R	66	75
12	Filler (Reserved for National Use)	X(54)	L	76	129
13	Filler (Reserved for Local Use)	X(63)		130	192

RECORD TYPE 99 - TAPE CONTROL

- Must be preceded by RT 95.
- Must be last valid record on tape.

MAGNETIC TAPE FILE AND RECORD SPECIFICATIONS FOR PROVIDERS

Record Name	Record Type	Record Size
Tape Control	99	192

FIELD NO.	FIELD NAME	PICTURE	FIELD SPECIFICATION	POSITION	
				FROM	THRU
1	Record Type '99'	XX	L	1	2
2	Submitter EIN	9(9)	L	3	11
3	Receiver Identification	9(5)	L	12	16
4	Receiver Sub-Identification	X(4)	L	17	20
5	Number of Batches Billed this Tape	9999	R	21	24
6	Accommodations Total Charges for the Tape	S9(9)V99	R	25	35
7	Accommodations Non-Covered Charges for the Tape	S9(9)V99	R	36	46
8	Ancillary Total Charges for the Tape	S9(9)V99	R	47	57
9	Ancillary Non-Covered Charges for the Tape	S9(9)V99	R	58	68
10	Filler (Reserved for National Use)	X(61)		69	129
11	Filler (Reserved for Local Use)	X(63)		130	192

ADDENDUM B - ALPHABETIC LISTING OF DATA ELEMENTS:

Data Element	Definition	Record	Field
Accident Hour	The hour when the accident occurred that necessitated medical treatment	20	12
* Accommodations Revenue Code	UB-82 revenue center code for the accommodation provided. Includes codes 10X through 21X.	50 Four additional iterations in related locations for record 50, fields 11 - 14.	4
* Accommodations Days	A numeric count of accommodations days in accordance with payer instructions. Includes UB-82 revenue codes 10X through 21X.	50 Four additional iterations in related locations for record 50, fields 11 -14.	7
* Accommodations Non-covered Charges	Accommodations charges pertaining to the related UB-82 accommodations revenue code that are covered by the primary payer as determined by the provider.	50 Four additional iterations in related locations for record 50, fields 11 -14.	9
Accommodations Non-covered Charges for the Batch	Sum of charges recorded in related field in record type 90, field 14	95	9
* Accommodations Rate	Per diem rate for related UB-82 accommodations revenue code.	50 Four additional iterations in related locations for record 50, fields 11 - 14.	6
* Accommodations Total Charges	Total charges for the related revenue code.	50	8
Accommodations Total Charges for the Batch	Total accommodation charges for this batch	95	8

* Complete for Medicare

Data Element	Definition	Record	Field
* Admission Date	The date the patient was admitted to the provider for inpatient care, outpatient service or start of care. For an admission notice for hospice care enter the effective date of election of hospice benefits.	20	18
Admission Hour	The hour during which the patient was admitted for inpatient or outpatient care.	20	19
Ancillary Date of Service	The date the associated ancillary service as identified by the UB-82 revenue center code was delivered.	60 Four additional iterations in related locations for record 60, fields 12 - 154.	6
Ancillary Non-Covered Charges	Charges pertaining to the related UB-82 ancillary revenue center code that the primary payer will not cover.	60 Four additional iterations in related locations for record 60, fields 12 - 15.	9
Ancillary Non-Covered Charges for the Batch	Sum of charges recorded in related field, record type 90, field 16.	95	11
*Ancillary Revenue Code	UB-82 revenue center code for the ancillary services provided. Includes codes 22X through 99X.	60 Four additional iterations in related locations for record 60, fields 12 - 15.	4
* Ancillary Total Charges	Total charges pertaining to the related UB-82 ancillary revenue center code. (And date, if applicable.)	60	8
Ancillary Total Charges for the Batch	Total ancillary charges for this batch	95	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Ancillary Units of Service	A quantitative measure of services rendered by UB-82 revenue center category to or for the patient to include such items as number of miles, pints of blood, number of renal dialysis treatments, etc.	60 Four additional iterations in related locations for record 60, fields 12 - 15.	7
Assignment of Benefits Certification Indicator	A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y=Benefits assigned N=Benefits not assigned	30	16
Attending Physician Name	Name of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment	80	8
* Attending Physician Number	Number assigned to identify physician named in Record 80, field 8	80	4
* Batch Number	Number assigned by the provider sequentially from 01 to nn to each batch of bills of a given type.	10	3
* Blood-Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.	40	13
* Blood-Furnished Pints	Total number of pints of whole blood or units of packed red cells furnished to the patient.	40	10
* Blood-Replaced Pints	The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by or on behalf of the patient.	40	11
* Blood-Unreplaced Pints	The number of pints of whole blood or units of packed red cells furnished to the patient that have not been replaced by or on behalf of the patient.	40	12
Blue Cross/Blue Shield Provider Number	The number assigned to the provider by Blue Cross.	10	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Certificate/ Social Security Number/Health Insurance Claim/ Identification Number	Insured's unique identification number assigned by the payer organization. Medicare: Enter the patient's Medicare HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.	30	7
* Co-Insurance	That amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer.	30	24
* Coinsurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness.	30	21
* Condition Codes	A code(s) used to identify conditions relating to this bill that may affect payer processing (Addendum C).	40	27-31
* Covered Days	The number of days covered by the primary payer, as qualified by the payer organization.	30	19
* Deductible	That amount assumed by the hospital to be applied to the patient's deductible amount involving the indicated payer.	30	23
Discharge Hour	Hour that the patient was discharged from inpatient care. (Addendum C)	20	23
* Employee ID Number	The identification number assigned by the employer to the insured identified in record 30, fields 11 - 13 as qualified by the payer organization, or as applicable, to the individual indicated by the employment info. code in record 21, field 10, or field 18.	21 31	9&17 14
* Employer Location	The specific location for the employer of the individual identified in record 30.	21 21 31	5-8 13-16 10-13

* Complete for Medicare

Data Element	Definition	Record	Field
* Employer Name	The name of the employer that might or does provide health care coverage for the individual identified in record 30.	21 21 31	4 12 9
* Employment Information Data	A code that indicates whether the employment information given in the related area applies to the patient, the patient's spouse, the patient's mother, or the patient's father. (See Addendum C)	21 21	10 18
Employment Status Code	A code used to define the employment status of the individual identified by the "Employment Information Data" code, or by name in record 30. (See Addendum C).	21 21 30	11 19 18
Estimated Amount Due	The amount estimated by the hospital to be due from the indicated payer. (Estimated responsibility less prior payments.)	30	25
Estimated Responsibility	The amount estimated by the hospital to be paid by the indicated payer.	30	26
Federal Tax Number	The number assigned to the provider by the federal government for tax reports purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).	10 95	4 2
Insurance Group Number	The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.	30	9
* Insured Address	Insured's current mailing address.	31	4 - 8
	Address Line 1	31	4
	Address Line 2	31	5
	City	31	6
	State	31	7
	Zip	31	8
Insured Group Name	Name of the group or plan through which the insurance is provided to the insured.	30	10
Insured's Name	Name of the individual in whose name the insurance is carried.	30	11-13
	Last Name	30	11
	First Name	30	12
	Middle Initial	30	13

* Complete for Medicare

Data Element	Definition	Record	Field
* Insured's Sex	A code indicating the sex of the insured. M=Male F=Female U=Unknown	30	14
* Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.	30	22
* Medicaid Provider Number	The number assigned to the provider by Medicaid.	10	8
* Medical Record Number	Number assigned to patient by hospital or other provider to assist in retrieval of medical records	20	25
* Medicare Provider Number	The number assigned to the provider by Medicare.	10	6
* Multiple Provider Billing Tape Indicator	A code indicating whether bills for more than one provider are contained on this tape submission, according to the following coding scheme. 1=Single Provider 2=Multiple Providers	01	3
Non-Covered Charges - Accommodations	Total of accommodation charges not covered by primary payer for this bill as reflected in record type 50, field 9 and subsequent accommodation packets in record type 50.	90	14
* Non-Covered Charges - Ancillaries	Total of "Ancillary Charges-Noncovered" for this bill as reflected in record type 60, field 9.	90	16
* Non-Covered Days	Days of care not covered by the primary payer.	30	20
* Number of Claims	A count of the number of record type 20 entries for this provider batch. (record type 10 to record type 95)	95	6
* Number of Batches Billed this Tape.	A count of the number of batches billed on this tape or transmission.	99	5

* Complete for Medicare

Data Element	Definition	Record	Field
* Number of Grace Days	Following the date of the PSRO/UR denial determination, this is the number of days determined by the PSRO/UR to be necessary to arrange for the patient's post discharge care.	40	8
* Occurrence Code	A code defining a significant event relating to this bill that may affect payer processing. (See Addendum C).	40	14, 16 18, 20 22
	Occurrence Code 1	40	14
	Occurrence Code 2	40	16
	Occurrence Code 3	40	18
	Occurrence Code 4	40	20
	Occurrence Code 5	40	22
* Occurrence Date	Date associated with the Occurrence Code in the preceding field.	40	15, 17 19, 21 23
	Occurrence Date 1	40	15
	Occurrence Date 2	40	17
	Occurrence Date 3	40	19
	Occurrence Date 4	40	21
	Occurrence Date 5	40	23
* Occurrence Span Code - 1	A code that identifies an event that relates to the payment of the claim. (See Addendum C)	40	24
* Occurrence Span Date - 1	The dates related to the Occurrence Span Code shown in the preceding field.	40	25&26
Operating Physician Name	Name used by the provider to identify the operating physician in the provider records.	80	9
* Operating Physician Number	Number used by the provider to identify the operating physician in the provider records.	80	5
* Other Diagnosis Codes	The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.	70	5-8
Other Physician ID NAME/NUMBER	The name and/or number of the licensed physician other than the attending physician as defined by the payer organization.	80	6,7, 10&11

* Complete for Medicare

Data Element	Definition	Record	Field
* Other Procedure Codes	The codes identifying the procedures, other than the principal procedure, performed during the billing period covered by this bill.	70	12, 15
* Other Procedure Dates	Date that the procedure indicated by the related code (preceding field) was performed	70	14, 17
* Patient Address	The address of the patient as qualified by the payer organization.	20	13-17
	Line 1		13
	Line 2		14
	City		15
	State (P.O. Code)		16
	Zip		17
* Patient Birthdate	The date of birth of the patient. Includes 4 pos. Year. (MMDDYYYY).	20	9
* Patient Control Number	Patient's unique alpha-numeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment.	20-90	3
* Patient Has Paid	Amount patient has paid to the provider towards this bill.	20	24
Patient Marital Status	The marital status of the patient at date of admission, outpatient service, or start of care. (See Addendum C).	20	12
* Patient Name	Last name, first name, and middle initial of the patient.	20	4 - 6
	Last name	20	4
	First name	20	5
	Middle Initial	20	6
* Patient's Relationship to Insured	A code indicating the relationship of the patient to the identified insured. (See Addendum C).	30	17
* Patient Sex	The sex of the patient as recorded at date of admission, outpatient service, or start of care. M=Male F=Female U=Unknown	20	7

* Complete for Medicare

Data Element	Definition	Record	Field
* Patient Status	A code indicating patient status as of the statement covers thru date. (See Addendum C).	20	22
* Physical Record Count (Excluding Screen)	The total number of physical records submitted for this bill, including all record types 20 through 8n, and excluding record type 90.	90	4
* Payer Identification	Number identifying each payer organization from which the provider might expect some payment for the bill. (See Addendum C).	30	5
* Payer Name	Name identifying each payer organization from which the provider might expect some payment for the bill.	30	8
Payer Sub-identification	The identification of the specific office within the insurance carrier designated as responsible for this claim.	30	6
* Primary Payer Code	Identifies reason another payer is primary to Medicare. (See Addendum C).	30	28
* Principal and Other Diagnoses Descriptions	Narrative description of the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing the hospitalization or use of hospital services) and other diagnoses. ICD-9-CM terminology should be used.	70	19
* Principal Diagnosis Code	The ICD-9-CM diagnosis codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization).	70	4
* Principal Procedure Code	The code that identifies the principal procedure performed during the period covered by this bill.	70	9
* Principal Procedure Date	The date on which the principal procedure described on the bill was performed.	70	11

* Complete for Medicare

best copy available

Data Element	Definition	Record	Field
* Principal and Other Procedures Descriptions	A narrative description of the principal procedure (i.e., the procedure that was performed for definitive treatment rather than the one performed for diagnostic or exploratory purposes or the procedure most related to the principal diagnosis) and other procedures. The principal procedure is to be shown first.	70	20
* Prior Payments - Payer and Patients	The amount the hospital has received toward payment of this bill prior to the billing date by the indicated payer.	30	27
Procedure Code	Procedure code reported in type 61 record to identify physician services so that reimbursement can be made as though the service had been provided in the physician's office.	61	4
Procedure Coding Method Used	An indicator that identifies the coding method used for procedure coding on the bill. (See Addendum C).	10	18
* Processing date ("Date Bill Submitted" on HCFA-1450).	Date the submitter prepares the file.	01	8
* Provider Address	Complete mailing address to which the provider wishes payment sent.	10	14-17
	Street address or box number	10	14
	City	10	15
	State (P.O. abbreviations)	10	16
	Zip	10	17
* Provider Name	Name of the provider submitting this batch of bills.	10	13
Provider Telephone Number	Telephone number, including area code, at which the provider wishes to be contacted for claims development.	10	12
* PSRO/PRO Approval Indicator	An indicator describing the determination arrived at by the PRO or PSRO.	40	5

* Complete for Medicare

Data Element	Definition	Record	Field
* PSRO/PRO Approved Stay Dates	The first and last days that were approved where not all of the stay has been approved by the PRO or PSRO.	40	6 - 7
* Receiver Identification	Number identifying to the provider the organization designated to receive this file. (See Addendum C).	01 95 99	6 3 3
Receiver Sub-Identification	The identification of the specific location within the receiver organization designated to receive the tape or transmission.	01 95 99	7 4 4
* Receiver Type Code	A code indicating the class of organization designated to receive this tape or transmission. (See Addendum C).	01	5
* Record Type nn Count	A count of record types 20-2n through 80-8n, fields 5 through 11 of this record. These fields should crossfoot to the total in field 4 of this record.	90	5 -11
* Reel Sequence Number	Sequence number from 01 to nn assigned to each reel in this file of records.	01	15
Reel Serial Number	Inventory number of the reel.	01	16
* Remarks	Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements.	90	17
* Release of Information Certification Indicator	A code indicating whether the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim. (See Addendum C).	30	15

* Complete for Medicare

Data Element	Definition	Record	Field
* Sequence Number	Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 20-2n, 40-4n, 70-7n and 80-8n will never have a sequence number greater than 01. The sequence number for record types 30 and 31 are used as matching criteria to determine which type 30 and type 31 records are associated, like sequence numbers indicating the records are associated.	30-3n 50-5n 60-6n	2 2 2
* Source of Admission	A code indicating the source of this admission. (See Addendum C).	20	11
* Source of Payment Code	A code indicating source of payment associated with this payer record. (See Addendum C).	30	4
* Special Program Indicator	A code indicating that the services included on this bill are related to a special program. (See Addendum C).	31	16
* Statement Covers Period	The beginning and ending service dates of the period covered by this bill.	20	20-21
* Submitter Address	Mailing address of the submitter of this file. Address City State Zip	01	10-13 10 11 12 13
* Submitter EIN	Federally assigned Employer Identification Number (EIN) of tape submitter. EIN is also referred to as Tax Identification Number (TIN).	1 99	2 2

* Complete for Medicare

Data Element	Definition	Record	Field
* Submitter Name	Name of provider, third party billing service, or other organization to which the receiver/processor should direct inquiries regarding this transmittal.	01	9
Submitter Telephone Number	Telephone number, including area code, at which the submitter wishes to be contacted for claim development.	01	14
* Total Days/Visits	Inpatient bills: the sum of all days reported in accommodation packets in record type 50. Outpatient and home health bills: the sum of all visits recorded as "units of service" for this bill record in record type 60, field 7.	90	12
	Sum of days/visits recorded in record type 90, field 12.	95	7
* Treatment Authorization Code	A number or other indicator that designates that the treatment covered by this bill has been authorized by the payer.	40	9
* Total Charges - Accommodations	Total accommodation charges for this bill	90	13
Total Charges - Ancillaries	Total ancillary charges for this bill	90	15
* Type of Admission	A code indicating the priority of this admission. (See Addendum C).	20	10

* Complete for Medicare

Data Element	Definition	Record	Field
* Type of Batch	A code indicating the types of bills that occur in this batch; i.e. between a provider record (record type 10), and a provider batch control (record type 95). (See Addendum C).	10 95	2 5
* Type of Bill	A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.) (See Addendum C).	40	4
* Value Amount	Amount of money related to the associated value code. (See Addendum C for Value Codes).	40	32, 34, 36, 38 40, 42 44&46
* Value Code	A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization. (See Addendum C).	40	33, 35 37, 39 41, 43 45&47
* Version Code	A code that indicates the version of the National Specifications submitted on this reel, disk, etc. 001 = UB-82 data set as finally approved 08/17/82.	01	19

* Complete for Medicare

ADDENDUM C - CODING STRUCTURES

	Page
Accident Hour	C-2
Admission Hour	C-2
Condition Codes	C-3
Discharge Hour	C-6
Employment Information Data	C-6
Employment Status Code	C-6
Occurrence Codes	C-7
Occurrence Span Codes	C-10
Patient Marital Status	C-10
Patient's Relationship to Insured	C-11
Patient Status	C-12
Payer Identification	C-12
Procedure Coding Method Used	C-12
PRO/UR Approval Indicator	C-13
Receiver Identification	C-13
Receiver Type	C-14
Release of Information Certification Indicator	C-14
Revenue Codes	C-15
Source of Admiscion	C-46
Source of Payment	C-47
Special Program Indicator	C-48
Type of Admission	C-49
Type of Batch	C-50
Type of Bill	C-51
Value Codes	C-52

Data Element: Accident Hour

Definition: The hour when the accident occurred that necessitated medical treatment.

00 - 23;
Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01
Noon (12:00-12:59) = 12
01:00-01:59 PM = 13
11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Admission Hour

Definition: The hour during which the patient was admitted for inpatient or outpatient care.

00 - 23;
Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01
Noon (12:00-12:59) = 12
01:00-01:59 PM = 13
11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Condition Codes

Data Definition: A Code(s) used to identify conditions relating to this bill that may affect payer processing.

Code Structure:

Code	Code Title	Definition
INSURANCE CODES		
01	Military Service Related	Medical condition incurred during military service.
02	Condition is Employment Related	Patient alleges that medical condition is due to environment/events resulting from employment.
03	Patient Covered by Insurance not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	HMO Enrollee	Medicare beneficiary is enrolled in an HMO.
05	Lien has been filed	Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
06	ESRD Patient in first year of entitlement covered by employer group health insurance	Code indicates Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during his first year of end stage renal disease entitlement.
07	Treatment of non-terminal condition for hospice patient.	The patient is a hospice enrollee, but the provider is not treating his terminal condition and is therefore requesting Medicare reimbursement.
08-16		Reserved for National assignment.
SPECIAL CONDITIONS		
17	Patient is Over 100 years old	Indicates that the patient is over 100 years old at date of admission or outpatient services. Not used for electronic billing.
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.

19	Child Retains Mother's Name	A patient who is a dependent child entitled to CHAMPUS or CHAMPVA benefits that does not have his father's last name.
20-30		Reserved for national assignment

STUDENT STATUS (Required when patient is a dependent child over 18 years old)

Note: Use only one of the following codes - lowest code value number takes precedence.

31	Patient is student (full time - day)	Patient declares that he or she is enrolled as a full time day student.
32	Patient is student (Cooperative/work study program)	Self Explanatory
33	Patient is student (full time - night)	Patient declares that he or she is enrolled as a full time night student.
34	Patient is student (part time)	Patient declares that he or she is enrolled as a part time student.
35		Reserved for National Assignment.

ACCOMMODATIONS

36	General care patient in a special unit	Patient temporarily placed in special care unit bed because no general care beds available.
37	Ward Accommodation-Patient's Request	Patient assigned to ward accommodations at patient's request.
38	Semi-Private Room Not Available	Indicates that either private or ward accommodations assigned because semi-private accommodations were not available.
39	Private Room Medically Necessary	Patient needs a private room for medical requirements.
40	Same Day Transfer	Patient transferred to another facility before midnight on the day of admission.
40-45		Reserved for National Assignment

CHAMPUS INFORMATION

46	Non-Availability Statement on File	A nonavailability statement must be be on file for each CHAMPUS claim for non emergency inpatient care when the CHAMPUS beneficiary resides within the catchment area (usually a 40 mile radius) of a Uniform Services Hospital.
47		Reserved for CHAMPUS
48-59		Reserved for National Assignment.

PROSPECTIVE PAYMENT

60	Day Outlier	A hospital being paid under a prospective payment system is reporting this stay as a day outlier
61	Cost Outlier	A hospital being paid under a prospective payment system is requesting additional payment for this stay as a cost outlier
62	Payer Code	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the claim was paid under a DRG.
63-70		Reserved for National Assignment

RENAL DIALYSIS SETTING

71	Full Care In Unit	Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
72	Self Care in Unit	Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self Care Training	Billing is for special dialysis services where a patient and his helper (if necessary) were learning to perform dialysis.
74	Home	Billing is for a patient who received dialysis services at home but where code 75 below does not apply.
75	Home - 100 Percent Reimbursement	Billing is for a patient who received dialysis services at home, using a dialysis machine that was purchased by Medicare under the 100 percent program.

76	Back-up Facility	Billing is for a patient who received dialysis services in a back-up facility.
77-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element: Discharge hour

Definition: Hour that the patient was discharged from inpatient care:

00 - 23;
Midnight (12:00-12:59) = 00
01:00-01:59 AM = 01
Noon (12:00-12:59) = 12
01:00-01:59 PM = 13
11:00-11:59 PM = 23
99 = UNKNOWN

Data Element: Employment Information Data.

Definition: A code that indicates whether the employment information given in the related areas applies to an insured, the patient or the patient's spouse.

Code Structure:
P - Patient Employment Information.
S - Spouse Employment Information.
F - Father's Employment Information.
M - Mother's Employment Information.

Data Element: Employment Status Code.

Definition: A code used to define the employment status of the individual identified by the "Employment Information Data" code.

Code	Code Title	Definition
1	Employed full time	Individual states that he or she is employed full time.
2	Employed part time	Individual states that he or she is employed part time.
3	Not employed	Individual states that he or she is not employed full time or part time.
4	Self Employed	Self-explanatory.
5	Retired	Self-explanatory.
6	On Active Military Duty	Self-explanatory.
7-8		Reserved for National assignment.
9	Unknown	Individual's employment status is unknown.

Data Element: Occurrence code.

Definition: A code defining a significant event relating to this bill that may affect payer processing.

ACCIDENT RELATED CODES

01	Auto Accident	Code indicating the date of an auto accident.
02	Auto Accident/ No Fault Insurance Involved	Code indicating the date of an accident where state has applicable no fault liability laws. (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability. This date could also be the date of an event for which a third party makes a nonjudical admission of liability. Medicare would become secondary payer in this case.
04	Accident/Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other Accident	Code indicating the date of an accident not described by the above codes.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
07-09		Reserved for National Assignment.

MEDICAL CONDITION CODES

10	Last Menstrual Period	Code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity-related condition.
11	Onset of Symptoms/Illness	Date the patient first became aware of symptoms/illness.
12-19		Reserved for National Assignment.

INSURANCE RELATED CODES

20	Guarantee of Payment Began	Code indicating the date on which the provider began claiming Medicare payment under the guarantee of payment provision. (HIM 10, 402.1, Item 21).
21	UR/PSRO Notice Received	Code indicating the date of receipt by the hospital of the UR Committee's (PSRO or other responsible group's) finding that an admission or further stay was not medically necessary (HIM 10, 402.1, Item 22).
22	Active Care Ended	Code indicating the date on which a covered level of care ended in a general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital. (HIM 10, 402.1, Item 23). Code not required where PSRO/UR approval is completed.
23	Benefits Exhausted	Code indicating the last date for which benefits are being claimed by the provider (HIM 10, 402.1, Item 24).
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the hospital from the insurer.
25	Date Benefits Terminated By Primary Payer	The date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Available	Code indicating the date on which a SNF bed became available to hospital inpatient who requires only SNF level care. (HIM 10, 405C).
27	Date Home Health Plan Established	Code indicating the date a home health plan of treatment was established (THIS CODE IS ONLY TO BE USED BY HOME HEALTH PROVIDERS), (HIM 11, 402, ITEM 13).
28-39		Reserved for National Assignment.

SERVICE RELATED CODES

40	Scheduled Date of Admission	The date on which a patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
41	Date of First Test for Pre-Admission Testing	The date on which the first outpatient diagnostic test was performed as part of a PAT program. This code may only be used if a date of admission was scheduled prior to the administration of the test(s).
42	Date of Discharge	To be used when "Through" date in "Statement Covers Period" is not the actual discharge date and the frequency code in the "Type of Bill" code is that of a final bill. For final bill for hospice care, enter the date the Medicare beneficiary terminated his election of hospice care.
43 -49		Reserved for National Assignment.
50-69		Reserved for State Assignment.
70-99		See Occurrence Span Codes. If this code is encountered in an Occurrence Code field, the date following is the "From Date" of the date span, the next Occurrence Code field must be blank, and the next date field is the "Through Date" of the date span.

Data Element: Occurrence Span Code-1.

Data Definition: A code that identifies an event that relates to the payment of the claim.

Code Structure

70	Qualifying Stay Dates (Medicare)	The from/thru date of at least a 3-day hospital stay that qualifies the patient for Medicare payment of SNF services billed. Code can be used only by SNF for billing. (HIM 10, 310.1, Item 11).
71	Prior Stay Dates	The from/thru dates given by the patient of any hospital, SNF, or nursing home stay that ended within 60 days of this hospital or SNF admission. (HIM 10, 310.1, Item 12).
72	First/Last Visit	The from/through dates of outpatient services. For use on outpatient bills only where the entire billing record is not represented by the actual from/through service dates shown in the "Statement Covers Period".
73	Benefit Eligibility Period	The inclusive dates during which CHAMPUS medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.
74	Noncovered Level of Care	The from/through dates of a period at a noncovered level of care in an otherwise covered stay.
75	SNF Level of Care	The from/through dates of a period of SNF level of care during an inpatient hospital stay. Used to show PSRO/PRO approval of patient's remaining in hospital because SNF bed not available. Code is not applicable to Swing Bed cases. For hospitals under prospective payment, this code is needed in day outlier cases only.
76-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element: Patient Marital Status.

Definition: The marital status of the patient at date of admission, outpatient service, or start of care:

S - Single
M - Married
X - Legally Separated
D - Divorced
W - Widowed
U - Unknown

Data Element: Patient's Relationship to Insured.

Definition: A code indicating the relationship of the patient to the identified insured:

01	Patient Is Insured	Self - explanatory
02	Spouse	Self - explanatory
03	Natural Child/ Insured has financial responsibility	Self - explanatory
04	Natural Child/ Insured does not have financial responsibility	Self - explanatory
05	Step Child	Self - explanatory
06	Foster Child	Self - explanatory
07	Ward of the Court	Patient is ward of insured as a result of a court order.
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
10	Handicapped dependent	Dependent child whose coverage extends beyond normal termination age limits as result of laws or agreements extending coverage.
11	Organ donor	Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.
12	Cadaver donor	Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.
13	Grandchild	Self - explanatory
14	Niece/Nephew	Self - explanatory
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.
16	Sponsored dependent	Individual not normally covered by insurance coverage but coverage has been specially arranged to include relationships such as grandparent or former spouse that would require further investigation by the payer.
17	Minor Dependent of a Minor Dependent	Patient is a minor, and the dependent of a minor that is in turn, a dependent but not the child of the insured.
18	Parent	Self explanatory
19	Grandparent	Self explanatory
20 -99		Reserved for National Assignment

Data Element: Patient status.

Definition: A code indicating patient status as of statement covers thru date:

Codes:

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice
08 -09	Reserved for National Assignment
10 -19	Discharge to be defined at State level, if necessary
20	Expired - (or did not recover - Christian Science Patient)
21 -29	Expired to be defined at State level, if necessary
30	Still patient
31 -39	Still patient to be defined at State level, if necessary
40	Expired at home
41	Expired in a hospital, SNF, or ICF
42	Expired - place unknown
43 -99	Reserved for National Assignment

Data Element: Payer Identification.

Definition: Number identifying each payer organization from which the provider might expect some reimbursement for the bill.

Blue Cross - The Blue Cross number (oonnn)
Commerical Insurers - NAIC assigned number (nnnnn)
Medicaid - State Agency assigned number
Medicare - One or two above, depending on intermediary
CHAMPUS - NAIC number

Data Element: Primary Payer Code.

Definition: Identifies reason another payer is primary to Medicare.

Codes:

Z	Medicare is Primary
A	Working Aged Bene/Spouse with EGHP
B	ESRD Bene in 12 month period with EGHP
C	Any conditional payment situation
D	Automobile No-Fault or any liability insurance
E	Workers' Compensation
F	PHS, Other Federal Agency
G	Disabled Bene under age 65 with LGHP
H	BL
I	VA

Data Element: Procedure Coding Method Used.

Definition: An indicator that identifies the coding method used for procedure coding on the bill.

1 -3 - Reserved for State and Local Assignment
4 - CPT-4
5 - HCPCS (HCFA Common Procedure Coding System)
6 -8 - Reserved for National Assignment
9 - ICD-9-CM

Data Element: PRO/UR Approval Indicator.

Definition: An indicator describing the determination arrived at by the PRO.

Code 1	Approved as Billed	Code indicates claim has been reviewed by the PRO and has been fully approved including any day or cost outlier.
2	Automatic Approval (Focused Review)	Code does not apply to Medicare claims.
3	Partial Approval	Code indicates the bill has been reviewed by the PRO and that some portion (days or services) has been denied. The From/Through dates of the approved portion of the stay, excluding grace days, and any period at a noncovered level of care (code "77" in Item 33), are shown in Items 88 and 89.
4	Admission Denied	Code indicates patient's need for inpatient services was reviewed and the PRO found that none of the stay was medically necessary.
5	Post-payment Review Applicable	Code indicates that any medical review will be completed after the claim is paid. The bill may be day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
6	Preadmission/ Preprocedure	code indicates that the PRO authorized this admission/procedure, but has not reviewed the services provided.

Data Element: Receiver Identification

Definition: Number identifying to the provider the organization designated to receive this file. Receivers accepting tapes on behalf of more than one third party payer are to be identified by their tax

Data Element: Receiver Type

Definition: A code indicating the class of organization designated to receive this tape or transmittion.

A - Self pay
B - Workers Compensation
C - Medicare
D - Medicaid
E - Other Federal program
F - Insurance company
G - Blue Cross
H - CHAMPUS
I - Other - local coding table applies
Z - Multiple principal
Sources of payment 1/

Data Element: Release of Information Certification Indicator

Definition: A code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

Codes:

Y-Yes	The hospital has signed written authority to release medical/billing information for purposes of claiming insurance benefits.
R-Restricted or Modified Release	The hospital has limited or restricted authority to release some medical/billing information for purposes of claiming insurance benefits.
N-No Release	The hospital does not have permission to release any medical/billing information.

Data Element: Revenue Code

Definition: A Code which identifies a specific accommodation, ancillary service or billing calculation.

Code Structure:

Major Category

PAYER AND RELATED INFORMATION (codes 001 - 099).

N.B.: THESE CODES SHOULD BE REPORTED IN RECORD TYPE 60, BUT THE AMOUNTS ASSOCIATED WITH THEM SHOULD NOT BE INCLUDED IN CONTROL TOTALS MAINTAINED IN RECORD TYPES 90 THRU 9N.

Rationale: To group items by payer and to assign similar items the same number.

001 Total Charge

01X
to
06X Reserved for National Assignment

07X
to
09X Reserved for State Use

ACCOMMODATION REVENUE CODES (10X - 21X)

10X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

	Subcategory	Standard Abbreviations
0	All-Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1	All-Inclusive Room and Board	ALL INCL R&B

11X Room & Board - Private Medical or General

Routine service charges for single bed rooms.

Rationale: Most third party payers require that private rooms be separately identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT
1 - Medical/Surgical/Gyn	MED-SUR-GY/PVT
2 - OB	OB/PVT
3 - Pediatric	PEDS/PVT
4 - Psychiatric	PSYCH/PVT
5 - Hospice	HOSPICE/PVT
6 - Detoxification	DETOX/PVT
7 - Oncology	ONCOLOGY/PVT
9 - Other	OTHER/PVT

12X Room & Board - Semi-private Two Bed (Medical or General)

Routine service charges incurred for accommodations with two beds.

Rationale: Most third party payers require that semi-private rooms be identified.

Room and Board - Semi-Private

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/SEMI
1 - Medical/Surgical/Gyn	MED-SUR-GY/2BED
2 - OB	OB/2BED
3 - Pediatric	PEDS/2BED
4 - Psychiatric	PSYCH/2BED
5 - Hospice	HOSPICE/2BED
6 - Detoxification	DETOX/2BED
7 - Oncology	ONCOLOGY/2BED
9 - Other	OTHER/2BED

13X **Semi-Private - Three and Four Beds**

Routine service charges incurred for accommodations with three and four beds.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/3&4 BED
1 - Medical/Surgical/Gyn	MED-SUR-GY/3&4 BED
2 - OB	OB/3&4BED
3 - Pediatric	PEDS/3&4BED
4 - Psychiatric	PSYCH/3&4BED
5 - Hospice	HOSPICE/3&4BED
6 - Detoxification	DETOX/3&4BED
7 - Oncology	ONCOLOGY/3&4BED
9 - Other	OTHER/3&4BED

14X **Private (Deluxe)**

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/PVT/DLX
1 - Medical/Surgical/Gyn	MED-SUR-GY/DLX
2 - OB	OB/DLX
3 - Pediatric	PEDS/DLX
4 - Psychiatric	PSYCH/DLX
5 - Hospice	HOSPICE/DLX
6 - Detoxification	DETOX/DLX
7 - Oncology	ONCOLOGY/DLX
9 - Other	OTHER/DLX

15X **Room & Board Ward (Medical or General)**

Routine service charge for accommodations with five or more beds.

Rationale: Most third party payers require ward accommodations to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	ROOM-BOARD/WARD
1 - Medical/Surgical/Gyn	MED-SUR-GY/WARD
2 - OB	OB/WARD
3 - Pediatric	PEDS/WARD
4 - Psychiatric	PSYCH/WARD
5 - Hospice	HOSPICE/WARD
6 - Detoxification	DETOX/WARD
7 - Oncology	ONCOLOGY/WARD
9 - Other	OTHER/WARD

16X **Other Room & Board**

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes.

Rationale: Provides the ability to identify services as required by payers or individual institutions.

Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

Subcategory	Standard Abbreviation
0 - General Classification	R&B
4 - Sterile Environment	R&B/STERILE
7 - Self Care	R&B/SELF
9 - Other	R&B/Other

17X **Nursery**

Charges for nursing care to newborn and premature infants in nurseries.

Rationale: Provides a breakdown of various levels of nursery care. Tertiary care is a level of care between premature and regular nursery care.

Subcategory	Standard Abbreviation
0 - General Classification	NURSERY
1 - Newborn	NURSERY/NEWBORN
2 - Premature	NURSERY/PREMIE
5 - NeoNatal ICU	NURSERY/ICU
9 - Other	NURSERY/OTHER

18X **Leave of Absence**

Charges (including zero charges) for holding a room while the patient is temporarily away from the provider.

NOTE: Charges are billable for codes 2 - 5

Subcategory	Standard Abbreviation
0 - General Classification	LEAVE OF ABSENCE OR LOA
2 - Patient Convenience - charges billable	LOA/PT CONV CHGS BILLABLE
3 - Theraputic Leave	LOA/THERAP
4 - ICF Mentally Retarded - any reason	LOA/ICF/MR
5 - Nursing Home (Hospitalization)	LOA/NURS HOME
9 - Other Leave of Absence	LOA/OTHER

19X Not Assigned

20X Intensive Care

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third party payers require that charges for this service are to be identified.

Subcategory	Standard Abbreviation
0 - General Classification	INTENSIVE CARE or (ICU)
1 - Surgical	ICU/SURGICAL
2 - Medical	ICU/MEDICAL
3 - Pediatric	ICU/PEDS
4 - Psychiatric	ICU/PSTAY
6 - Post ICU	POST ICU
7 - Burn Care	ICU/BURN CARE
8 - Trauma	ICU/TRAMA
9 - Other Intensive Care	ICU/OTHER

21X Coronary Care

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Rationale: If a discrete unit exists for rendering such services, the hospital or third party may wish to identify the service.

Subcategory	Standard Abbreviation
0 - General Classification	CORONARY CARE or (CCU)
1 - Myocardial Infarction	CCU/MYO INFARC
2 - Pulmonary Care	CCU/PULMONARY
3 - Heart Transplant	CCU/TRANSPLANT
4 - Post-CCU	POST CCU
9 - Other Coronary Care	CCU/OTHER

ANCILLARY REVENUE CODES (22X - 99X)

22X **Special Charges**

Charges incurred during an inpatient stay or on a daily basis for certain services.

Rationale: Some hospitals prefer to identify the components of services rendered in greater detail and thus break out charges for items that normally would be considered part of routine services.

Subcategory	Standard Abbreviation
0 - General Classification	SPECIAL CHARGES
1 - Admission Charge	ADMIT CHARGE
2 - Technical Support Charge	TECH SUPPT CHG
3 - U.R. Service Charge	UR CHARGE
4 - Late Discharge, medically necessary	LATE DISCH/MED NEC
9 - Other Special Charges	OTHER SPEC CHG

23X **Incremental Nursing Charge Rate**

Charge for nursing service assessed in addition to room and board.

Subcategory	Standard Abbreviation
0 - General Classification	NURSING INCREM
1 - Nursery	NUR INCR/NURSERY
2 - OB	NUR INCR/OB
3 - ICU (includes transitional care)	NUR INCR/ICU
4 - CCU (includes transitional care)	NUR INCR/CCU
5 - Hospice	NUR INCR/HOSPICE
9 - Other	NUR INCR/OTHER

24X **All Inclusive Ancillary**

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

Subcategory	Standard Abbreviation
0 - General Classification	ALL INCL ANCIL
9 - Other Inclusive Ancillary	ALL INCL ANCIL/OTHER

25X Pharmacy

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of licensed pharmacist.

Rationale: Additional breakdowns are provided for items that individual hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	PHARMACY
1 - Generic Drugs	DRUGS/GENERIC
2 - Nongeneric drugs	DRUGS/NONGENERIC
3 - Take Home Drugs	DRUGS/TAKEHOME
4 - Less Than Effective Drugs	DRUGS/LESS
6 - Experimental Drugs	DRUGS/EXPERIMT
7 - Non-prescription	DRUGS/NONPSCRPT
8 - IV Solutions	IV SOLUTIONS
9 - Other Pharmacy	DRUGS/OTHER

26X IV Therapy

Administration of intravenous solution by specially trained personnel to individuals requiring such treatment. This code should be used only when a discrete service unit exists.

Subcategory	Standard Abbreviation
0 - General Classification	IV THERAPY
1 - Infusion Pump	IV THER/INFSN PUMP
9 - Other IV Therapy	IV THERAPY/OTHER

27X **Medical/Surgical Supplies**

Charges for supply items required for patient care.

Rationale: Additional breakdowns are provided for items that hospitals may wish to identify because of internal or third party payer requirements.

Subcategory	Standard Abbreviation
0 - General Classification	MED-SUR SUPPLIES
1 - Nonsterile Supply	NONSTER SUPPLY
2 - Sterile Supply	STERILE SUPPLY
3 - Take Home Supplies	TAKEHOME SUPPLY
4 - Prosthetic Devices	PROSTHETIC DEV
5 - Pace maker	PACE MAKER
6 - Intraocular Lens	INTR OC LENS
7 - Oxygen-Take Home	02/TAKEHOME
8 - Other Implants	SUPPLY/IMPLANTS
9 - Other Devices	SUPPLY/OTHER

28X **Oncology**

Charges for the treatment of tumors and related diseases.

Subcategory	Standard Abbreviation
0 - General Classification	ONCOLOGY
9 - Other Oncology	ONCOLOGY/OTHER

29X **Durable Medical Equipment (Other Than Renal)**

Charge for medical equipment that can withstand repeated use (excluding renal equipment).

Rationale: Medicare requires a separate revenue center for billing.

Subcategory	Standard Abbreviation
0 - General Classification	MED EQUIP/DURAB
1 - Rental	MED EQUIP/RENT
2 - Purchase of new DME	MED EQUIP/NEW
3 - Purchase of used DME	MED EQUIP/USED
9 - Other Equipment	MED EQUIP/OTHER

30X **Laboratory**

Charges for the performance of diagnostic and routine clinical laboratory tests.

Rationale: A breakdown of the major areas in the laboratory is provided in order to meet hospital needs or third party billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	LABORATORY or (LAB)
1 - Chemistry	LAB/CHEMISTRY
2 - Immunology	LAB/IMMUNOLOGY
3 - Renal Patient (Home)	LAB/RENAL HOME
4 - Nonroutine Dialysis	LAB/NR DIALYSIS
5 - Hematology	LAB/HEMOTOLOGY
6 - Bacteriology & Microbiology	LAB/BACT-MICRO
7 - Urology	LAB/UROLOGY
9 - Other Laboratory	LAB/OTHER

31X **Laboratory Pathological**

Charges for diagnostic and routine laboratory tests on tissues and culture.

Rationale: A breakdown of the major areas that hospitals may wish to identify is provided.

Subcategory	Standard Abbreviation
0 - General Classification	PATHOLOGY LAB or (PATH LAB)
1 - Cytology	PATHOL/CYTOLOGY
2 - Histology	PATHOL/HYSTOL
4 - Biopsy	PATHOL/BIOPSY
9 - Other	PATHOL/OTHER

32X Radiology - Diagnostic

Charges for diagnostic radiology services provided for the examination and care of patients. Includes: taking, processing, examining and interpreting radiographs and fluorographs.

Rationale: A breakdown is provided of the major areas and procedures that individual hospitals or third party payers may wish to identify.

Subcategory	Standard Abbreviation
0 - General Classification	DX X-RAY
1 - Angiocardiography	DX X-RAY/ANGIO
2 - Arthrography	DX X-RAY/ARTH
3 - Arteriography	DX X-RAY/ARTER
4 - Chest X-Ray	DX X-RAY/CHEST
9 - Other	DX X-RAY/OTHER

33X Radiology - Therapeutic

Charges for therapeutic radiology services and chemotherapy are required for care and treatment of patients. Includes therapy by injection or ingestion of radioactive substances.

Rationale: A breakdown is provided of the major areas that hospitals or third parties may wish to identify. Chemotherapy - IV was added at the request of Ohio.

Subcategory	Standard Abbreviation
0 - General Classification	RX X-RAY
1 - Chemotherapy - Injected	CHEMOTHER/INJ
2 - Chemotherapy - Oral	CHEMOTHER/ORAL
3 - Radiation Therapy	RADIATION RX
5 - Chemotherapy - IV	CHEMOTHERP-IV
9 - Other	RX X-RAY/OTHER

34X Nuclear Medicine

Charges for procedures and tests performed by a radioisotope laboratory utilizing radioactive materials as required for diagnosis and treatment of patients.

Rationale: A breakdown is provided in case hospitals desire or are required to identify the type of service rendered.

Subcategory	Standard Abbreviation
0 - General Classification	NUCLEAR MEDICINE or (NUC MED)
1 - Diagnostic	NUC MED/DX
2 - Therapeutic	NUC MED/RX
9 - Other	NUC MED/OTHER

35X CT Scan

Charges for computed tomographic scans of the head and other parts of the body.

Rationale: Due to coverage limitations some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	CT SCAN
1 - Head Scan	CT SCAN/HEAD
2 - Body Scan	CT SCAN/BODY
9 - Other CT Scans	CT SCAN/OTHER

36X Operating Room Services

Charges for services provided to patients by specially trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	OR SERVICES
1 - Minor Surgery	OR/MINOR
2 - Organ Transplant-other than kidney	OR/ORGAN TRANS
7 - Kidney Transplant	OR/KIDNEY TRANS
9 - Other Operating Room Services	OR/OTHER

37X Anesthesia

Charges for anesthesia services in the hospital.

Rationale: Provides additional identification of services. In particular, acupuncture was identified because it is not covered by some payers, including Medicare.

Subcategory	Standard Abbreviation
0 - General Classification	ANESTHESIA
4 - Acupuncture	ANESTHE/ACUPUNC
9 - Other Anesthesia	ANESTHE/OTHER

38X Blood

Rationale: Charges for blood must be separately identified for private payer purposes.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD
1 - Packed Red Cells	BLOOD/PKD RED
2 - Whole Blood	BLOOD/WHOLE
3 - Plasma	BLOOD/PLASMA
4 - Platelets	BLOOD/PALTELETES
5 - Leucocytes	BLOOD/LEUCOCYTES
6 - Other Components	BLOOD/COMPONENTS
7 - Other Derivatives (Cryopricipatates)	BLOOD/DERIVATIVES
9 - Other Blood	BLOOD/OTHER

39X Blood Storage and Processing

Charges for the storage and processing of whole blood.

Subcategory	Standard Abbreviation
0 - General Classification	BLOOD/STOR-PROC
1 - Blood Administration	BLOOD/ADMIN.
9 - Other Blood Storage & Processing	BLOOD/OTHER STOR

40X Other Imaging Services

Subcategory	Standard Abbreviation
0 - General Classification	IMAGE SERVICE
1 - Mammography	MAMMOGRAPHY
2 - Ultrasound	ULTRASOUND
9 - Other Imaging Services	OTHER IMAG SVS

41X Respiratory Services

Charges for administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy through measurement of inhaled and exhaled gases and analysis of blood and evaluation of the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	RESPIRATORY SVC
2 - Inhalation Services	INHALATION SVC
3 - Hyperbaric Oxygen Therapy	HYPERBARIC 02
9 - Other Respiratory Services	OTHER RESPIR SVS

42X Physical Therapy

Charges for therapeutic exercises, massage and utilization of effective properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	PHYSICAL THERP
1 - Visit Charge	PHYS THERP/VISIT
2 - Hourly Charge	PHYS THERP/HOUR
3 - Group Rate	PHYS THERP/GROUP
4 - Evaluation or Re-evaluation	PHYS THERP/EVAL
9 - Other Physical Therapy	OTHER PHYS THERP

43X Occupational Therapy

Charges for teaching manual skills and independence in personal care to stimulate mental and emotional activity on the part of patients.

Subcategory	Standard Abbreviation
0 - General Classification	OCCUPATION THER
1 - Visit Charge	OCCUP THERP/VISIT
2 - Hourly Charge	OCCUP THERP/HOUR
3 - Group Rate	OCCUP THERP/GROUP
4 - Evaluation or Re-evaluation	OCCUP THERP/EVAL
9 - Other Occupational Therapy (may include restorative therapy)	OTHER OCCUP THER

44X Speech-Language Pathology

Charges for services provided to persons with impaired functional communications skills.

Subcategory	Standard Abbreviation
0 - General Classification	SPEECH PATHOL
1 - Visit Charge	SPEECH PATH/VISIT
2 - Hourly Charge	SPEECH PATH/HOUR
3 - Group Rate	SPEECH PATH/GROUP
4 - Evaluation or Re-evaluation	SPEECH PATH/EVAL
9 - Other Speech-Language Pathology	OTHER SPEECH PAT

45X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

Rationale: Permits identification of particular items for payers

Subcategory	Standard Abbreviation
0 - General Classification	EMERG ROOM
9 - Other Emergency Room	OTHER EMER ROOM

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 760 "Treatment or Observation Room."

46X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases and analysis of blood and for tests that evaluate the patient's ability to exchange oxygen and other gases.

Rationale: Permits identification of this service if it exists in the hospital.

Subcategory	Standard Abbreviation
0 - General Classification	PULMONARY FUNC
9 - Other Pulmonary Function	OTHER PULMON FUNC

47X Audiology

Charges for the detection and management of communication handicaps centering in whole or in part on the hearing function.

Rationale: Permits identification of particular services.

Subcategory	Standard Abbreviation
0 - General Classification	AUDIOLOGY
1 - Diagnostic	AUDIOLOGY/DX
2 - Treatment	AUDIOLOGY/RX
9 - Other Audiology	OTHER AUDIOL

48X Cardiology

Charges for cardiac procedures rendered in a separate unit within the hospital. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

Rationale: This category was established to reflect a growing trend to incorporate these charges in a separate unit.

Subcategory	Standard Abbreviation
0 - General Classification	CARDIOLOGY
1 - Cardiac Cath Lab	CARDIAC CATH LAB
2 - Stress Test	STRESS TEST
9 - Other Cardiology	OTHER CARDIOL

49X Ambulatory Surgical Care

Charges for ambulatory surgery which are not covered by any other category.

Subcategory	Standard Abbreviation
0 - General Classification	AMBUL SURG
9 - Other Ambulatory Surgical Care	OTHER AMBL SURG

NOTE: Observation or hold beds are not reported under this code. They are reported under revenue code 760 "Treatment or Observation Room."

50X Outpatient Services

Outpatient charges (other than those for scheduled Preadmission Testing) for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of services. These charges are incorporated on the inpatient bill of Medicare patients.

Subcateogry	Standard Abbreviation
0 - General Classification	OUTPATIENT SVS
9 - Other Outpatient Services	OUTPATIENT/OTHER

51X Clinic

Clinic (nonemergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	CLINIC
1 - Chronic Pain Center	CHRONIC PAIN CL
2 - Dental Clinic	DENTAL CLINIC
9 - Other Clinic	OTHER CLINIC

52X Free-Standing Clinic

Rationale: Provides a breakdown of some clinics that hospitals or third party payers may require.

Subcategory	Standard Abbreviation
0 - General Classification	FREESTAND CLINIC
1 - Rural Health-Clinic	RURAL/CLINIC
2 - Rural Health-Home	RURAL/HOME
3 - Family Practice	FAMILY PRACTICE
9 - Other Freestanding Clinic	OTHER FR/STD CLINIC

53X Osteopathic Services

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumbar spine by a doctor of osteopathy.

Rationale: There is a service unique to osteopathic hospitals and cannot be accommodated in any of the existing codes.

Subcategory	Standard Abbreviations
0 - General Classification	OSTEOPATH SVS
1 - Osteopathic Therapy	OSTEOPATH RX
9 - Other Osteopathic Services	OTHER OSTEOPATH

54X Ambulance

Charges for ambulance service, usually on an unscheduled basis to the ill and injured who require immediate medical attention.

Rationale: Provides subcategories that third party payers or hospitals may wish to recognize. Heart mobile is a specially designed ambulance transport for cardiac patients.

Subcategory	Standard Abbreviation
0 - General Classification	AMBULANCE
1 - Supplies	AMBUL/SUPPLY
2 - Medical Transport	AMBUL/MED TRANS
3 - Heart Mobile	AMBUL/HEARTMOBL
4 - Oxygen	AMBUL/0XY
5 - Air Ambulance	AIR AMBULANCE
6 - Neo-natal ambulance	AMBUL/NEO-NATAL
9 - Other Ambulance	OTHER AMBULANCE

55X Skilled Nursing

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services or a service charge for home health billing.

Subcategory	Standard Abbreviation
0 - General Classification	SKILLED NURSING
1 - Visit Charge	SKILLED NURS/VISIT
2 - Hourly Charge	SKILLED NURS/HOUR
9 - Other Skilled Nursing	SKILLED NURS/OTHER

56X Medical Social Services

Charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

Rationale: Necessary for Medicare home health billing requirements. May be used at other times as required by hospital.

Subcategory	Standard Abbreviation
0 - General Classification	MED SOCIAL SVS
1 - Visit Charge	MED SOC SERV/VISIT
2 - Hourly Charge	MED SOC SERV/HOUR
9 - Other Med. Soc. Services	MED SOC SERV/OTHER

57X Home Health Aide (Home Health)

Charges made by a HHA for personnel that are primarily responsible for the personal care of the patient.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	AIDE/HOME HEALTH
1 - Visit Charge	AIDE/HOME HLTH/VISIT
2 - Hourly Charge	AIDE/HOME HLTH/HOUR
9 - Other Home Health Aide	AIDE/HOME HLTH/OTHER

58X Other Visits (Home Health)

Charges by a HHA for visits other than physical therapy, occupational therapy or speech therapy, which must be specifically identified.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	VISIT/HOME HEALTH
1 - Visit Charge	VISIT/HOME HLTH/VISIT
2 - Hourly Charge	VISIT/HOME HLTH/HOUR
9 - Other Home Health Visits	VISIT/HOME HLTH/OTHER

59X Units of Service (Home Health)

Revenue code used by a HHA that bills on the basis of units of service.

Rationale: Necessary for Medicare home health billing requirements.

Subcategory	Standard Abbreviation
0 - General Classification	UNIT/HOME HEALTH
9 - Home Health Other Units	UNIT/HOME HLTH/OTHER

60X Not Assigned (May be reserved for other Clinics)

61X MRI

Charges for Magnetic Resonance Imaging of the brain and other parts of the body.

Rationale: Due to coverage limitations some third party payers require that the specific test be identified.

Subcategory	Standard Abbreviation
0 - General Classification	MRI
1 - Brain (including Brainstem)	MRI - BRAIN
2 - Spinal Cord (including Spine)	MRI - SPINE
9 - Other MRI	MRI - OTHER

62X Not Assigned

63X Not Assigned

64X Not Assigned

65X Hospice Services

Charges for hospice care services for a terminally ill patient if he elects these services in lieu of other services for the terminal condition.

Rationale: The level of hospice care provided for each day during a hospice election period determines the amount of Medicare payment for that day.

Subcategory	Standard Abbreviation
0 - General Classification	HOSPICE
1 - Routine Home Care	HOSPICE/RTN HOME
2 - Continuous Home Care - 1/2	HOSPICE/CTNS HOME
5 - Inpatient Care	HOSPICE/IP RESPITE
6 - General Inpatient Care (Non-Respite)	HOSPICE/IP NON RESPITE
7 - Physician Services	HOSPICE/PHYSICIAN
9 - Other Hospice	HOSPICE/OTHER

66X Not Assigned

67X Not Assigned

68X Not Assigned

69X Not Assigned

70X Cast Room

Charges for services related to the application, maintenance and removal of casts.

Rationale: Permits identification of this service if necessary.

71X Recovery Room

Rationale: Permits identification of particular services if necessary.

Subcategory	Standard Abbreviation
0 - General Classification	RECOVERY ROOM
9 - Other Recovery Room	OTHER RECOV RM

72X Labor Room/Delivery

Charges for labor and delivery room services provided by specially trained nursing personnel to patients, including prenatal care during labor, assistance during delivery, postnatal care in the recovery room, and minor gynecologic procedures if they are performed in the delivery suite.

Rationale: Provides a breakdown of items that may require further clarification. Infant circumcision is included because it is not covered by all third party payers.

Subcategory	Standard Abbreviation
0 - General Classification	DELIVROOM/LABOR
1 - Labor	LABOR
2 - Delivery	DELIVERY ROOM
3 - Circumcision	CIRCUMCISION
4 - Birthing Center	BIRTHING CENTER
9 - Other Labor Room/Delivery	OTHER/DELIV-LABOR

73X EKG/ECG (Electrocardiogram)

Charges for operation of specialized equipment to record electromotive variations in actions of the heart muscle on an electrocardiograph for diagnosis of heart ailments.

Subcategory	Standard Abbreviation
0 - General Classification	EKG/ECG
1 - Holter Monitor	HOLTER MONT
2 - Telemetry (includes fetal monitoring)	TELEMETRY
9 - Other EKG/ECG	OTHER EKG-ECG

74X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

Subcateogry	Standard Abbreviation
0 - General Classification	EEG
9 - Other EEG	OTHER EEG

75X Gastro-Intestinal Services

Procedure room charges for endoscopic procedures not performed in an operating room.

Subcategory	Standard Abbreviation
0 - General Classification	GASTR-INTS SVS
9 - Other Gastro-Intestinal	OTHER GASTRO-INTS

76X Treatment or Observation Room

Charges for minor procedures performed in the observation room or other room.

Subcategory	Standard Abbreviation
0 - General Classification	TREATMENT ROOM
9 - Other Treatment Room	OTHER TREATMENT RM

77X Not Assigned

78X Not Assigned

79X Lithotripsy

Charges for the use of lithotripsy in the treatment of kidney stones.

Subcategory	Standard Abberviation
0 - General Classification	LITHOTRIPSY
9 - Other Lithotripsy	LITHOTRIPSY/OTHER

80X Inpatient Renal Dialysis

A waste removal process, performed in an inpatient setting, that uses an artifical kidney when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

Rationale: Specific identification required for billing purposes.

Subcategory	Standard Abbreviation
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT
2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD

Subcategory	Standard Abbreviation
0 - General Classification	RENAL DIALYSIS
1 - Inpatient Hemodialysis	DIALY/INPT
2 - Inpatient Peritoneal (Non-CAPD)	DIALY/INPT/PER
3 - Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/INPT/CAPD
4 - Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/INPT/CCPD
9 - Other Inpatient Dialysis	DIALY/INPT/OTHER

81X Organ Acquisition

The acquisition of a kidney, heart, or liver for use in transplantation.

Rationale: Living donor is a living person from whom a kidney, heart, or liver is obtained for transplantation. Cadaver is an individual who has been pronounced dead according to medical and legal criteria, from whom a kidney or heart is obtained for transplantation.

Medicare requires detailed revenue coding; therefore, codes for this series may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	KIDNEY ACQUISIT
1 - Living Donor - Kidney	KIDNEY/LIVE
2 - Cadaver Donor - Kidney	KIDNEY/CADAVER
3 - Unknown Donor - Kidney	KIDNEY/UNKNOWN
4 - Other Kidney Acquisition	KIDNEY/OTHER
5 - Cadaver Donor - Heart	HEART/CADAVER
6 - Other Heart Acquisition	HEART/OTHER
7 - Donor - Liver	LIVER ACQUISIT
9 - Other Organ Acquisition	ORGAN/OTHER

82X Hemodialysis - Outpatient or Home Dialysis

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

Rationale: Detailed revenue coding is required; therefore, services may not be summed at the zero level.

Subcategory	Standard Abbreviation
0 - General Classification	HEMO/OP OR HOME
1 - Hemodialysis/Composite or other rate	HEMO/COMPOSITE
2 - Home Supplies	HEMO/HOME/SUPPL
3 - Home Equipment	HEMO/HOME/EQUIP
4 - Maintenance/100%	HEMO/HOME/100%
5 - Support Services	HEMO/HOME/SUPSERV
9 - Other Hemodialysis Outpatient	HEMO/HOME/OTHER

83X **Peritoneal dialysis - Outpatient or Home**

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed indirectly by flushing a special solution between the abdominal covering and the tissue.

Subcategory	Standard Abbreviation
0 - General Classification	PERITONEAL/OP OR HOME
1 - Peritoneal/Composite or other rate	PERTNL/COMPOSITE
2 - Home Supplies	PERTNL/HOME/SUPPL
3 - Home Equipment	PERTNL/HOME/EQUIP
4 - Maintenance/100%	PERTNL/HOME/100%
5 - Support Services	PERTNL/HOME/SUPSERV
9 - Other Peritoneal Dialysis	PERTNL/HOME/OTHER

84X **Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient**

A continuous dialysis process, performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0 - General Classification	CAPD/OP OR HOME
1 - CAPD/Composite or other rate	CAPD/COMPOSITE
2 - Home Supplies	CAPD/HOME/SUPPL
3 - Home Equipment	CAPD/HOME/EQUIP
4 - Maintenance/100%	CAPD/HOME/100%
5 - Support Services	CAPD/HOME/SUPSERV
9 - Other CAPD Dialysis	CAPD/HOME/OTHER

85X **Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient**

A continuous dialysis process, performed in an outpatient or home setting, which uses the patient's peritoneal membrane as a dialyzer.

Subcategory	Standard Abbreviation
0 - General Classification	CCPD/OP OR HOME
1 - CCPD/Composite or other rate	CCPD/COMPOSITE
2 - Home Supplies	CCPD/HOME/SUPPL
3 - Home Equipment	CCPD/HOME/EQUIP
4 - Maintenance/100%	CCPD/HOME/100%
5 - Support Services	CCPD/HOME/SUPSERV
9 - Other CCPD Dialysis	CCPD/HOME/OTHER

86X **Reserved for Dialysis (National Assignment)**

87X **Reserved for Dialysis (State Assignment)**

88X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

Rationale: Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session.

Subcategory	Standard Abbreviations
0 - General Classification	DIALY/MISC
1 - Ultrafiltration	DIALY/ULTRAFILT
9 - Misc. Dialysis Other	DIALY/MISC/OTHER

89X Other Donor Bank

Charges for the acquisition, storage and preservation of all human organs (excluding kidneys).

Rationale: Provides a breakdown identifying the specific organ category.

Subcategory	Standard Abbreviation
0 - General Classification	DONOR BANK
1 - Bone	DONOR BANK/BONE
2 - Organ (other than kidney)	DONOR BANK/ORGN
3 - Skin	DONOR BANK/SKIN
9 - Other Donor Bank	OTHER DONOR BANK

90X Psychiatric/Psychological Treatments

Subcategory	Standard Abbreviation
0 - General Classification	PSTAY TREATMENT
1 - Electroshock Treatment	ELECTRO SHOCK
2 - Milieu Therapy	MILIEU THERAPY
3 - Play Therapy	PLAY THERAPY
9 - Other	OTHER PSTAY RX

91X Psychiatric/Psychological Services

Charges for providing nursing care and employee, professional services for emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment.

Rationale: Provides additional identification of services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PSTAY SERVICES
1 - Rehabilitation	PSTAY/REHAB
2 - Day Care	PSTAY/DAYCARE
3 - Night Care	PSTAY/NIGHTCARE
4 - Individual Therapy	PSTAY/INDIV RX
5 - Group Therapy	PSTAY/GROUP RX
6 - Family Therapy	PSTAY/FAMILY RX
7 - Bio Feedback	PSTAY/BIOFEED
8 - Testing	PSTAY/TESTING
9 - Other	PSTAY/OTHER

92X Other Diagnostic Services

Charges for other diagnostic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER DX SVS
1 - Peripheral Vascular Lab	PERI VASCUL LAB
2 - Electromyelogram	EMG
3 - Pap Smear	PAP SMEAR
4 - Allergy test	ALLERGY TEST
5 - Pregnancy test	PREG TEST
9 - Other Diagnostic Service	ADDITIONAL DX SVS

93X Not Assigned

94X Other Therapeutic Services

Charges for other therapeutic services not otherwise categorized.

Subcategory	Standard Abbreviations
0 - General Classification	OTHER RX SVS
1 - Recreational Therapy	RECREATION RX
2 - Education/Training (includes diabetes related dietary therapy)	EDUC/TRAINING
3 - Cardiac Rehabilitation	CARDIAC REHAB
4 - Drug Rehabilitation	DRUG REHAB
5 - Alcohol Rehabilitation	ALCOHOL REHAB
6 - Air Fluidized Support Beds	AIR FLUID BEDS
9 - Other Therapeutic Services	ADDITIONAL RX SVS

95X Not Assigned

96X Professional Fees

Charges for medical professionals that the hospitals or third party payers require to be separately identified on the billing form. Services that were not identified separately prior to uniform billing implementation should not be separately identified on the uniform bill.

Subcategory	Standard Abbreviations
0 - General Classification	PRO FEE
1 - Psychiatric	PRO FEE/PSTAY
2 - Opthalmology	PRO FEE/EYE
3 - Anesthesiologist (MD)	PRO FEE/ANES MD
4 - Anesthetist (CRNA)	PRO FEE/ANES CRNA
9 - Other Professional Fees	OTHER PRO FEE

97X Professionals Fees (cont.)

Subcategory	Standard Abbreviations
1 - Laboratory	PRO FEE/LAB
2 - Radiology - Diagnostic	PRO FEE/RAD/DX
3 - Radiology - Therapeutic	PRO FEE/RAD/RX
4 - Radiology - Nuclear Medicine	PRO FEE/NUC MED
5 - Operating Room	PRO FEE/OR
6 - Respiratory Therapy	PRO FEE/RESPIR
7 - Physical Therapy	PRO FEE/PHYSI
8 - Occupational Therapy	PRO FEE/OCUPA
9 - Speech Pathology	PRO FEE/SPEECH

98X Professional Fees (cont.)

Subcategory	Standard Abbreviations
1 - Emergency Room	PRO FEE/ER
2 - Outpatient Services	PRO FEE/OUTPT
3 - Clinic	PRO FEE/CLINIC
4 - Medical Social Services	PRO FEE/SOC SVC
5 - EKG	PRO FEE/EKG
6 - EEG	PRO FEE/EEG
7 - Hospital Visit	PRO FEE/HOS VIS
8 - Consultation	PRO FEE/CONSULT
9 - Private Duty Nurse	FEE/PVT NURSE

99X Patient Convenience Items

Charges for items that are generally considered by the third party payers to be strictly convenience items and, as such, are not covered.

Rationale: Permits identification of particular services as necessary.

Subcategory	Standard Abbreviation
0 - General Classification	PT CONVENIENCE
1 - Cafeteria/Guest Tray	CAFETERIA
2 - Private Linen Service	LINEN
3 - Telephone/Telegraph	TELEPHONE
4 - TV/Radio	TV/RADIO
5 - Nonpatient Room Rentals	NONPT ROOM RENT
6 - Late Discharge Charge	LATE DISCHARGE
7 - Admission Kits	ADMIT KITS
8 - Beauty Shop/Barber	BARBER/BEAUTY
9 - Other Patient Convenience Items	PT CONVENCE/OTH

Data Element: Source of admission

Definition: A code indicating the source of this admission.

Code:

1 - Physician Referral	The patient was admitted to this facility upon the recommendation of his or her personal physician.
2 - Clinic Referral	The patient was admitted to this facility upon the recommendation of this facility's clinic physician.
3 - HMO Referral	The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.
4 - Transfer from a Hospital	The patient was admitted to this facility as a transfer from an acute care facility where he or she was an inpatient.
5 - Transfer from a Skilled Nursing Facility	The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was an inpatient.
6 - Transfer from Another Health Care Facility	The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility.
7 - Emergency Room	The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.
8 - Court/Law Enforcement	The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative.
9 - Information Not Available	The means by which the patient was admitted to this hospital is not known.

Code Structure (Newborn):

1 - Normal Delivery	A baby delivered without complications.
2 - Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
3 - Sick baby	A baby delivered with medical complications, other than those relating to premature status.
4 - Extra Mural Birth	A newborn born in a non-sterile environment.
5 -8	Reserved for national assignment
9 -	Information Not Available

Data Element: Source of Payment

Definition: A code indicating source of payment associated with this payer record.

A - Self pay
B - Workers Compensation
C - Medicare
D - Medicaid
E - Other Federal Programs
F - Insurance company
G - Blue Cross
H - CHAMPUS
I - Other - local coding table applies

Data Element: Special Program Indicator

Definition: A code indicating that the services included on this bill are related to a special program.

Code Structure

01	EPSDT/CHAP	Early and Periodic Screening, Diagnosis and Treatment.
02	Physically Handicapped Children's Program	Services provided under this program receive special funding through Title 8 of the Social Security Act or the CHAMPUS Program for the Handicapped.
03	Special Federal Funding	This code has been designed for uniform use by state uniform billing committees.
04	Family Planning	This code has been designed for uniform use by state uniform billing committees.
05	Disability	This code has been designed for uniform use by state uniform billing committees.
06	PPV/Medicare 100% payment	This code identifies that pneumococcal pneumonia vaccine (PPV) services given should be reimbursed under a special Medicare program provision.
07	Induced abortion - danger to life	Abortion was performed to avoid danger to woman's life.
08	Induced abortion Victim rape/incest	Self explanatory.
09-79		Reserved for National Assignment.
80-99		Reserved for State Assignment.

Data Element:	Type of Admission
Definition:	A Code indicating the priority of this admission.

1 = Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.
2 = Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
3 = Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4 = Newborn	Necessitates the use of special Source of Admission codes.
5-8	Reserved for National Assignment
9	Information Not Available

Data Element: Type of batch

Definition: A code indicating the type of bill that occurs in this batch; i.e., between a provider record (record type 10) and a batch control (record type 95). The "Type of Batch" code is exactly the same as the "Type of Bill" code shown on the following page.

Data Element: Type of Bill

Definition: A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)

Code Structure

Type of Facility - 1st Digit

Hospital	1
Skilled Nursing	2
Home Health	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Intermediate Care	6
Clinic	7
Special Facility	8
Reserved for National Use	9

Bill Classification (Except Clinics and Special Facilities) - 2nd Digit

Inpatient (Including Part A)	1
Inpatient (Part B only)	2
Outpatient	3
Other (for Medicare Part B use only)	4
Intermediate Care - Level I	5
Intermediate Care - Level II	6
Intermediate Care - Level III	7
Swing Beds	8
Reserved for National Assignment	9

Bill Classification (Clinics) 2nd digit		Bill Classification - Special Facilities - 2nd digit
Rural Health	1	Hospice (non-hospital based)
Free Standing Renal Dialysis Center	2	Hospice (hospital based)
Free Standing	3	Ambulatory Surgical Center
CORF	4	Free Standing Birthing Center
Reserved for National Use	5-8	Reserved for National Use
Other	9	Other

Frequency - 3rd Digit

Non-Payment/Zero claim	0
Admit thru Discharge Claim	1
Interim - First claim	2
Interim - Continuing claim	3
Interim - Last claim	4
Late Charge(s) Only Claim	5
Adjustment of prior claim	6
Replacement of prior claim	7
Void/cancel of prior claim	8
Reserve for National Assignment	9

Data Element: Value Code

Data Definition: A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization.

Code Structure

01	Most Common Semi-Private Rate	To provide for the recording of hospital's most common semi-private rate.
02	Hospital has no Semi-Private Rooms	Entering this code requires $0.00 amount.
05	Professional Component included in Charges and also billed separate to Carrier.	For use on Medicare bills and Medicaid bills if State specifies the need for this information.
06	Medicare Blood Deductible	Total cash blood deductible, if appropriate.
07	Medicare Cash Deductible	Medicare cash deductible to be used only if 06 is used and there is a cash deductible.
08	Medicare Life Time Reserve Amount in the first calendar year.	Medicare life time reserve amount charged in the year of admission.
09	Medicare Coinsurance Amount in the First Calendar Year.	Medicare co-insurance amount charged in the year of admission.
10	Medicare Life Time Reserve Amount in the second calendar year.	Medicare life time reserve amount charged in the year of discharge where the bil spans two calendar years.
11	Medicare Coinsurance Amount in the second Calendar Year.	Medicare co-insurance amount charged in the year of discharge where the bil spans two calendar years.
12	Working Aged Beneficiary/ Spouse with Employer Group Health Plan	Amount shown is that portion of a payment from a higher priority employer group health insurance made on behalf of an aged beneficiary that the provider is applying to Medicare covered services on this bill. (Hospital Manual, SS 471-472). If six zeroes are entered, the provider is claiming conditional Medicare payment.

12	ESRD Beneficiary in the 12 month coordination period with EGHP	Amount shown is that portion of a payment from a higher priority EGHP made on behalf of an ESRD beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
14	Automobile, No Fault or any Liability Insurance	Amount shown is that portion of a payment from a higher priority automobile, no fault or liability insurance made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
15	WC	Amount shown is that portion of a payment from a higher priority WC made in behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes are entered, the provider is claiming conditional Medicare payment.
16	PHS or Other Federal Agency	Amount shown is that portion of a payment from a higher priority PHS or other Federal agency made in behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill.
17	Outlier Amount	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of day or cost outlier payment to be made.
18	Disproportionate Share Amount	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of the disproportionate share payment to be made.
19	Indirect Medical Education Amount	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of the indirect medical education payment to be made.
20		Reserved for National Assignment.
31	Patient Liability Amount	Indicates the amount shown is that which was approved by you or the PRO to charge the beneficiary for noncovered accommodations, diagnostic procedures, or treatments.

41	BL	Amount shown is that portion of a payment from a higher priority BL made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill. If six zeros are entered, the provider is claiming conditional Medicare payment.
42	VA	Amount shown is that portion of a payment from a higher priority VA made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill.
43	Disabled Beneficiary Under Age 65 with LGHP	Amount shown is that portion of a payment from a higher priority LGHP made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill.
70	Interest Amount	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Code indicates the amount of interest applied to this bill.
71	Funding of ESRD Networks	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Code indicates the amount the Medicare payment was reduced to help fund the ESRD networks.
72-79		Reserved for National Assignment.

MEDICAID SPECIFIC CODES

21	Catastrophic	Medicaid-eligibility requirements to be determined at State level.
22	Surplus	Medicaid-eligibility requirements to be determined at State level.
23	Recurring Monthly Income	Medicaid-eligibility requirements to be determined at State level.
24	Medicaid Rate Code	Medicaid-eligibility requirements to be determined at state level.
25-29		Reserved for National Assignment - Medicaid.
30	Preadmission Testing	Reflects charges for preadmission outpatient diagnostic services for a patient in preparation for a previously scheduled admission.
31-79		Reserved for National Assignment.
80-99		Reserved for State and Local Assignment.

Home Health Data Elements-Cross Reference
HCFA-485 Home Health Certification and Plan of Treatment

Form Item	Form Description	Location in Electronic Record	Comments
1	Patient's HICN	RT 30, Field 7 RT 74, Field 5	
2	SOC Date	RT 71, Field 5	Start of Care Date.
3	Certification Period	RT 71, Field 6-7	
4	Medical Record Number	RT 20, Field 25 RT 74, Field 6	
5	Provider Number	RT 10, Field 6	
6	Patient's Name and Address	RT 20, Fields 4-6 and 13-17 RT 74, Fields 7-9	Patient's Name present RT 74.
7	Provider's Name and Address	RT 10, Fields 13-17	
8	Date of Birth	RT 20, Field 8 RT 74, Field 10	
9	Sex	RT 20, Field 7 RT 74, Field 11	
10	Medications	RT 73	Narrative
11	Principal Diagnosis		ICD-9-CM code only and most recent date (i.e., date of onset or date of exacerbation).
	ICD-9-CM Code	RT 70, Field 4 RT 74, Field 12	
	Date Onset/Exacerbation	RT 71, Field 8	
12	Surgical Procedure		ICD-9-CM procedural code only and date for the one procedure most relevant to the care being provided.
	ICD-9-CM Code	RT 71, Field 9	
	Date of Procedure	RT 71, Field 10	
13	Other Pertinent Diagnoses		ICD-9-CM diagnostic codes and most recent date (i.e., onset or exacerbation).
	ICD-9-CM Codes	RT 70, Fields 5-8 RT 74, Fields 13-16	
	Dates of Onset/Exacerbation	RT 71, Fields, 11-14	

Home Health Data Elements-Cross Reference
HCFA-485 Home Health Certification and Plan of Treatment (Cont)

Form Item	Form Description	Location in Electronic Record	Comments
14	DME and Supplies	RT 61 RT 73	HCPCS codes for DME billed. Narrative.
15	Safety Measures	RT 73	Narrative.
16	Nutritional Requirements	RT 73	Narrative.
17	Allergies	RT 73	Narrative.
18A	Functional Limitations	RT 71, Field 15	Code for each functional limitation.
18B	Activities Permitted	RT 71, Field 16	Code for each activity indicated.
		RT 73, 48617	Description of other, 18A 18B.
19	Mental Status	RT 71, Field 17	Codes for each description indicated.
		RT 73, 48616	Description of other.
20	Prognosis	RT 71, Field 18	Code for prognosis indicated.
21	Orders for Disciplines and Treatments	RT 73	Narrative.
22	Goals/Rehabilitation Potential/Discharge Plans	RT 73	Narrative.
23	Verbal Start of Care Date	RT 71, Field 19	
24	Attending Physician's Name and Address	RT 71, Fields 20-23	Name and ZIP code.
25	Date HHA Received Signed POT	Not present	Present on hardcopy form in agency file if applicable.
26	Physician Certification	Not present -	See Item 27
27	Attending Physician's Signature and Date	Not present	The physician's certification signature must be present on the hardcopy form retained in the agency files. The form must be dated by the physician or contain a date in Item 25.

Home Health Data Elements-Cross Reference
HCFA-486 Medical Update and Patient Information

Form Item	Form Description	Location in Electronic Record	Comments
1	HICN No.	RT 30, Field 7 RT 74, Field 11	
2	SOC Date	RT 71, Field 5	
3	Certification Period	RT 71, Fields 6-7	
4	Medical Record Number	RT 20, Field 25 RT 74, Field 6	
5	Provider Number	RT 10, Field 6	
6	Patient's Name	RT 20, Field 4-6 RT 74, Fields 7-9	
7	Provider Name	RT 10, Field 13	
8	Medicare Covered	RT 71, Field 24	Y-(Covered) N-(Noncovered)
9	Date Physician Last Saw Patient	RT 71, Field 25	
10	Date Last Contacted Physician	RT 71, Field 26	
11	Patient Receiving Care in 1861 J1 Facility	RT 71, Field 27	Y-(Yes), N-(No), D(Do Not Know).
12	Certification/Recertification/ Modified	RT 71, Field 28	C-(Cert), R-(Recert) M-(Modified)
13	Specific Services and Treatments	RT 72	A separate 72 record is required for each discipline ordered.
14	Dates of Last Inpatient Stay-	RT 71, Fields 29-30	

Home Health Data Elements-Cross Reference
HCFA-486 Medical Update and Patient Information (Cont)

Form Item	Form Description	Location in Electronic Record	Comments
15	Type of Facility	RT 71, Field 31	
16	Updated Information	RT 73	Narrative.
17	Functional Limitations/ Reasons Homebound/Prior Functional Status	RT 73	Narrative.
18	Supplementary Plan of Treatment on File	RT 73	Narrative. Present only if applicable.
19	Unusual Home/Social Environment	RT 73	Narrative. Optional.
20	Indicate times when the HHA made visit(s) and the patient was not at home and reasons for absence.	RT 73	Narrative.
21	Specify known medical and/or nonmedical reasons patient regularly leaves home and frequency	RT 73	Narrative.
22	Signature and Date of Nurse or Therapist Completing Form	Not present	Must be on hardcopy form retained in the HHA's files.

Record Type 71 - Plan of Treatment and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
Data ID	Identifies submittal of 485 and 486 data or 486 data only 1 = 485 and 486 2 = 486 only	4	-----
SOC Date	Date covered home health services began.	5	485-2
Certification Period	From/To dates of period to be covered by this plan of treatment.	6-7	" 3
Date of Onset/Exacerbation of Principal Diagnosis	The date of onset or date of exacerbation of the diagnosis shown as principal in Record Type 70 or 74.	8	" 11
Surgical Procedure Code	The ICD-9-CM code describing the surgical procedure (if any) most relevant to the care being rendered.	9	" 12
Date of Surgical Procedure	The date the surgery (Field 9) was performed	10	" 12
Dates of Onset/Exacerbation	The date of onset or exacerbation of the secondary diagnoses shown in Record Type 70 or 74. The related dates are entered in the same order as the secondary diagnosis codes.	11-14	" 13
Functional Limitations	Codes describing the patient's functional limitations as assessed by the physician. "Other" is described in Record Type 73 (48617).	15	" 18A

Record Type 71 - Plan of Treatment and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
	1= Amputation 2= Bowel/Bladder (Incontinence) 3= Contracture 4= Hearing 5= Paralysis 6= Endurance 7= Ambulation 8= Speech 9= Legally Blind A= Dyspnea with Minimal Exertion B= Other		
Activities Permitted	Codes describing the activities permitted by the physician or for which physician's orders are present. "Other" is described in Record Type 73 (48617). 1= Complete Bedrest 2= Bedrest BRP 3= Up as Tolerated 4= Transfer Bed/Chair 5= Exercises Prescribed 6= Partial Weight Bearing 7= Independent at Home 8= Crutches 9= Cane A= Wheelchair B= Walker C= No Restrictions D= Other	16	485-18B
Mental Status	Codes describing the patient's mental condition "Other" is described in Record Type 73 (48616). 1 = Oriented 2 = Comatose 3 = Forgetful 4 = Depressed	17	485-19

Record Type 71 - Plan of Treatment and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
	5 = Disoriented 6 = Lethargic 7 = Agitated 8 = Other		
Prognosis	Code indicating physician's prognosis for patient. 1 = Poor 2 = Guarded 3 = Fair 4 = Good 5 = Excellent	18	485-20
Verbal Start of Care Date MMDDYY	The date the agency received the verbal orders from the physician, if this is prior to the date care started.	19	485-23
(Attending) Physician's Name o Last Name o First Name o Initial	The name of the attending physician who established the plan of treatment. (This should be the physician who certifies and recertifies the medical necessity of the home health visits and/or services.	20-22	485-24
Physician's ZIP Code	The nine-digit ZIP code from the address field on the HCFA-485.	23	485-24
Medicare Covered	The following applicable codes: Y = Covered N = Noncovered	24	486-8
Date Physician Last Saw Patient	Date if (known) that patient was last seen by physician.	25	486-9

Record Type 71 - Plan of Treatment and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
Date Agency Last Contacted Physician	Date of agency's most recent physician contact. Purpose stated in Record Type 73 (48616).	26	486-10
Patient Receiving Care in 1861 J1 Facility	Y = Yes N = No D = Do not know	27	486-11
Cert/Recert/Mod	One of following applicable codes: C = Certification R = Recertification M = Modified	28	486-12
Dates of Last Inpatient Stay	From/To dates of most recent inpatient stay.	29-30	486-14
Type of Facility	Coding indicating type of facility from which patient was most recently discharged. A = Acute S = SNF I = ICF R = Rehabilitation Facility O = Other	31	486-15

Record Type 72 - Specific Services and Treatments - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
Discipline	Code indicating discipline(s) ordered by physician. SN = Skilled Nursing PT = Physical Therapy ST = Speech Therapy OT = Occupational Therapy MS = Medical Social Worker AI = Home Health Aide	5	486-13
Visits (This Bill) Rel. to Prior Certification	Total visits on this bill rendered prior to recertification "To" date.	6	486-13
Frequency of Visits	Code indicating frequency of visits during the period covered by the plan of treatment. Code is 3 positions. Position 1 is a numeric expression of number of times. Positions 2-3 are an alpha expression of period of time. Enter the frequency codes in the order being rendered. n = 1-9 xx = da = day wk = week mo = month q = every n days bb = for PRN visits	7	486-13
Duration of Visits	Code indicating length of time type visits will be rendered at the frequency shown. The code is 3 positions and is always numeric except for PRN ORDERS. nnn = 001-999 xxx = PRN	7	486-13

Record Type 72 - Specific Services and Treatments - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference HCFA-485/486
	The period of time for the duration is, with the exceptions below, always the same as the period of time in the frequency. Exceptions: q (every) frequency is always a duration of nnn days. bb (blank) frequency is always PRN duration. Examples: Daily visits times 10 days 1 da 10 One visit every 2 months 1 qb 60 Two visits PRN 2 bb PRN		
Treatment Codes	Codes describing the treatment ordered by the physician. Show in ascending order. Valid codes are: A01-A30 = Skilled Nursing B01-B15 = Physical Therapy C01-C09 = Speech Therapy D01-D11 = Occupational Therapy E01-E06 = Medical Social Services F01-F15 = Home Health Aide One or more codes must be present for each discipline (e.g., SN, PT, etc.).	8	486-13
Total Visits Projected This Cert.	Total Covered visits to be rendered by each discipline during the period covered by the plan of treatment. Include PRN visits.	9	486-13

Record Type 73 - Medical Update and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference
Medications	The physician's orders for all medications (dose, frequency, route of administration). The letter "N" will be used after New Medications, letter C for "Changed" orders. Show none if no medication are ordered.		485-10
Durable Medical Equipment (DME) and Medical Supplies	The DME ordered by the physician. All nonroutine supplies which are required to carry out the physician's orders.		485-14
Safety Measures	The physician's instructions for safety measures.		485-15
Nutritional Requirements	Physician's order for diet. This includes therapeutic diet and/or any specific dietary requirements and fluid restrictions.		485-16
Allergies	Patient's allergies, e.g., medications, foods, adhesive tape, iodine, etc.		485-17
Orders for Disciplines and Treatments	Specific physician orders.		485-21
Goals/Rehabilitation Potential/Discharge Plans	Succinct description of information provided by physician.		485-22

Record Type 73 - Medical Update and Patient Information - Data Definitions and Codes

Data Element	Definition	Field	Cross Reference
Updated Information	New orders, clinical facts, discipline summaries.		486-16
Functional Limitations/ Reason Homebound	Expansion of functional limitations and description of the reason homebound. "Other" is described where indicated for functional limitations and/or activities permitted.		486-17
Supplementary Plan	Description of services on a supplemental plan of treatment.		486-18
Unusual Home/Social Environment	Description of home/social environment which would further justify need for services or homebound condition.		486-19
Types and Reasons Patient Not at Home	Number of times agency made a visit and patient was absent from home and reason for absence if known.		486-20
Medical/Nonmedical Reasons Patient Leaves Home	Reasons patient leaves home and frequency of occurrence. Record will also indicate if patient does not leave home.		486-21

Record Type 74 - Patient Information - Data Definitions and Codes

This record is used only to submit the HCFA-485/486 data without an accompanying bill record (UB-82). The fields in this record are those obtained from the record types comprising the bill when the HCFA-485/486 and UB-82 are submitted together.

Data Element	Definition	Field	Cross Reference
HICN	Patient's HICN number.	5	485-1
Medical Record Number	Number used to access patient's medical record.	6	485-4
Patient Name Last Name First Name Initial	Patient's name.	9	485-6
Date of Birth	Patient's date of birth	10	485-8
Sex	M - (Male) F - (Female)	11	485-9
Principal Diagnosis	The 5 position ICD-9-CM code for the diagnosis most related to the current plan of treatment.	12	485-11
Secondary Diagnosis	Up to four secondary diagnoses codes pertinent to the case. Use ICD-9-CM codes.	13-16	485-13

ADDENDUM E - MCE Edit Types

Page

Age Conflict (Edit Type 5)
- Newborn Diagnoses E-2
- Pediatric Diagnoses - Age 0 Through 17 E-4
- Maternity Diagnoses - Age 12 Through 55 E-5
- Adult Diagnoses - Age Greater Than 14 E-16

Sex Conflict (Edit Type 6)
- Diagnoses Allowed for Females Only E-18
- Procedures Allowed for Females Only E-32
- Diagnoses Allowed for Males Only E-35
- Procedures Allowed for Males Only E-37

Manifestations Not Allowed as Principal Diagnosis (Edit Type 7) E-39

Nonspecific Principal Diagnoses (Edit Type 8) E-42

Questionable Admissions - Principal Diagnosis Only (Edit Type 9) E-51

Unacceptable Principal Diagnoses (Edit Type 10) E-52

Nonspecific O.R. Procedures (Edit Type 11) E-58

Noncovered O.R. Procedures (Edit Type 12) E-59

Open Biopsy Procedures (Edit Type 13) E-60

MSP Alert (Edit Type 14) E-61

Bilateral Procedure (Edit Type 15) E-69

NEWBORN DIAGNOSES

27701	CYSTIC FIBROSIS W ILEUS
7620	PLACENTA PREVIA AFF NB
7621	PLACENTA HEM NEC AFF NB
7622	ABN PLAC NEC/NOS AFF NB
7623	PLACENT TRANSFUSION SYN
7624	PROLAPSED CORD AFF NB
7625	OTH UMBIL CORD COMPRESS
7626	UMBIL COND NEC AFF NB
7627	CHORIOAMNIONITIS AFF NB
7628	ABN AMNION NEC AFF NB
7630	BREECH DEL/EXTRAC AFF NB
7640	LIGHT-FOR-DATES
7641	LIGHT-FOR-DATES W MALNUT
7642	FETAL MALNUTRITION NOS
7649	FETAL GROWTH RETARD NOS
7650	EXTREME IMMATURITY
7651	PRETERM INFANTS NEC
7660	EXCEPTIONALLY LARGE BABY
7661	HEAVY-FOR-DATE INFAN NEC
7662	POST-TERM INFANT NOS
7670	CEREBRAL HEM AT BIRTH
7671	SCALP INJURY AT BIRTH
7672	CLAVICLE FX AT BIRTH
7680	FETAL DEATH-ANOXIA NOS
7681	FET DEATH-ANOXIA DUR LAB
7682	FET DISTRESS BEFOR LABOR
7683	FETAL DISTRESS DUR LABOR
7684	FETAL DISTRESS NOS
7685	SEVERE BIRTH ASPHYXIA
7686	MILD/MOD BIRTH ASPHYXIA
769	RESPIRATORY DISTRESS SYN
7700	CONGENITAL PNEUMONIA
7701	NB MASSIVE ASPIRAT SYN
7702	NB INTERSTIT EMPHYSEMA
7703	NB PULMONARY HEMORRHAGE
7704	PRIMARY ATELECTASIS
7705	NB ATELECTASIS NEC/NOS
7706	NB TRANSITORY TACHYPNEA
7707	PERINATAL CHR RESP DIS
7708	POST-BIRTH RESP PROB NEC
7710	CONGENITAL RUBELLA
7711	CONG CYTOMEGALOVIRUS INF
7712	CONGENITAL INFEC NEC
7713	TETANUS NEONATORUM
7714	OMPHALITIS OF NEWBORN
7715	NEONATAL INFEC MASTITIS
7716	NEONATAL CONJUNCTIVITIS
7717	NEONATAL CANDIDA INFECT
7718	PERINATAL INFECTION NEC
7720	FETAL BLOOD LOSS NEC
7721	NB INTRAVENTRICULAR HEM
7722	NB SUBARACHNOID HEMORR
7723	POST-BIRTH UMBIL HEMORR
7724	NB GI HEMORRHAGE
7725	NB ADRENAL HEMORRHAGE
7726	NB CUTANEOUS HEMORRHAGE
7728	NEONATAL HEMORRHAGE NEC
7730	NB HEMOLYT DIS:RH ISOIMM
7731	NB HEMOLYT DIS-ABO ISOIM
7732	NB HEMOLYT DIS-ISOIM NEC
7733	HYDROPS FETALIS:ISOIMM
7734	NB KERNICTERUS:ISOIMMUN
7735	NB LATE ANEMIA:ISOIMMUN
7740	PERINAT JAUND-HERED ANEM
7741	PERINAT JAUND:HEMOLYSIS
7742	NEONAT JAUND PRETERM DEL
77430	DELAY CONJUGAT JAUND NOS
77431	NEONAT JAUND IN OTH DIS
77439	DELAY CONJUGAT JAUND NEC
7744	FETAL/NEONATAL HEPATITIS
7745	PERINATAL JAUNDICE NEC
7746	FETAL/NEONATAL JAUND NOS
7747	NB KERNICTERUS
7750	INFANT DIABET MOTHER SYN
7751	NEONAT DIABETES MELLITUS
7752	NEONAT MYASTHENIA GRAVIS
7753	NEONATAL THYROTOXICOSIS
7754	HYPOCALCEM/HYPOMAGNES NB
7755	NEONATAL DEHYDRATION
7756	NEONATAL HYPOGLYCEMIA
7757	LATE METAB ACIDOSIS NB
7758	TRANSIENT MET DIS NB NEC
7760	NB HEMORRHAGIC DISEASE
7761	NEONATAL THROMBOCYTOPEN
7762	DISSEM INTRAVASC COAG NB
7763	OTH NEONATAL COAG DIS
7764	POLYCYTHEMIA NEONATORUM
7765	CONGENITAL ANEMIA
7766	ANEMIA OF PREMATURITY
7767	NEONATAL NEUTROPENIA
7768	TRANSIENT HEMAT DIS NEC
7771	MECONIUM OBSTRUCTION
7772	INTEST OBST-INSPISS MILK
7773	SWALLOWED BLOOD SYNDROME
7774	TRANSITORY ILEUS OF NB
7775	NECROT ENTEROCOLITIS NB
7776	PERINATAL INTEST PERFOR
7778	PERINAT GI SYS DIS NEC
7780	HYDROPS FETALIS NO ISOIM
7781	SCLEREMA NEONATORUM

NEWBORN DIAGNOSES

7782 NB COLD INJURY SYNDROME
7783 NB HYPOTHERMIA NEC
7784 NB TEMP REGULAT DIS NEC
7785 EDEMA OF NEWBORN NEC/NOS
7787 NB BREAST ENGORGEMENT
7788 NB INTEGUMENT COND NEC
7790 CONVULSIONS IN NEWBORN
7791 NB CEREB IRRIT NEC/NOS
7792 CNS DYSFUNCTION SYN NB
7793 NB FEEDING PROBLEMS
7794 NB DRUG REACTION/INTOXIC
7795 NB DRUG WITHDRAWAL SYNDR
7796 TERMINATION OF PREGNANCY
7798 PERINATAL CONDITION NEC
V300 SINGLE LIVEBORN-IN HOSP
V301 SINGL LIVEBRN-BEFORE ADM
V310 TWIN, MATE LB-IN HOSP
V311 TWIN, MATE LB-BEFORE ADM
V320 TWIN, MATE SB-IN HOSP
V321 TWIN, MATE SB-BEFORE ADM
V330 TWIN NOS-IN HOSPITAL
V331 TWIN NOS-BEFORE ADMISSN
V340 OTH MULTIPLE NB-IN HOSP
V341 OTH MULT NB-BEFORE ADM
V360 MULTIPLE NB/SB-IN HOSP
V361 MULT NB/SB-BEFORE ADM
V370 MULT BIRTH NOS-IN HOSP
V371 MULT BRTH NOS-BEFORE ADM
V390 LIVEBORN NOS-IN HOSP
V391 LIVEBORN NOS-BEFORE ADM

PEDIATRIC DIAGNOSES - AGE 0 THROUGH 17

2591 SEXUAL PRECOCITY NEC
31389 EMOTIONAL DIS CHILD NEC
3139 EMOTIONAL DIS CHILD NOS
33181 REYE'S SYNDROME
7511 ATRESIA SMALL INTESTINE
7512 ATRESIA LARGE INTESTINE
75161 BILIARY ATRESIA
7980 SUDDEN INFANT DEATH SYND
9955 CHILD MALTREATMENT SYND
V200 FOUNDLING HEALTH CARE
V201 CARE OF HEALTHY CHLD NEC
V202 ROUTIN CHILD HEALTH EXAM

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

630 HYDATIDIFORM MOLE
631 OTH ABN PROD CONCEPTION
632 MISSED ABORTION
6330 ABDOMINAL PREGNANCY
6331 TUBAL PREGNANCY
6332 OVARIAN PREGNANCY
6338 ECTOPIC PREGNANCY NEC
6339 ECTOPIC PREGNANCY NOS
63400 SPON ABOR W PEL INF-UNSP
63401 SPON ABOR W PELV INF-INC
63402 SPON ABOR W PEL INF-COMP
63410 SPON ABORT W HEMORR-UNSP
63411 SPON ABORT W HEMORR-INC
63412 SPON ABORT W HEMORR-COMP
63420 SPON AB W PEL DAMAG-UNSP
63421 SPON AB W PELV DAMAG-INC
63422 SPON AB W PEL DAMAG-COMP
63430 SPON AB W REN FAIL-UNSP
63431 SPON AB W REN FAIL-INC
63432 SPON AB W REN FAIL-COMP
63440 SPON AB W METAB DIS-UNSP
63441 SPON AB W METAB DIS-INC
63442 SPON AB W METAB DIS-COMP
63450 SPON ABORT W SHOCK-UNSP
63451 SPON ABORT W SHOCK-INC
63452 SPON ABORT W SHOCK-COMP
63460 SPON ABORT W EMBOL-UNSP
63461 SPON ABORT W EMBOL-INC
63462 SPON ABORT W EMBOL-COMP
63470 SPON AB W COMPL NEC-UNSP
63471 SPON AB W COMPL NEC-INC
63472 SPON AB W COMPL NEC-COMP
63480 SPON AB W COMPL NOS-UNSP
63481 SPON AB W COMPL NOS-INC
63482 SPON AB W COMPL NOS-COMP
63490 SPON ABORT UNCOMPL-UNSP
63491 SPON ABORT UNCOMPL-INC
63492 SPON ABORT UNCOMPL-COMP
63500 LEG ABOR W PELV INF-UNSP
63501 LEG ABOR W PELV INF-INC
63502 LEG ABOR W PELV INF-COMP
63510 LEGAL ABOR W HEMORR-UNSP
63511 LEGAL ABORT W HEMORR-INC
63512 LEGAL ABOR W HEMORR-COMP
63520 LEG AB W PELV DAMAG-UNSP
63521 LEG AB W PELV DAMAG-INC
63522 LEG AB W PELV DAMAG-COMP
63530 LEG ABOR W REN FAIL-UNSP
63531 LEG ABOR W REN FAIL-INC
63532 LEG ABOR W REN FAIL-COMP
63540 LEG AB W METAB DIS-UNSP
63541 LEG AB W METAB DIS-INC
63542 LEG AB W METAB DIS-COMP
63550 LEGAL ABORT W SHOCK-UNSP
63551 LEGAL ABORT W SHOCK-INC
63552 LEGAL ABORT W SHOCK-COMP
63560 LEGAL ABORT W EMBOL-UNSP
63561 LEGAL ABORT W EMBOL-INC
63562 LEGAL ABORT W EMBOL-COMP
63570 LEG AB W COMPL NEC-UNSP
63571 LEG AB W COMPL NEC-INC
63572 LEG AB W COMPL NEC-COMP
63580 LEG AB W COMPL NOS-UNSP
63581 LEG AB W COMPL NOS-INC
63582 LEG AB W COMPL NOS-COMP
63590 LEGAL ABORT UNCOMPL-UNSP
63591 LEGAL ABORT UNCOMPL-INC
63592 LEGAL ABORT UNCOMPL-COMP
63600 ILLEG AB W PELV INF-UNSP
63601 ILLEG AB W PELV INF-INC
63602 ILLEG AB W PELV INF-COMP
63610 ILLEG AB W HEMORR-UNSPEC
63611 ILLEG AB W HEMORR-INC
63612 ILLEG AB W HEMORR-COMP
63620 ILLEG AB W PEL DAMG-UNSP
63621 ILLEG AB W PEL DAMAG-INC
63622 ILLEG AB W PEL DAMG-COMP
63630 ILLEG AB W REN FAIL-UNSP
63631 ILLEG AB W REN FAIL-INC
63632 ILLEG AB W REN FAIL-COMP
63640 ILLEG AB W MET DIS-UNSP
63641 ILLEG AB W METAB DIS-INC
63642 ILLEG AB W MET DIS-COMP
63650 ILLEG ABORT W SHOCK-UNSP
63651 ILLEG ABORT W SHOCK-INC
63652 ILLEG ABORT W SHOCK-COMP
63660 ILLEG AB W EMBOLISM-UNSP
63661 ILLEG AB W EMBOLISM-INC
63662 ILLEG AB W EMBOLISM-COMP
63670 ILLG AB W COMPL NEC-UNSP
63671 ILLEG AB W COMPL NEC-INC
63672 ILLG AB W COMPL NEC-COMP
63680 ILLG AB W COMPL NOS-UNSP
63681 ILLEG AB W COMPL NOS-INC
63682 ILLG AB W COMPL NOS-COMP
63690 ILLEG ABORT UNCOMPL-UNSP
63691 ILLEG ABORT UNCOMPL-INC
63692 ILLEG ABORT UNCOMPL-COMP
63700 ABORT NOS W PEL INF-UNSP
63701 ABORT NOS W PEL INF-INC

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

63702 ABORT NOS W PEL INF-COMP
63710 ABORT NOS W HEMORR-UNSP
63711 ABORT NOS W HEMORR-INC
63712 ABORT NOS W HEMORR-COMP
63720 AB NOS W PELV DAMAG-UNSP
63721 AB NOS W PELV DAMAG-INC
63722 AB NOS W PELV DAMAG-COMP
63730 AB NOS W RENAL FAIL-UNSP
63731 AB NOS W RENAL FAIL-INC
63732 AB NOS W RENAL FAIL-COMP
63740 AB NOS W METAB DIS-UNSP
63741 AB NOS W METAB DIS-INC
63742 AB NOS W METAB DIS-COMP
63750 ABORT NOS W SHOCK-UNSP
63751 ABORT NOS W SHOCK-INC
63752 ABORT NOS W SHOCK-COMP
63760 AB NOS W EMBOLISM-UNSP
63761 AB NOS W EMBOLISM-INC
63762 AB NOS W EMBOLISM-COMP
63770 AB NOS W COMPL NEC-UNSP
63771 AB NOS W COMPL NEC-INC
63772 AB NOS W COMPL NEC-COMP
63780 AB NOS W COMPL NOS-UNSP
63781 AB NOS W COMPL NOS-INC
63782 AB NOS W COMPL NOS-COMP
63790 AB NOS UNCOMPLICAT-UNSP
63791 AB NOS UNCOMPLICAT-INC
63792 AB NOS UNCOMPLICAT-COMP
6380 ATTEM ABORT W PELVIC INF
6381 ATTEM ABORT W HEMORRHAGE
6382 ATTEM ABORT W PELV DAMAG
6383 ATTEM ABORT W RENAL FAIL
6384 ATTEM ABOR W METABOL DIS
6385 ATTEM ABORTION W SHOCK
6386 ATTEMP ABORT W EMBOLISM
6387 ATTEMP ABORT W COMPL NEC
6388 ATTEMP ABORT W COMPL NOS
6389 ATTEMPTED ABORT UNCOMPL
6390 POSTABORTION GU INFECT
6391 POSTABORTION HEMORRHAGE
6392 POSTABORT PELVIC DAMAGE
6393 POSTABORT RENAL FAILURE
6394 POSTABORT METABOLIC DIS
6395 POSTABORTION SHOCK
6396 POSTABORTION EMBOLISM
6398 POSTABORTION COMPL NEC
6399 POSTABORTION COMPL NOS
64000 THREATENED ABORT-UNSPEC
64001 THREATENED ABORT-DELIVER
64003 THREATEN ABORT-ANTEPART

64080 HEM EARLY PREG NEC-UNSP
64081 HEM EARLY PREG NEC-DELIV
64083 HEM EARLY PG NEC-ANTEPAR
64090 HEMORR EARLY PREG-UNSPEC
64091 HEM EARLY PREG-DELIVERED
64093 HEM EARLY PREG-ANTEPART
64100 PLACENTA PREVIA-UNSPEC
64101 PLACENTA PREVIA-DELIVER
64103 PLACENTA PREVIA-ANTEPART
64110 PLACENTA PREV HEM-UNSPEC
64111 PLACENTA PREV HEM-DELIV
64113 PLACEN PREV HEM-ANTEPART
64120 PREM SEPAR PLACEN-UNSPEC
64121 PREM SEPAR PLACEN-DELIV
64123 PREM SEPAR PLAC-ANTEPART
64130 COAG DEF HEMORR-UNSPEC
64131 COAG DEF HEMORR-DELIVER
64133 COAG DEF HEMORR-ANTEPART
64180 ANTEPART HEM NEC-UNSPEC
64181 ANTEPARTUM HEM NEC-DELIV
64183 ANTEPART HEM NEC-ANTEPAR
64190 ANTEPART HEM NOS-UNSPEC
64191 ANTEPARTUM HEM NOS-DELIV
64193 ANTEPART HEM NOS-ANTEPAR
64200 ESSEN HYPERTEN PREG-UNSP
64201 ESSEN HYPERTEN-DELIVERED
64202 ESSEN HYPERTEN-DEL W P/P
64203 ESSEN HYPERTEN-ANTEPART
64204 ESSEN HYPERTEN-POSTPART
64210 RENAL HYPERTEN PREG-UNSP
64211 RENAL HYPERTEN PG-DELIV
64212 RENAL HYPERTEN-DEL P/P
64213 RENAL HYPERTEN-ANTEPART
64214 RENAL HYPERTEN-POSTPART
64220 OLD HYPERTEN PREG-UNSPEC
64221 OLD HYPERTEN NEC-DELIVER
64222 OLD HYPERTEN-DELIV W P/P
64223 OLD HYPERTEN NEC-ANTEPAR
64224 OLD HYPERTEN NEC-POSTPAR
64230 TRANS HYPERTEN PREG-UNSP
64231 TRANS HYPERTEN-DELIVERED
64232 TRANS HYPERTEN-DEL W P/P
64233 TRANS HYPERTEN-ANTEPART
64234 TRANS HYPERTEN-POSTPART
64240 MILD/NOS PREECLAMP-UNSP
64241 MILD/NOS PREECLAMP-DELIV
64242 MILD PREECLAMP-DEL W P/P
64243 MILD/NOS PREECLAMP-ANTEP
64244 MILD/NOS PREECLAMP-P/P
64250 SEVERE PREECLAMP-UNSPEC

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

64251 SEVERE PREECLAMP-DELIVER
64252 SEV PREECLAMP-DEL W P/P
64253 SEV PREECLAMP-ANTEPARTUM
64254 SEV PREECLAMP-POSTPARTUM
64260 ECLAMPSIA-UNSPECIFIED
64261 ECLAMPSIA-DELIVERED
64262 ECLAMPSIA-DELIV W P/P
64263 ECLAMPSIA-ANTEPARTUM
64264 ECLAMPSIA-POSTPARTUM
64270 TOX W OLD HYPERTEN-UNSP
64271 TOX W OLD HYPERTEN-DELIV
64272 TOX W OLD HYP-DEL W P/P
64273 TOX W OLD HYPER-ANTEPART
64274 TOX W OLD HYPER-POSTPART
64290 HYPERTEN PREG NOS-UNSPEC
64291 HYPERTENS NOS-DELIVERED
64292 HYPERTENS NOS-DEL W P/P
64293 HYPERTENS NOS-ANTEPARTUM
64294 HYPERTENS NOS-POSTPARTUM
64300 MILD HYPEREM GRAV-UNSPEC
64301 MILD HYPEREM GRAV-DELIV
64303 MILD HYPEREMESIS-ANTEPAR
64310 HYPEREM W METAB DIS-UNSP
64311 HYPEREM W METAB DIS-DEL
64313 HYPEREM W METAB-ANTEPART
64320 LATE VOMIT OF PREG-UNSP
64321 LATE VOMIT OF PREG-DELIV
64323 LATE VOMIT PREG-ANTEPART
64380 VOMIT COMPL PREG-UNSPEC
64381 VOMIT COMPL PREG-DELIVER
64383 VOMIT COMPL PREG-ANTEPAR
64390 VOMIT OF PREG NOS-UNSPEC
64391 VOMIT OF PREG NOS-DELIV
64393 VOMIT OF PG NOS-ANTEPART
64400 THREAT PREM LABOR-UNSPEC
64403 THRT PREM LABOR-ANTEPART
64410 THREAT LABOR NEC-UNSPEC
64413 THREAT LABOR NEC-ANTEPAR
64420 EARLY ONSET DELIV-UNSPEC
64421 EARLY ONSET DELIVERY-DEL
64500 PROLONGED PREG-UNSPEC
64501 PROLONGED PREG-DELIVERED
64503 PROLONGED PREG-ANTEPART
64600 PAPYRACEOUS FETUS-UNSPEC
64601 PAPYRACEOUS FETUS-DELIV
64603 PAPYRACEOUS FET-ANTEPAR
64610 EDEMA IN PREG-UNSPEC
64611 EDEMA IN PREG-DELIVERED
64612 EDEMA IN PREG-DEL W P/P
64613 EDEMA IN PREG-ANTEPARTUM
64614 EDEMA IN PREG-POSTPARTUM
64620 RENAL DIS PREG NOS-UNSP
64621 RENAL DIS NOS-DELIVERED
64622 RENAL DIS NOS-DEL W P/P
64623 RENAL DIS NOS-ANTEPARTUM
64624 RENAL DIS NOS-POSTPARTUM
64630 HABITUAL ABORTER-UNSPEC
64631 HABITUAL ABORTER-DELIVER
64633 HABITUAL ABORT-ANTEPART
64640 NEURITIS OF PREG-UNSPEC
64641 NEURITIS-DELIVERED
64642 NEURITIS-DELIVERED W P/P
64643 NEURITIS OF PREG-ANTEPAR
64644 NEURITIS OF PREG-POSTPAR
64650 BACTERIURIA PREG-UNSPEC
64651 ASYM BACTERIURIA-DELIVER
64652 ASY BACTERURIA-DEL W P/P
64653 ASY BACTERIURIA-ANTEPART
64654 ASY BACTERIURIA-POSTPART
64660 GU INFECT IN PREG-UNSPEC
64661 GU INFECTION-DELIVERED
64662 GU INFECTION-DELIV W P/P
64663 GU INFECTION-ANTEPARTUM
64664 GU INFECTION-POSTPARTUM
64670 LIVER DIS IN PREG-UNSPEC
64671 LIVER DISORDER-DELIVERED
64673 LIVER DISORDER-ANTEPART
64680 PREG COMPL NEC-UNSPEC
64681 PREG COMPL NEC-DELIVERED
64682 PREG COMPL NEC-DEL W P/P
64683 PREG COMPL NEC-ANTEPART
64684 PREG COMPL NEC-POSTPART
64690 PREG COMPL NOS-UNSPEC
64691 PREG COMPL NOS-DELIVERED
64693 PREG COMPL NOS-ANTEPART
64700 SYPHILIS IN PREG-UNSPEC
64701 SYPHILIS-DELIVERED
64702 SYPHILIS-DELIVERED W P/P
64703 SYPHILIS-ANTEPARTUM
64704 SYPHILIS-POSTPARTUM
64710 GONORRHEA IN PREG-UNSPEC
64711 GONORRHEA-DELIVERED
64712 GONORRHEA-DELIVER W P/P
64713 GONORRHEA-ANTEPARTUM
64714 GONORRHEA-POSTPARTUM
64720 OTHER VD IN PREG-UNSPEC
64721 OTHER VD-DELIVERED
64722 OTHER VD-DELIVERED W P/P
64723 OTHER VD-ANTEPARTUM
64724 OTHER VD-POSTPARTUM

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

64730 TB IN PREG-UNSPECIFIED
64731 TUBERCULOSIS-DELIVERED
64732 TUBERCULOSIS-DELIV W P/P
64733 TUBERCULOSIS-ANTEPARTUM
64734 TUBERCULOSIS-POSTPARTUM
64740 MALARIA IN PREG-UNSPEC
64741 MALARIA-DELIVERED
64742 MALARIA-DELIVERED W P/P
64743 MALARIA-ANTEPARTUM
64744 MALARIA-POSTPARTUM
64750 RUBELLA IN PREG-UNSPEC
64751 RUBELLA-DELIVERED
64752 RUBELLA-DELIVERED W P/P
64753 RUBELLA-ANTEPARTUM
64754 RUBELLA-POSTPARTUM
64760 OTH VIRUS IN PREG-UNSPEC
64761 OTH VIRAL DIS-DELIVERED
64762 OTH VIRAL DIS-DEL W P/P
64763 OTH VIRAL DIS-ANTEPARTUM
64764 OTH VIRAL DIS-POSTPARTUM
64780 INF DIS IN PREG NEC-UNSP
64781 INFECT DIS NEC-DELIVERED
64782 INFECT DIS NEC-DEL W P/P
64783 INFECT DIS NEC-ANTEPART
64784 INFECT DIS NEC-POSTPART
64790 INFECT IN PREG NOS-UNSP
64791 INFECT NOS-DELIVERED
64792 INFECT NOS-DELIVER W P/P
64793 INFECT NOS-ANTEPARTUM
64794 INFECT NOS-POSTPARTUM
64800 DIABETES IN PREG-UNSPEC
64801 DIABETES-DELIVERED
64802 DIABETES-DELIVERED W P/P
64803 DIABETES-ANTEPARTUM
64804 DIABETES-POSTPARTUM
64810 THYROID DYSFUN PREG-UNSP
64811 THYROID DYSFUNC-DELIVER
64812 THYROID DYSFUN-DEL W P/P
64813 THYROID DYSFUNC-ANTEPART
64814 THYROID DYSFUNC-POSTPART
64820 ANEMIA IN PREG-UNSPEC
64821 ANEMIA-DELIVERED
64822 ANEMIA-DELIVERED W P/P
64823 ANEMIA-ANTEPARTUM
64824 ANEMIA-POSTPARTUM
64830 DRUG DEPEND PREG-UNSPEC
64831 DRUG DEPENDENCE-DELIVER
64832 DRUG DEPENDEN-DEL W P/P
64833 DRUG DEPENDENCE-ANTEPART
64834 DRUG DEPENDENCE-POSTPART
64840 MENTAL DIS PREG-UNSPEC
64841 MENTAL DISORDER-DELIVER
64842 MENTAL DIS-DELIV W P/P
64843 MENTAL DISORDER-ANTEPART
64844 MENTAL DISORDER-POSTPART
64850 CONGEN CV DIS PREG-UNSP
64851 CONGEN CV DIS-DELIVERED
64852 CONGEN CV DIS-DEL W P/P
64853 CONGEN CV DIS-ANTEPARTUM
64854 CONGEN CV DIS-POSTPARTUM
64860 CV DIS NEC PREG-UNSPEC
64861 CV DIS NEC PREG-DELIVER
64862 CV DIS NEC-DELIVER W P/P
64863 CV DIS NEC-ANTEPARTUM
64864 CV DIS NEC-POSTPARTUM
64870 BONE DISORD IN PREG-UNSP
64871 BONE DISORDER-DELIVERED
64872 BONE DISORDER-DEL W P/P
64873 BONE DISORDER-ANTEPARTUM
64874 BONE DISORDER-POSTPARTUM
64880 ABN GLUCOSE IN PREG-UNSP
64881 ABN GLUCOSE TOLER-DELIV
64882 ABN GLUCOSE-DELIV W P/P
64883 ABN GLUCOSE-ANTEPARTUM
64884 ABN GLUCOSE-POSTPARTUM
64890 OTH CURR COND PREG-UNSP
64891 OTH CURR COND-DELIVERED
64892 OTH CURR COND-DEL W P/P
64893 OTH CURR COND-ANTEPARTUM
64894 OTH CURR COND-POSTPARTUM
650 NORMAL DELIVERY
65100 TWIN PREGNANCY-UNSPEC
65101 TWIN PREGNANCY-DELIVERED
65103 TWIN PREGNANCY-ANTEPART
65110 TRIPLET PREGNANCY-UNSPEC
65111 TRIPLET PREGNANCY-DELIV
65113 TRIPLET PREG-ANTEPARTUM
65120 QUADRUPLET PREG-UNSPEC
65121 QUADRUPLET PREG-DELIVER
65123 QUADRUPLET PREG-ANTEPART
65180 MULTI GESTAT NEC-UNSPEC
65181 MULTI GESTAT NEC-DELIVER
65183 MULTI GEST NEC-ANTEPART
65190 MULTI GESTAT NOS-UNSPEC
65191 MULT GESTATION NOS-DELIV
65193 MULTI GEST NOS-ANTEPART
65200 UNSTABLE LIE-UNSPECIFIED
65201 UNSTABLE LIE-DELIVERED
65203 UNSTABLE LIE-ANTEPARTUM
65210 CEPHALIC VERS NOS-UNSPEC

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

65211 CEPHALIC VERS NOS-DELIV
65213 CEPHAL VERS NOS-ANTEPART
65220 BREECH PRESENTAT-UNSPEC
65221 BREECH PRESENTAT-DELIVER
65223 BREECH PRESENT-ANTEPART
65230 TRANSV/OBLIQ LIE-UNSPEC
65231 TRANSVER/OBLIQ LIE-DELIV
65233 TRANSV/OBLIQ LIE-ANTEPAR
65240 FACE/BROW PRESENT-UNSPEC
65241 FACE/BROW PRESENT-DELIV
65243 FACE/BROW PRES-ANTEPART
65250 HIGH HEAD AT TERM-UNSPEC
65251 HIGH HEAD AT TERM-DELIV
65253 HIGH HEAD TERM-ANTEPART
65260 MULT GEST MALPRESEN-UNSP
65261 MULT GEST MALPRES-DELIV
65263 MULT GES MALPRES-ANTEPAR
65270 PROLAPSED ARM-UNSPEC
65271 PROLAPSED ARM-DELIVERED
65273 PROLAPSED ARM-ANTEPART
65280 MALPOSITION NEC-UNSPEC
65281 MALPOSITION NEC-DELIVER
65283 MALPOSITION NEC-ANTEPART
65290 MALPOSITION NOS-UNSPEC
65291 MALPOSITION NOS-DELIVER
65293 MALPOSITION NOS-ANTEPART
65300 PELVIC DEFORM NOS-UNSPEC
65301 PELVIC DEFORM NOS-DELIV
65303 PELV DEFORM NOS-ANTEPART
65310 CONTRACT PELV NOS-UNSPEC
65311 CONTRACT PELV NOS-DELIV
65313 CONTRAC PELV NOS-ANTEPAR
65320 INLET CONTRACTION-UNSPEC
65321 INLET CONTRACTION-DELIV
65323 INLET CONTRACT-ANTEPART
65330 OUTLET CONTRACTION-UNSP
65331 OUTLET CONTRACTION-DELIV
65333 OUTLET CONTRACT-ANTEPART
65340 FETOPELV DISPROP-UNSPEC
65341 FETOPELV DISPROPOR-DELIV
65343 FETOPEL DISPROP-ANTEPART
65350 FETAL DISPROP NOS-UNSPEC
65351 FETAL DISPROP NOS-DELIV
65353 FETAL DISPRO NOS-ANTEPAR
65360 HYDROCEPHAL FETUS-UNSPEC
65361 HYDROCEPH FETUS-DELIVER
65363 HYDROCEPH FETUS-ANTEPART
65370 OTH ABN FET DISPROP-UNSP
65371 OTH ABN FET DISPRO-DELIV
65373 OTH ABN FET DISFRO-ANTEP
65380 DISPROPORTION NEC-UNSPEC
65381 DISPROPORTION NEC-DELIV
65383 DISPROPOR NEC-ANTEPARTUM
65390 DISPROPORTION NOS-UNSPEC
65391 DISPROPORTION NOS-DELIV
65393 DISPROPOR NOS-ANTEPARTUM
65400 CONG ABN UTER PREG-UNSP
65401 CONGEN ABN UTERUS-DELIV
65402 CONG ABN UTER-DEL W P/P
65403 CONGEN ABN UTER-ANTEPART
65404 CONGEN ABN UTER-POSTPART
65410 UTER TUMOR IN PREG-UNSP
65411 UTERINE TUMOR-DELIVERED
65412 UTERINE TUMOR-DEL W P/P
65413 UTERINE TUMOR-ANTEPARTUM
65414 UTERINE TUMOR-POSTPARTUM
65420 PREV C-SECT NOS-UNSPEC
65421 PREV C-SECT NOS-DELIVER
65423 PREV C-SECT NOS-ANTEPART
65430 RETROVERT UTERUS-UNSPEC
65431 RETROVERT UTERUS-DELIVER
65432 RETROVERT UTER-DEL W P/P
65433 RETROVERT UTER-ANTEPART
65434 RETROVERT UTER-POSTPART
65440 ABN GRAV UTERUS NEC-UNSP
65441 ABN UTERUS NEC-DELIVERED
65442 ABN UTERUS NEC-DEL W P/P
65443 ABN UTERUS NEC-ANTEPART
65444 ABN UTERUS NEC-POSTPART
65450 CERV INCOMPET PREG-UNSP
65451 CERVICAL INCOMPET-DELIV
65452 CERV INCOMPET-DEL W P/P
65453 CERV INCOMPET-ANTEPARTUM
65454 CERV INCOMPET-POSTPARTUM
65460 ABN CERVIX NEC PREG-UNSP
65461 ABN CERVIX NEC-DELIVERED
65462 ABN CERVIX NEC-DEL W P/P
65463 ABN CERVIX NEC-ANTEPART
65464 ABN CERVIX NEC-POSTPART
65470 ABN VAGINA IN PREG-UNSP
65471 ABNORM VAGINA-DELIVERED
65472 ABNORM VAGINA-DEL W P/P
65473 ABNORM VAGINA-ANTEPARTUM
65474 ABNORM VAGINA-POSTPARTUM
65480 ABN VULVA IN PREG-UNSPEC
65481 ABNORMAL VULVA-DELIVERED
65482 ABNORMAL VULVA-DEL W P/P
65483 ABNORMAL VULVA-ANTEPART
65484 ABNORMAL VULVA-POSTPART
65490 ABN PEL NOS IN PREG-UNSP

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

65491 ABN PELV ORG NOS-DELIVER
65492 ABN PELV NOS-DELIV W P/P
65493 ABN PELV ORG NOS-ANTEPAR
65494 ABN PELV ORG NOS-POSTPAR
65500 FETAL CNS MALFORM-UNSPEC
65501 FETAL CNS MALFORM-DELIV
65503 FETAL CNS MALFOR-ANTEPAR
65510 FETAL CHROMOS ABN-UNSPEC
65511 FETAL CHROMOSO ABN-DELIV
65513 FET CHROMO ABN-ANTEPART
65520 FAMIL HEREDIT DIS-UNSPEC
65521 FAMIL HEREDIT DIS-DELIV
65523 FAMIL HERED DIS-ANTEPART
65530 FET DAMG D/T VIRUS-UNSP
65531 FET DAMG D/T VIRUS-DELIV
65533 FET DAMG D/T VIRUS-ANTEP
65540 FET DAMG D/T DIS-UNSPEC
65541 FET DAMG D/T DIS-DELIVER
65543 FET DAMG D/T DIS-ANTEPAR
65550 FETAL DAMG D/T DRUG-UNSP
65551 FET DAMAG D/T DRUG-DELIV
65553 FET DAMG D/T DRUG-ANTEPA
65560 RADIAT FETAL DAMAG-UNSP
65561 RADIAT FETAL DAMAG-DELIV
65563 RADIAT FET DAMAG-ANTEPAR
65580 FETAL ABNORM NEC-UNSPEC
65581 FETAL ABNORM NEC-DELIVER
65583 FETAL ABNORM NEC-ANTEPAR
65590 FETAL ABNORM NOS-UNSPEC
65591 FETAL ABNORM NOS-DELIVER
65593 FETAL ABNORM NOS-ANTEPAR
65600 FETAL-MATERNAL HEM-UNSP
65601 FETAL-MATERNAL HEM-DELIV
65603 FETAL-MATERN HEM-ANTEPAR
65610 RH ISOIMMUNIZATION-UNSP
65611 RH ISOIMMUNIZAT-DELIVER
65613 RH ISOIMMUNIZAT-ANTEPART
65620 ABO ISOIMMUNIZATION-UNSP
65621 ABO ISOIMMUNIZAT-DELIVER
65623 ABO ISOIMMUNIZAT-ANTEPAR
65630 FETAL DISTRESS-UNSPEC
65631 FETAL DISTRESS-DELIVERED
65633 FETAL DISTRESS-ANTEPART
65640 INTRAUTERINE DEATH-UNSP
65641 INTRAUTER DEATH-DELIVER
65643 INTRAUTER DEATH-ANTEPART
65650 POOR FETAL GROWTH-UNSPEC
65651 POOR FETAL GROWTH-DELIV
65653 POOR FETAL GRTH-ANTEPART
65660 EXCESS FETAL GRTH-UNSPEC
65661 EXCESS FETAL GRTH-DELIV
65663 EXCESS FET GRTH-ANTEPART
65670 OTH PLACENT COND-UNSPEC
65671 OTH PLACENT COND-DELIVER
65673 OTH PLACENT COND-ANTEPAR
65680 FET/PLAC PROB NEC-UNSPEC
65681 FET/PLAC PROB NEC-DELIV
65683 FET/PLAC PROB NEC-ANTEPA
65690 FET/PLAC PROB NOS-UNSPEC
65691 FET/PLAC PROB NOS-DELIV
65693 FET/PLAC PROB NOS-ANTEPA
65700 POLYHYDRAMNIOS-UNSPEC
65701 POLYHYDRAMNIOS-DELIVERED
65703 POLYHYDRAMNIOS-ANTEPART
65800 OLIGOHYDRAMNIOS-UNSPEC
65801 OLIGOHYDRAMNIOS-DELIVER
65803 OLIGOHYDRAMNIOS-ANTEPAR
65810 PREM RUPT MEMBRAN-UNSPEC
65811 PREM RUPT MEMBRAN-DELIV
65813 PREM RUPT MEMB-ANTEPART
65820 PROLONG RUPT MEMB-UNSPEC
65821 PROLONG RUPT MEMB-DELIV
65823 PROLONG RUP MEMB-ANTEPAR
65830 ARTIFIC RUPT MEMBR-UNSP
65831 ARTIFIC RUPT MEMBR-DELIV
65833 ARTIF RUPT MEMB-ANTEPART
65840 AMNIOTIC INFECTION-UNSP
65841 AMNIOTIC INFECTION-DELIV
65843 AMNIOTIC INFECT-ANTEPART
65880 AMNIOTIC PROB NEC-UNSPEC
65881 AMNIOTIC PROB NEC-DELIV
65883 AMNION PROB NEC-ANTEPART
65890 AMNIOTIC PROB NOS-UNSPEC
65891 AMNIOTIC PROB NOS-DELIV
65893 AMNION PROB NOS-ANTEPART
65900 FAIL MECHAN INDUCT-UNSP
65901 FAIL MECH INDUCT-DELIVER
65903 FAIL MECH INDUCT-ANTEPAR
65910 FAIL INDUCTION NOS-UNSP
65911 FAIL INDUCTION NOS-DELIV
65913 FAIL INDUCT NOS-ANTEPART
65920 PYREXIA IN LABOR-UNSPEC
65921 PYREXIA IN LABOR-DELIVER
65923 PYREXIA IN LABOR-ANTEPAR
65930 SEPTICEMIA IN LABOR-UNSP
65931 SEPTICEM IN LABOR-DELIV
65933 SEPTICEM IN LABOR-ANTEPA
65940 GRAND MULTIPARITY-UNSPEC
65941 GRAND MULTIPARITY-DELIV
65943 GRAND MULTIPARITY-ANTEPA

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

65950 ELDERLY PRIMIGRAVID-UNSP
65951 ELDERLY PRIMIGRAVIDA-DEL
65953 ELDER PRIMIGRAVID-ANTEPA
65980 COMPLIC LABOR NEC-UNSP
65981 COMPLIC LABOR NEC-DELIV
65983 COMPL LABOR NEC-ANTEPART
65990 COMPLIC LABOR NOS-UNSP
65991 COMPLIC LABOR NOS-DELIV
65993 COMPL LABOR NOS-ANTEPART
66000 OBSTRUCT/FET MALPOS-UNSP
66001 OBSTRUC/FET MALPOS-DELIV
66003 OBSTRUC/FET MALPOS-ANTEP
66010 BONY PELV OBSTRUC-UNSPEC
66011 BONY PELV OBSTRUCT-DELIV
66013 BONY PELV OBSTRUC-ANTEPA
66020 ABN PELV TISS OBSTR-UNSP
66021 ABN PELV TIS OBSTR-DELIV
66023 ABN PELV TIS OBSTR-ANTEP
66030 PERSIST OCCIPITPOST-UNSP
66031 PERSIST OCCIPTPOST-DELIV
66033 PERSIST OCCIPTPOST-ANTEP
66040 SHOULDER DYSTOCIA-UNSPEC
66041 SHOULDER DYSTOCIA-DELIV
66043 SHOULDER DYSTOCIA-ANTEPA
66050 LOCKED TWINS-UNSPECIFIED
66051 LOCKED TWINS-DELIVERED
66053 LOCKED TWINS-ANTEPARTUM
66060 FAIL TRIAL LAB NOS-UNSP
66061 FAIL TRIAL LAB NOS-DELIV
66063 FAIL TRIAL LAB NOS-ANTEP
66070 FAILED FORCEP NOS-UNSPEC
66071 FAILED FORCEPS NOS-DELIV
66073 FAIL FORCEPS NOS-ANTEPAR
66080 OBSTRUC LABOR NEC-UNSPEC
66081 OBSTRUCT LABOR NEC-DELIV
66083 OBSTRUC LABOR NEC-ANTEPA
66090 OBSTRUC LABOR NOS-UNSPEC
66091 OBSTRUCT LABOR NOS-DELIV
66093 OBSTRUC LABOR NOS-ANTEPA
66100 PRIM UTERINE INERT-UNSP
66101 PRIM UTERINE INERT-DELIV
66103 PRIM UTER INERT-ANTEPART
66110 SEC UTERINE INERT-UNSPEC
66111 SEC UTERINE INERT-DELIV
66113 SEC UTERINE INERT-ANTEPA
66120 UTERINE INERTIA NEC-UNSP
66121 UTERINE INERT NEC-DELIV
66123 UTERINE INERT NEC-ANTEPA
66130 PRECIPITATE LABOR-UNSPEC
66131 PRECIPITATE LABOR-DELIV
66133 PRECIPITATE LABOR-ANTEPA
66140 UTER DYSTOCIA NOS-UNSPEC
66141 UTER DYSTOCIA NOS-DELIV
66143 UTER DYSTOCIA NOS-ANTEPA
66190 ABNORMAL LABOR NOS-UNSP
66191 ABNORMAL LABOR NOS-DELIV
66193 ABNORM LABOR NOS-ANTEPAR
66200 PROLONGED 1ST STAGE-UNSP
66201 PROLONG 1ST STAGE-DELIV
66203 PROLONG 1ST STAGE-ANTEPA
66210 PROLONGED LABOR NOS-UNSP
66211 PROLONG LABOR NOS-DELIV
66213 PROLONG LABOR NOS-ANTEPA
66220 PROLONGED 2ND STAGE-UNSP
66221 PROLONG 2ND STAGE-DELIV
66223 PROLONG 2ND STAGE-ANTEPA
66230 DELAY DEL 2ND TWIN-UNSP
66231 DELAY DEL 2ND TWIN-DELIV
66233 DELAY DEL 2 TWIN-ANTEPAR
66300 CORD PROLAPSE-UNSPEC
66301 CORD PROLAPSE-DELIVERED
66303 CORD PROLAPSE-ANTEPARTUM
66310 CORD AROUND NECK-UNSPEC
66311 CORD AROUND NECK-DELIVER
66313 CORD AROUND NECK-ANTEPAR
66320 CORD COMPRESS NEC-UNSPEC
66321 CORD COMPRESS NEC-DELIV
66323 CORD COMPRES NEC-ANTEPAR
66330 CORD ENTANGLE NEC-UNSPEC
66331 CORD ENTANGLE NEC-DELIV
66333 CORD ENTANGL NEC-ANTEPAR
66340 SHORT CORD-UNSPECIFIED
66341 SHORT CORD-DELIVERED
66343 SHORT CORD-ANTEPARTUM
66350 VASA PREVIA-UNSPECIFIED
66351 VASA PREVIA-DELIVERED
66353 VASA PREVIA-ANTEPARTUM
66360 VASC LESION CORD-UNSPEC
66361 VASC LESION CORD-DELIVER
66363 VASC LESION CORD-ANTEPAR
66380 CORD COMPLICAT NEC-UNSP
66381 CORD COMPLICAT NEC-DELIV
66383 CORD COMPL NEC-ANTEPART
66390 CORD COMPLICAT NOS-UNSP
66391 CORD COMPLICAT NOS-DELIV
66393 CORD COMPL NOS-ANTEPART
66400 DEL W 1 DEG LACERAT-UNSP
66401 DEL W 1 DEG LACERAT-DEL
66404 DEL W 1 DEG LAC-POSTPART
66410 DEL W 2 DEG LACERAT-UNSP

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

66411 DEL W 2 DEG LACERAT-DEL
66414 DEL W 2 DEG LAC-POSTPART
66420 DEL W 3 DEG LACERAT-UNSP
66421 DEL W 3 DEG LACERAT-DEL
66424 DEL W 3 DEG LAC-POSTPART
66430 DEL W 4 DEG LACERAT-UNSP
66431 DEL W 4 DEG LACERAT-DEL
66434 DEL W 4 DEG LAC-POSTPART
66440 OB PERINEAL LAC NOS-UNSP
66441 OB PERINEAL LAC NOS-DEL
66444 PERINEAL LAC NOS-POSTPAR
66450 OB PERINEAL HEMATOM-UNSP
66451 OB PERINEAL HEMATOMA-DEL
66454 PERIN HEMATOMA-POSTPART
66480 OB PERIN TRAUM NEC-UNSP
66481 OB PERINEAL TRAU NEC-DEL
66484 PERIN TRAUM NEC-POSTPART
66490 OB PERIN TRAUM NOS-UNSP
66491 OB PERINEAL TRAU NOS-DEL
66494 PERIN TRAUM NOS-POSTPART
66500 PRELABOR RUPT UTER-UNSP
66501 PRELABOR RUPT UTERUS-DEL
66503 PRELAB RUPT UTER-ANTEPAR
66510 RUPTURE UTERUS NOS-UNSP
66511 RUPTURE UTERUS NOS-DELIV
66512 RUPT UTER NOS-DEL W P/P
66514 RUPT UTERUS NOS-POSTPART
66520 INVERSION OF UTERUS-UNSP
66522 INVERS UTERUS-DEL W P/P
66524 INVERS UTERUS-POSTPART
66530 LACERAT OF CERVIX-UNSPEC
66531 LACERAT OF CERVIX-DELIV
66534 LACER OF CERVIX-POSTPART
66540 HIGH VAGINAL LACER-UNSP
66541 HIGH VAGINAL LACER-DELIV
66544 HIGH VAGINAL LAC-POSTPAR
66550 OB INJ PELV ORG NEC-UNSP
66551 OB INJ PELV ORG NEC-DEL
66554 INJ PELV ORG NEC-POSTPAR
66560 DAMAGE TO PELVIC JT-UNSP
66561 DAMAGE TO PELVIC JT-DEL
66564 DAMAGE PELVIC JT-POSTPAR
66570 OB PELVIC HEMATOMA-UNSP
66571 OB PELVIC HEMATOMA-DELIV
66572 PELVIC HEMATOM-DEL W PP
66574 PELVIC HEMATOMA-POSTPART
66580 OB TRAUMA NEC-UNSPEC
66581 OB TRAUMA NEC-DELIVERED
66582 OB TRAUMA NEC-DEL W P/P
66583 OB TRAUMA NEC-ANTEPARTUM
66584 OB TRAUMA NEC-POSTPARTUM
66590 OB TRAUMA NOS-UNSPEC
66591 OB TRAUMA NOS-DELIVERED
66592 OB TRAUMA NOS-DEL W P/P
66593 OB TRAUMA NOS-ANTEPARTUM
66594 OB TRAUMA NOS-POSTPARTUM
66600 THIRD-STAGE HEM-UNSPEC
66602 THRD-STAGE HEM-DEL W P/P
66604 THIRD-STAGE HEM-POSTPART
66610 POSTPARTUM HEM NEC-UNSP
66612 POSTPA HEM NEC-DEL W P/P
66614 POSTPART HEM NEC-POSTPAR
66620 DELAY P/PART HEM-UNSPEC
66622 DELAY P/P HEM-DEL W P/P
66624 DELAY P/PART HEM-POSTPAR
66630 POSTPART COAGUL DEF-UNSP
66632 P/P COAG DEF-DEL W P/P
66634 POSTPART COAG DEF-POSTPA
66700 RETAIN PLACENTA NOS-UNSP
66702 RETND PLAC NOS-DEL W P/P
66704 RETAIN PLAC NOS-POSTPART
66710 RETAIN PROD CONCEPT-UNSP
66712 RET PROD CONC-DEL W P/P
66714 RET PROD CONCEPT-POSTPAR
66800 PULM COMPL IN DEL-UNSPEC
66801 PULM COMPL IN DEL-DELIV
66802 PULM COMPLIC-DEL W P/P
66803 PULM COMPLICAT-ANTEPART
66804 PULM COMPLICAT-POSTPART
66810 HEART COMPL IN DEL-UNSP
66811 HEART COMPL IN DEL-DELIV
66812 HEART COMPL-DEL W P/P
66813 HEART COMPLIC-ANTEPART
66814 HEART COMPLIC-POSTPART
66820 CNS COMPL LABOR/DEL-UNSP
66821 CNS COMPL LAB/DEL-DELIV
66822 CNS COMPLIC-DEL W P/P
66823 CNS COMPL IN DEL-ANTEPAR
66824 CNS COMPL IN DEL-POSTPAR
66880 ANESTH COMP DEL NEC-UNSP
66881 ANESTH COMPL NEC-DELIVER
66882 ANESTH COMPL NEC-DEL P/P
66883 ANESTH COMPL ANTEPARTUM
66884 ANESTH COMPL-POSTPARTUM
66890 ANESTH COMP DEL NOS-UNSP
66891 ANESTH COMPL NOS-DELIVER
66892 ANESTH COMPL NOS-DEL P/P
66893 ANESTH COMPL-ANTEPARTUM
66894 ANESTH COMPL-POSTPARTUM
66900 MATERNAL DISTRESS-UNSPEC

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

66901 MATERNAL DISTRESS-DELIV
66902 MATERN DISTRES-DEL W P/P
66903 MATERN DISTRESS-ANTEPAR
66904 MATERN DISTRESS-POSTPART
66910 OBSTETRIC SHOCK-UNSPEC
66911 OBSTETRIC SHOCK-DELIVER
66912 OBSTET SHOCK-DELIV W P/P
66913 OBSTETRIC SHOCK-ANTEPAR
66914 OBSTETRIC SHOCK-POSTPART
66920 MATERN HYPOTENS SYN-UNSP
66921 MATERN HYPOTEN SYN-DELIV
66922 MATERN HYPOTEN-DEL W P/P
66923 MATERN HYPOTENS-ANTEPAR
66924 MATERN HYPOTENS-POSTPART
66930 AC REN FAIL W DELIV-UNSP
66932 AC REN FAIL-DELIV W P/P
66934 AC RENAL FAILURE-POSTPAR
66940 OTH OB SURG COMPL-UNSPEC
66941 OTH OB COMPL-DELIVERED
66942 OTH OB COMPL-DELIV W P/P
66944 OTH OB SURG COMPL-POSTPA
66950 FORCEP DELIV NOS-UNSPEC
66951 FORCEP DELIV NOS-DELIVER
66960 BREECH EXTR NOS-UNSPEC
66961 BREECH EXTR NOS-DELIVER
66970 CESAREAN DELIV NOS-UNSP
66971 CESAREAN DELIVERY NOS
66980 COMPL LAB/DELIV NEC-UNSP
66981 COMP LAB/DELIV NEC-DELIV
66982 COMPL DEL NEC-DEL W P/P
66983 COMPL DELIV NEC-ANTEPAR
66984 COMPL DELIV NEC-POSTPART
66990 COMPL LAB/DELIV NOS-UNSP
66991 COMP LAB/DELIV NOS-DELIV
66992 COMPL DEL NOS-DEL W P/P
66993 COMPL DELIV NOS-ANTEPAR
66994 COMPL DELIV NOS-POSTPART
67000 MAJOR PUERP INFECT-UNSP
67002 MAJOR PUERP INF-DEL P/P
67004 MAJOR PUERP INF-POSTPART
67100 VARIC VEIN LEG PREG-UNSP
67101 VARICOSE VEIN LEG-DELIV
67102 VARIC VEIN LEG-DEL W P/P
67103 VARIC VEIN LEG-ANTEPART
67104 VARIC VEIN LEG-POSTPART
67110 VARIC VULVA PREG-UNSPEC
67111 VARICOSE VULVA-DELIVERED
67112 VARICOSE VULVA-DEL W P/P
67113 VARICOSE VULVA-ANTEPART
67114 VARICOSE VULVA-POSTPART
67120 THROMBOPHLEB PREG-UNSPEC
67121 THROMBOPHLEBITIS-DELIVER
67122 THROMBOPHLEB-DELIV W P/P
67123 THROMBOPHLEBIT-ANTEPART
67124 THROMBOPHLEBIT-POSTPART
67130 DEEP THROMB ANTEPAR-UNSP
67131 DEEP THROM ANTEPAR-DELIV
67133 DEEP VEIN THROMB-ANTEPAR
67140 DEEP THROMB POSTPAR-UNSP
67142 THROMB POSTPAR-DEL W P/P
67144 DEEP VEIN THROMB-POSTPAR
67150 THROMBOSIS NEC PREG-UNSP
67151 THROMBOSIS NEC-DELIVERED
67152 THROMB NEC-DELIV W P/P
67153 THROMBOSIS NEC-ANTEPART
67154 THROMBOSIS NEC-POSTPART
67180 VEN COMPL PREG NEC-UNSP
67181 VENOUS COMPL NEC-DELIVER
67182 VEN COMP NEC-DELIV W P/P
67183 VENOUS COMPL NEC-ANTEPAR
67184 VENOUS COMPL NEC-POSTPAR
67190 VEN COMPL PREG NOS-UNSP
67191 VENOUS COMPL NOS-DELIVER
67192 VEN COMP NOS-DELIV W P/P
67193 VENOUS COMPL NOS-ANTEPAR
67194 VENOUS COMPL NOS-POSTPAR
67200 PUERPERAL PYREXIA-UNSPEC
67202 PUERP PYREXIA-DEL W P/P
67204 PUERP PYREXIA-POSTPARTUM
67300 OB AIR EMBOLISM-UNSPEC
67301 OB AIR EMBOLISM-DELIVER
67302 OB AIR EMBOL-DELIV W P/P
67303 OB AIR EMBOLISM-ANTEPART
67304 OB AIR EMBOLISM-POSTPART
67310 AMNIOTIC EMBOLISM-UNSPEC
67311 AMNIOTIC EMBOLISM-DELIV
67312 AMNIOT EMBOL-DELIV W P/P
67313 AMNIOTIC EMBOL-ANTEPART
67314 AMNIOTIC EMBOL-POSTPART
67320 OB PULM EMBOL NOS-UNSPEC
67321 PULM EMBOL NOS-DELIVERED
67322 PULM EMBOL NOS-DEL W P/P
67323 PULM EMBOL NOS-ANTEPART
67324 PULM EMBOL NOS-POSTPART
67330 OB PYEMIC EMBOL-UNSPEC
67331 OB PYEMIC EMBOL-DELIVER
67332 OB PYEM EMBOL-DEL W P/P
67333 OB PYEMIC EMBOL-ANTEPART
67334 OB PYEMIC EMBOL-POSTPART
67380 OB PULMON EMBOL NEC-UNSP

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

67381 PULMON EMBOL NEC-DELIVER
67382 PULM EMBOL NEC-DEL W P/P
67383 PULMON EMBOL NEC-ANTEPAR
67384 PULMON EMBOL NEC-POSTPAR
67400 PUERP CEREBVASC DIS-UNSP
67401 PUERP CEREBVAS DIS-DELIV
67402 CEREBVAS DIS-DELIV W P/P
67403 CEREBROVASC DIS-ANTEPART
67404 CEREBROVASC DIS-POSTPART
67410 DISRUPT C-SECT WND-UNSP
67412 DISRUPT C-SECT-DEL W P/P
67414 DISRUPT C-SECT-POSTPART
67420 DISRUPT PERINEUM-UNSPEC
67422 DISRUPT PERIN-DEL W P/P
67424 DISRUPT PERINEUM-POSTPAR
67430 OB SURG COMPL NEC-UNSPEC
67432 OB SURG COMPL-DEL W P/P
67434 OB SURG COMP NEC-POSTPAR
67440 PLACENTAL POLYP-UNSPEC
67442 PLACENT POLYP-DEL W P/P
67444 PLACENTAL POLYP-POSTPART
67480 PUERP COMPL NEC-UNSPEC
67482 PUERP COMP NEC-DEL W P/P
67484 PUERP COMPL NEC-POSTPART
67490 PUERP COMPL NOS-UNSPEC
67492 PUERP COMP NOS-DEL W P/P
67494 PUERP COMPL NOS-POSTPART
67500 INFECT NIPPLE PREG-UNSP
67501 INFECT NIPPLE-DELIVERED
67502 INFECT NIPPLE-DEL W P/P
67503 INFECT NIPPLE-ANTEPARTUM
67504 INFECT NIPPLE-POSTPARTUM
67510 BREAST ABSCESS PREG-UNSP
67511 BREAST ABSCESS-DELIVERED
67512 BREAST ABSCESS-DEL W P/P
67513 BREAST ABSCESS-ANTEPART
67514 BREAST ABSCESS-POSTPART
67520 MASTITIS IN PREG-UNSPEC
67521 MASTITIS-DELIVERED
67522 MASTITIS-DELIV W P/P
67523 MASTITIS-ANTEPARTUM
67524 MASTITIS-POSTPARTUM
67580 BREAST INF PREG NEC-UNSP
67581 BREAST INFECT NEC-DELIV
67582 BREAST INF NEC-DEL W P/P
67583 BREAST INF NEC-ANTEPART
67584 BREAST INF NEC-POSTPART
67590 BREAST INF PREG NOS-UNSP
67591 BREAST INFECT NOS-DELIV
67592 BREAST INF NOS-DEL W P/P
67593 BREAST INF NOS-ANTEPART
67594 BREAST INF NOS-POSTPART
67600 RETRACT NIPPLE PREG-UNSP
67601 RETRACTED NIPPLE-DELIVER
67602 RETRACT NIPPLE-DEL W P/P
67603 RETRACT NIPPLE-ANTEPART
67604 RETRACT NIPPLE-POSTPART
67610 CRACKED NIPPLE PREG-UNSP
67611 CRACKED NIPPLE-DELIVERED
67612 CRACKED NIPPLE-DEL W P/P
67613 CRACKED NIPPLE-ANTEPART
67614 CRACKED NIPPLE-POSTPART
67620 BREAST ENGORGE-UNSPEC
67621 BREAST ENGORGE-DELIVERED
67622 BREAST ENGORGE-DEL W P/P
67623 BREAST ENGORGE-ANTEPART
67624 BREAST ENGORGE-POSTPART
67630 BREAST DIS PREG NEC-UNSP
67631 BREAST DIS NEC-DELIVERED
67632 BREAST DIS NEC-DEL W P/P
67633 BREAST DIS NEC-ANTEPART
67634 BREAST DIS NEC-POSTPART
67640 LACTATION FAIL-UNSPEC
67641 LACTATION FAIL-DELIVERED
67642 LACTATION FAIL-DEL W P/P
67643 LACTATION FAIL-ANTEPART
67644 LACTATION FAIL-POSTPART
67650 SUPPR LACTATION-UNSPEC
67651 SUPPR LACTATION-DELIVER
67652 SUPPR LACTAT-DEL W P/P
67653 SUPPR LACTATION-ANTEPAR
67654 SUPPR LACTATION-POSTPART
67660 GALACTORRHEA PREG-UNSPEC
67661 GALACTORRHEA-DELIVERED
67662 GALACTORRHEA-DEL W P/P
67663 GALACTORRHEA-ANTEPARTUM
67664 GALACTORRHEA-POSTPARTUM
67680 LACTATION DIS NEC-UNSPEC
67681 LACTATION DIS NEC-DELIV
67682 LACTAT DIS NEC-DEL W P/P
67683 LACTAT DIS NEC-ANTEPART
67684 LACTAT DIS NEC-POSTPART
67690 LACTATION DIS NOS-UNSPEC
67691 LACTATION DIS NOS-DELIV
67692 LACTAT DIS NOS-DEL W P/P
67693 LACTAT DIS NOS-ANTEPART
67694 LACTAT DIS NOS-POSTPART
7923 ABN FIND-AMNIOTIC FLUID
V230 PREG W HX OF INFERTILITY
V231 PREG W HX-TROPHOBLAS DIS

MATERNITY DIAGNOSES - AGE 12 THROUGH 55

V232	PREG W HX OF ABORTION
V233	GRAND MULTIPARITY
V234	PREG W POOR OBSTETRIC HX
V235	PREG W POOR REPRODUCT HX
V238	SUPRV HIGH-RISK PREG NEC
V239	SUPRV HIGH-RISK PREG NOS
V240	POSTPART CARE AFTER DEL
V270	DELIVER-SINGLE LIVEBORN
V271	DELIVER-SINGLE STILLBORN
V272	DELIVER-TWINS, BOTH LIVE
V273	DEL-TWINS, 1 NB, 1 SB
V274	DELIVER-TWINS, BOTH SB
V275	DEL-MULT BIRTH, ALL LIVE
V276	DEL-MULT BRTH, SOME LIVE
V277	DEL-MULT BIRTH, ALL SB
V279	OUTCOME OF DELIVERY NOS
V280	SCREENING-CHROMOSOM ANOM
V281	SCREEN-ALPHAFETOPROTEIN
V282	SCREEN BY AMNIOCENT NEC
V616	ILLEGITIMATE PREGNANCY
V617	UNWANTED PREGNANCY NEC

ADULT DIAGNOSES - AGE GREATER THAN 14

2900	SENILE DEMENTIA UNCOMP
29010	PRESENILE DEMENTIA
29011	PRESENILE DELIRIUM
29013	PRESENILE DEPRESSION
29020	SENILE DELUSION
29021	SENILE DEPRESSIVE
2903	SENILE DELIRIUM
29040	ARTERIOSCLER DEMENT NOS
29041	ARTERIOSCLER DELIRIUM
29042	ARTERIOSCLER DELUSION
2909	SENILE PSYCHOT COND NOS
30285	GENDER IDENT DIS, ADULT
33520	AMYOTROPHIC SCLEROSIS
340	MULTIPLE SCLEROSIS
36610	SENILE CATARACT NOS
36619	SENILE CATARACT NEC
37401	SENILE ENTROPION
37411	SENILE ECTROPION
4100	AMI ANTEROLATERAL WALL
4101	AMI ANTERIOR WALL NEC
4102	AMI INFEROLATERAL WALL
4103	AMI INFEROPOSTERIOR WALL
4104	AMI INFERIOR WALL NEC
4105	AMI LATERAL WALL NEC
4106	TRUE POSTERIOR INFARCT
4107	SUBENDOCARDIAL INFARCT
4108	MYOCARDIAL INFARCT NEC
4109	MYOCARDIAL INFARCT NOS
4110	POST MI SYNDROME
4111	INTERMED CORONARY SYND
4118	AC ISCHEMIC HRT DIS NEC
412	OLD MYOCARDIAL INFARCT
4130	ANGINA DECUBITUS
4131	PRINZMETAL ANGINA
4139	ANGINA PECTORIS NEC/NOS
4140	CORONARY ATHEROSCLEROSIS
4292	ASCVD
4330	BASILAR ARTERY OCCLUSION
4331	CAROTID ARTERY OCCLUSION
4332	VERTEBRAL ART OCCLUSION
4333	MULT PRECEREB OCCLUSION
4338	PRECEREB OCCLUSION NEC
4339	PRECEREB OCCLUSION NOS
4340	CEREBRAL THROMBOSIS
4341	CEREBRAL EMBOLISM
4349	CEREBR ARTERY OCCLUS NOS
4358	TRANS CEREB ISCHEMIA NEC
4359	TRANS CEREB ISCHEMIA NOS
436	CVA
4370	CEREBRAL ATHEROSCLEROSIS
4400	AORTIC ATHEROSCLEROSIS
4401	RENAL ARTERY ATHEROSCLER
4402	ATHEROSCLEROS-EXTREMITY
4408	ATHEROSCLEROSIS NEC
4409	ATHEROSCLEROSIS NOS
4410	DISSECTING ANEURYSM
4411	RUPTUR THORACIC ANEURYSM
4412	THORACIC AORTIC ANEURYSM
4413	RUPT ABD AORTIC ANEURYSM
4414	ABDOM AORTIC ANEURYSM
4415	RUPT AORTIC ANEURYSM NOS
4419	AORTIC ANEURYSM NOS
4420	UPPER EXTREMITY ANEURYSM
4421	RENAL ARTERY ANEURYSM
4422	ILIAC ARTERY ANEURYSM
4423	LOWER EXTREMITY ANEURYSM
44281	ANEURYSM OF NECK
44282	SUBCLAVIAN ANEURYSM
44283	SPLENIC ARTERY ANEURYSM
44284	VISCERAL ANEURYSM NEC
44289	ANEURYSM NEC
4429	ANEURYSM NOS
4540	LEG VARICOSITY W ULCER
4541	LEG VARICOSITY W INFLAM
4542	VARICOS LEG ULCER/INFLAM
4549	VARICOSE VEIN OF LEG NOS
4570	POSTMASTECT LYMPHEDEMA
496	CHR AIRWAY OBSTRUCT NEC
500	COAL WORKERS' PNEUMOCON
501	ASBESTOSIS
5710	ALCOHOLIC FATTY LIVER
5711	AC ALCOHOLIC HEPATITIS
5712	ALCOHOL CIRRHOSIS LIVER
5713	ALCOHOL LIVER DAMAGE NOS
57400	CHOLELITH W AC CHOLECYST
57401	CHOLELITH/AC GB INF-OBST
57410	CHOLELITH W CHOLECYS NEC
57411	CHOLELITH/GB INF NEC-OBS
57420	CHOLELITHIASIS NOS
57421	CHOLELITHIAS NOS W OBSTR
57430	CHOLEDOCHOLITH/AC GB INF
57431	CHOLEDOCHLITH/AC GB-OBST
57440	CHOLEDOCHLITH/GB INF NEC
57441	CHOLEDOCHLITH/GB NEC-OBS
57450	CHOLEDOCHOLITHIASIS NOS
57451	CHOLEDOCHLITH NOS W OBST
5750	ACUTE CHOLECYSTITIS
5751	CHOLECYSTITIS NEC
5752	OBSTRUCTION GALLBLADDER
5753	HYDROPS OF GALLBLADDER

ADULT DIAGNOSES - AGE GREATER THAN 14

5760	POSTCHOLECYSTECTOMY SYND
5770	ACUTE PANCREATITIS
5771	CHRONIC PANCREATITIS
5772	PANCREAT CYST/PSEUDOCYST
600	HYPERPLASIA OF PROSTATE
6010	ACUTE PROSTATITIS
6011	CHRONIC PROSTATITIS
6012	ABSCESS OF PROSTATE
6013	PROSTATOCYSTITIS
6018	PROSTATIC INFLAM DIS NEC
6019	PROSTATITIS NOS
6020	CALCULUS OF PROSTATE
6021	PROSTATIC CONGEST/HEMORR
6028	PROSTATIC DISORDERS NEC
6060	AZOOSPERMIA
6061	OLIGOSPERMIA
6068	MALE INFERTILITY NEC
6069	MALE INFERTILITY NOS
60784	IMPOTENCE, ORGANIC ORIGN
6101	DIFFUS CYSTIC MASTOPATHY
7220	CERVICAL DISC DISPLACMNT
72210	LUMBAR DISC DISPLACEMENT
72211	THORACIC DISC DISPLACMNT
7222	DISC DISPLACEMENT NOS
72232	SCHMORLS NODE-LUMBAR
7224	CERVICAL DISC DEGEN
72251	THORACIC DISC DEGEN
72252	LUMB/LUMBOSAC DISC DEGEN
7226	DISC DEGENERATION NOS
72270	DISC DIS W MYELOPATH NOS
72271	CERV DISC DIS W MYELOPAT
72272	THOR DISC DIS W MYELOPAT
72273	LUMB DISC DIS W MYELOPAT
72280	POSTLAMINECTOMY SYND NOS
72281	POSTLAMINECT SYND-CERV
72282	POSTLAMINECT SYND-THORAC
72283	POSTLAMINECT SYND-LUMBAR
72290	DISC DIS NEC/NOS-UNSPEC
72291	DISC DIS NEC/NOS-CERV
72293	DISC DIS NEC/NOS-LUMBAR
72400	SPINAL STENOSIS NOS
72401	SPINAL STENOSIS-THORACIC
72402	SPINAL STENOSIS-LUMBAR
72409	SPINAL STENOSIS-OTH SITE
7286	CONTRACTED PALMAR FASCIA
99581	ADULT MALTREATMENT SYND
V7101	OBSV-ADULT ANTISOC BEHAV

DIAGNOSES ALLOWED FOR FEMALES ONLY

01660	TB OVARY & TUBE-UNSPEC
01661	TB OVARY & TUBE-NO EXAM
01662	TB OVARY/TUBE-EXAM UNKN
01663	TB OVARY & TUBE-MICRO DX
0166[illegible]	TB OVARY & TUBE-CULT DX
01665	TB OVARY & TUBE-HISTO DX
01666	TB OVARY & TUBE-OTH TEST
01670	TB FEMALE GEN NEC-UNSPEC
01671	TB FEM GEN NEC-NO EXAM
01672	TB FEM GEN NEC-EXAM UNKN
01673	TB FEM GEN NEC-MICRO DX
01674	TB FEM GEN NEC-CULT DX
01675	TB FEM GEN NEC-HISTO DX
01676	TB FEM GEN NEC-OTH TEST
05411	HERPETIC VULVOVAGINITIS
05412	HERPETIC ULCER OF VULVA
09815	GC CERVICITIS (ACUTE)
09816	GC ENDOMETRITIS (ACUTE)
09817	ACUTE GC SALPINGITIS
09835	GC CERVICITIS, CHRONIC
09836	GC ENDOMETRITIS, CHRONIC
09837	GC SALPINGITIS (CHRONIC)
1121	CANDIDAL VULVOVAGINITIS
13101	TRICHOMONAL VAGINITIS
1740	MALIG NEO NIPPLE
1741	MAL NEO BREAST-CENTRAL
1742	MAL NEO BREAST UP-INNER
1743	MAL NEO BREAST LOW-INNER
1744	MAL NEO BREAST UP-OUTER
1745	MAL NEO BREAST LOW-OUTER
1746	MAL NEO BREAST-AXILLARY
1748	MALIGN NEOPL BREAST NEC
1749	MALIGN NEOPL BREAST NOS
179	MALIG NEOPL UTERUS NOS
1800	MALIG NEO ENDOCERVIX
1801	MALIG NEO EXOCERVIX
1808	MALIG NEO CERVIX NEC
1809	MAL NEO CERVIX UTERI NOS
181	MALIGNANT NEOPL PLACENTA
1820	MALIG NEO CORPUS UTERI
1821	MAL NEO UTERINE ISTHMUS
1828	MAL NEO BODY UTERUS NEC
1830	MALIGN NEOPL OVARY
1832	MAL NEO FALLOPIAN TUBE
1833	MAL NEO BROAD LIGAMENT
1834	MALIG NEO PARAMETRIUM
1835	MAL NEO ROUND LIGAMENT
1838	MAL NEO ADNEXA NEC
1839	MAL NEO ADNEXA NOS
1840	MALIGN NEOPL VAGINA
1841	MAL NEO LABIA MAJORA
1842	MAL NEO LABIA MINORA
1843	MALIGN NEOPL CLITORIS
1844	MALIGN NEOPL VULVA NOS
1848	MAL NEO FEMALE GENIT NEC
1849	MAL NEO FEMALE GENIT NOS
1986	SECOND MALIG NEO OVARY
2180	SUBMUCOUS LEIOMYOMA
2181	INTRAMURAL LEIOMYOMA
2182	SUBSEROUS LEIOMYOMA
2189	UTERINE LEIOMYOMA NOS
2190	BENIGN NEO CERVIX UTERI
2191	BENIGN NEO CORPUS UTERI
2198	BENIGN NEO UTERUS NEC
2199	BENIGN NEO UTERUS NOS
220	BENIGN NEOPLASM OVARY
2210	BEN NEO FALLOPIAN TUBE
2211	BENIGN NEOPLASM VAGINA
2212	BENIGN NEOPLASM VULVA
2218	BEN NEO FEM GENITAL NEC
2219	BEN NEO FEM GENITAL NOS
2331	CA IN SITU CERVIX UTERI
2332	CA IN SITU UTERUS NEC
2333	CA IN SITU FEM GEN NEC
2360	UNCERT BEHAV NEO UTERUS
2361	UNC BEHAV NEO PLACENTA
2362	UNC BEHAV NEO OVARY
2363	UNC BEHAV NEO FEMALE NEC
2560	HYPERESTROGENISM
2561	OVARIAN HYPERFUNC NEC
2562	POSTABLATIV OVARIAN FAIL
2563	OVARIAN FAILURE NEC
2564	POLYCYSTIC OVARIES
2568	OVARIAN DYSFUNCTION NEC
2569	OVARIAN DYSFUNCTION NOS
30273	INHIBITED FEMALE ORGASM
30276	FUNCTIONAL DYSPAREUNIA
30651	PSYCHOGENIC VAGINISMUS
30652	PSYCHOGENIC DYSMENORRHEA
4566	VULVAL VARICES
6140	AC SALPINGO-OOPHORITIS
6141	CHR SALPINGO-OOPHORITIS
6142	SALPINGO-OOPHORITIS NOS
6143	ACUTE PARAMETRITIS
6144	CHRONIC PARAMETRITIS
6145	AC PELV PERITONITIS-FEM
6146	FEM PELVIC PERITON ADHES
6147	CHR PELV PERITON NEC-FEM
6148	FEM PELV INFLAM DIS NEC
6149	FEM PELV INFLAM DIS NOS

DIAGNOSES ALLOWED FOR FEMALES ONLY

6150 AC UTERINE INFLAMMATION
6151 CHR UTERINE INFLAMMATION
6159 UTERINE INFLAM DIS NOS
6160 CERVICITIS
61610 VAGINITIS NOS
61611 VAGINITIS IN OTH DISEASE
6162 BARTHOLIN'S GLAND CYST
6163 BARTHOLIN'S GLND ABSCESS
6164 ABSCESS OF VULVA NEC
61650 ULCERATION OF VULVA NOS
61651 VULVAR ULCER IN OTH DIS
6168 FEMALE GEN INFLAM NEC
6169 FEMALE GEN INFLAM NOS
6170 UTERINE ENDOMETRIOSIS
6171 OVARIAN ENDOMETRIOSIS
6172 TUBAL ENDOMETRIOSIS
6173 PELV PERIT ENDOMETRIOSIS
6174 VAGINAL ENDOMETRIOSIS
6175 INTESTINAL ENDOMETRIOSIS
6176 ENDOMETRIOSIS IN SCAR
6178 ENDOMETRIOSIS NEC
6179 ENDOMETRIOSIS NOS
6180 PROLAPSE OF VAGINAL WALL
6181 UTERINE PROLAPSE
6182 UTEROVAG PROLAPS-INCOMPL
6183 UTEROVAG PROLAPS-COMPLET
6184 UTERVAGINAL PROLAPSE NOS
6185 POSTOP VAGINAL PROLAPSE
6186 VAGINAL ENTEROCELE
6187 OLD LACER PELVIC MUSCLE
6188 GENITAL PROLAPSE NEC
6189 GENITAL PROLAPSE NOS
6190 URIN-GENITAL FISTUL, FEM
6191 DIGEST-GENIT FISTUL, FEM
6192 GENITAL-SKIN FISTUL, FEM
6198 FEM GENITAL FISTULA NEC
6199 FEM GENITAL FISTULA NOS
6200 FOLLICULAR CYST OF OVARY
6201 CORPUS LUTEUM CYST
6202 OVARIAN CYST NEC/NOS
6203 ACQ ATROPHY OVARY & TUBE
6204 PROLAPSE OF OVARY & TUBE
6205 TORSION OF OVARY OR TUBE
6206 BROAD LIGAMENT LACER SYN
6207 BROAD LIGAMENT HEMATOMA
6208 NONINFL DIS OVA/ADNX NEC
6209 NONINFL DIS OVA/ADNX NOS
6210 POLYP OF CORPUS UTERI
6211 CHR UTERINE SUBINVOLUTN
6212 HYPERTROPHY OF UTERUS
6213 ENDOMETRIAL HYPERPLASIA
6214 HEMATOMETRA
6215 INTRAUTERINE SYNECHIAE
6216 MALPOSITION OF UTERUS
6217 CHR INVERSION OF UTERUS
6218 DISORDERS OF UTERUS NEC
6219 DISORDER OF UTERUS NOS
6220 EROSION/ECTROPION CERVIX
6221 DYSPLASIA OF CERVIX
6222 LEUKOPLAKIA OF CERVIX
6223 OLD LACERATION OF CERVIX
6224 STRICTURE OF CERVIX
6225 INCOMPETENCE OF CERVIX
6226 HYPERTROPHIC ELONG CERVX
6227 MUCOUS POLYP OF CERVIX
6228 NONINFLAM DIS CERVIX NEC
6229 NONINFLAM DIS CERVIX NOS
6230 DYSPLASIA OF VAGINA
6231 LEUKOPLAKIA OF VAGINA
6232 STRICTURE OF VAGINA
6233 TIGHT HYMENAL RING
6234 OLD VAGINAL LACERATION
6235 NONINFECT VAG LEUKORRHEA
6236 VAGINAL HEMATOMA
6237 POLYP OF VAGINA
6238 NONINFLAM DIS VAGINA NEC
6239 NONINFLAM DIS VAGINA NOS
6240 DYSTROPHY OF VULVA
6241 ATROPHY OF VULVA
6242 HYPERTROPHY OF CLITORIS
6243 HYPERTROPHY OF LABIA
6244 OLD LACERATION OF VULVA
6245 HEMATOMA OF VULVA
6246 POLYP OF LABIA AND VULVA
6248 NONINFLAM DIS VULVA NEC
6249 NONINFLAM DIS VULVA NOS
6250 DYSPAREUNIA
6251 VAGINISMUS
6252 MITTELSCHMERZ
6253 DYSMENORRHEA
6254 PREMENSTRUAL TENSION
6255 PELVIC CONGESTION SYND
6256 FEM STRESS INCONTINENCE
6258 FEM GENITAL SYMPTOMS NEC
6259 FEM GENITAL SYMPTOMS NOS
6260 ABSENCE OF MENSTRUATION
6261 SCANTY MENSTRUATION
6262 EXCESSIVE MENSTRUATION
6263 PUBERTAL MENORRHAGIA
6264 IRREGULAR MENSTRUATION

DIAGNOSES ALLOWED FOR FEMALES ONLY

6265	OVULATION BLEEDING
6266	METRORRHAGIA
6267	POSTCOITAL BLEEDING
6268	MENSTRUAL DISORDER NEC
6269	MENSTRUAL DISORDER NOS
6270	PREMENOPAUSE MENORRHAGIA
6271	POSTMENOPAUSAL BLEEDING
6272	FEMALE CLIMACTERIC STATE
6273	ATROPHIC VAGINITIS
6274	ARTIFIC MENOPAUSE STATES
6278	MENOPAUSAL DISORDER NEC
6279	MENOPAUSAL DISORDER NOS
6280	INFERTILITY-ANOVULATION
6281	INFERTIL-PITUITARY ORIG
6282	INFERTILITY-TUBAL ORIGIN
6283	INFERTILITY-UTERINE ORIG
6284	INFERTIL-CERVICAL ORIG
6288	FEMALE INFERTILITY NEC
6289	FEMALE INFERTILITY NOS
6290	HEMATOCELE, FEMALE NEC
6291	HYDROCELE CANAL NUCK-FEM
6298	FEMALE GENITAL DIS NEC
6299	FEMALE GENITAL DIS NOS
630	HYDATIDIFORM MOLE
631	OTH ABN PROD CONCEPTION
632	MISSED ABORTION
6330	ABDOMINAL PREGNANCY
6331	TUBAL PREGNANCY
6332	OVARIAN PREGNANCY
6338	ECTOPIC PREGNANCY NEC
6339	ECTOPIC PREGNANCY NOS
63400	SPON ABOR W PEL INF-UNSP
63401	SPON ABOR W PELV INF-INC
63402	SPON ABOR W PEL INF-COMP
63410	SPON ABORT W HEMORR-UNSP
63411	SPON ABORT W HEMORR-INC
63412	SPON ABORT W HEMORR-COMP
63420	SPON AB W PEL DAMAG-UNSP
63421	SPON AB W PELV DAMAG-INC
63422	SPON AB W PEL DAMAG-COMP
63430	SPON AB W REN FAIL-UNSP
63431	SPON AB W REN FAIL-INC
63432	SPON AB W REN FAIL-COMP
63440	SPON AB W METAB DIS-UNSP
63441	SPON AB W METAB DIS-INC
63442	SPON AB W METAB DIS-COMP
63450	SPON ABORT W SHOCK-UNSP
63451	SPON ABORT W SHOCK-INC
63452	SPON ABORT W SHOCK-COMP
63460	SPON ABORT W EMBOL-UNSP
63461	SPON ABORT W EMBOL-INC
63462	SPON ABORT W EMBOL-COMP
63470	SPON AB W COMPL NEC-UNSP
63471	SPON AB W COMPL NEC-INC
63472	SPON AB W COMPL NEC-COMP
63480	SPON AB W COMPL NOS-UNSP
63481	SPON AB W COMPL NOS-INC
63482	SPON AB W COMPL NOS-COMP
63490	SPON ABORT UNCOMPL-UNSP
63491	SPON ABORT UNCOMPL-INC
63492	SPON ABORT UNCOMPL-COMP
63500	LEG ABOR W PELV INF-UNSP
63501	LEG ABOR W PELV INF-INC
63502	LEG ABOR W PELV INF-COMP
63510	LEGAL ABOR W HEMORR-UNSP
63511	LEGAL ABORT W HEMORR-INC
63512	LEGAL ABOR W HEMORR-COMP
63520	LEG AB W PELV DAMAG-UNSP
63521	LEG AB W PELV DAMAG-INC
63522	LEG AB W PELV DAMAG-COMP
63530	LEG ABOR W REN FAIL-UNSP
63531	LEG ABOR W REN FAIL-INC
63532	LEG ABOR W REN FAIL-COMP
63540	LEG AB W METAB DIS-UNSP
63541	LEG AB W METAB DIS-INC
63542	LEG AB W METAB DIS-COMP
63550	LEGAL ABORT W SHOCK-UNSP
63551	LEGAL ABORT W SHOCK-INC
63552	LEGAL ABORT W SHOCK-COMP
63560	LEGAL ABORT W EMBOL-UNSP
63561	LEGAL ABORT W EMBOL-INC
63562	LEGAL ABORT W EMBOL-COMP
63570	LEG AB W COMPL NEC-UNSP
63571	LEG AB W COMPL NEC-INC
63572	LEG AB W COMPL NEC-COMP
63580	LEG AB W COMPL NOS-UNSP
63581	LEG AB W COMPL NOS-INC
63582	LEG AB W COMPL NOS-COMP
63590	LEGAL ABORT UNCOMPL-UNSP
63591	LEGAL ABORT UNCOMPL-INC
63592	LEGAL ABORT UNCOMPL-COMP
63600	ILLEG AB W PELV INF-UNSP
63601	ILLEG AB W PELV INF-INC
63602	ILLEG AB W PELV INF-COMP
63610	ILLEG AB W HEMORR-UNSPEC
63611	ILLEG AB W HEMORR-INC
63612	ILLEG AB W HEMORR-COMP
63620	ILLEG AB W PEL DAMG-UNSP
63621	ILLEG AB W PEL DAMAG-INC
63622	ILLEG AB W PEL DAMG-COMP

DIAGNOSES ALLOWED FOR FEMALES ONLY

63630	ILLEG AB W REN FAIL-UNSP
63631	ILLEG AB W REN FAIL-INC
63632	ILLEG AB W REN FAIL-COMP
63640	ILLEG AB W MET DIS-UNSP
63641	ILLEG AB W METAB DIS-INC
63642	ILLEG AB W MET DIS-COMP
63650	ILLEG ABORT W SHOCK-UNSP
63651	ILLEG ABORT W SHOCK-INC
63652	ILLEG ABORT W SHOCK-COMP
63660	ILLEG AB W EMBOLISM-UNSP
63661	ILLEG AB W EMBOLISM-INC
63662	ILLEG AB W EMBOLISM-COMP
63670	ILLG AB W COMPL NEC-UNSP
63671	ILLEG AB W COMPL NEC-INC
63672	ILLG AB W COMPL NEC-COMP
63680	ILLG AB W COMPL NOS-UNSP
63681	ILLEG AB W COMPL NOS-INC
63682	ILLG AB W COMPL NOS-COMP
63690	ILLEG ABORT UNCOMPL-UNSP
63691	ILLEG ABORT UNCOMPL-INC
63692	ILLEG ABORT UNCOMPL-COMP
63700	ABORT NOS W PEL INF-UNSP
63701	ABORT NOS W PEL INF-INC
63702	ABORT NOS W PEL INF-COMP
63710	ABORT NOS W HEMORR-UNSP
63711	ABORT NOS W HEMORR-INC
63712	ABORT NOS W HEMORR-COMP
63720	AB NOS W PELV DAMAG-UNSP
63721	AB NOS W PELV DAMAG-INC
63722	AB NOS W PELV DAMAG-COMP
63730	AB NOS W RENAL FAIL-UNSP
63731	AB NOS W RENAL FAIL-INC
63732	AB NOS W RENAL FAIL-COMP
63740	AB NOS W METAB DIS-UNSP
63741	AB NOS W METAB DIS-INC
63742	AB NOS W METAB DIS-COMP
63750	ABORT NOS W SHOCK-UNSP
63751	ABORT NOS W SHOCK-INC
63752	ABORT NOS W SHOCK-COMP
63760	AB NOS W EMBOLISM-UNSP
63761	AB NOS W EMBOLISM-INC
63762	AB NOS W EMBOLISM-COMP
63770	AB NOS W COMPL NEC-UNSP
63771	AB NOS W COMPL NEC-INC
63772	AB NOS W COMPL NEC-COMP
63780	AB NOS W COMPL NOS-UNSP
63781	AB NOS W COMPL NOS-INC
63782	AB NOS W COMPL NOS-COMP
63790	AB NOS UNCOMPLICAT-UNSP
63791	AB NOS UNCOMPLICAT-INC
63792	AB NOS UNCOMPLICAT-COMP
6380	ATTEM ABORT W PELVIC INF
6381	ATTEM ABORT W HEMORRHAGE
6382	ATTEM ABORT W PELV DAMAG
6383	ATTEM ABORT W RENAL FAIL
6384	ATTEM ABOR W METABOL DIS
6385	ATTEM ABORTION W SHOCK
6386	ATTEMP ABORT W EMBOLISM
6387	ATTEMP ABORT W COMPL NEC
6388	ATTEMP ABORT W COMPL NOS
6389	ATTEMPTED ABORT UNCOMPL
6390	POSTABORTION GU INFECT
6391	POSTABORTION HEMORRHAGE
6392	POSTABORT PELVIC DAMAGE
6393	POSTABORT RENAL FAILURE
6394	POSTABORT METABOLIC DIS
6395	POSTABORTION SHOCK
6396	POSTABORTION EMBOLISM
6398	POSTABORTION COMPL NEC
6399	POSTABORTION COMPL NOS
64000	THREATENED ABORT-UNSPEC
64001	THREATENED ABORT-DELIVER
64003	THREATEN ABORT-ANTEPART
64080	HEM EARLY PREG NEC-UNSP
64081	HEM EARLY PREG NEC-DELIV
64083	HEM EARLY PG NEC-ANTEPAR
64090	HEMORR EARLY PREG-UNSPEC
64091	HEM EARLY PREG-DELIVERED
64093	HEM EARLY PREG-ANTEPART
64100	PLACENTA PREVIA-UNSPEC
64101	PLACENTA PREVIA-DELIVER
64103	PLACENTA PREVIA-ANTEPART
64110	PLACENTA PREV HEM-UNSPEC
64111	PLACENTA PREV HEM-DELIV
64113	PLACEN PREV HEM-ANTEPART
64120	PREM SEPAR PLACEN-UNSPEC
64121	PREM SEPAR PLACEN-DELIV
64123	PREM SEPAR PLAC-ANTEPART
64130	COAG DEF HEMORR-UNSPEC
64131	COAG DEF HEMORR-DELIVER
64133	COAG DEF HEMORR-ANTEPART
64180	ANTEPART HEM NEC-UNSPEC
64181	ANTEPARTUM HEM NEC-DELIV
64183	ANTEPART HEM NEC-ANTEPAR
64190	ANTEPART HEM NOS-UNSPEC
64191	ANTEPARTUM HEM NOS-DELIV
64193	ANTEPART HEM NOS-ANTEPAR
64200	ESSEN HYPERTEN PREG-UNSP
64201	ESSEN HYPERTEN-DELIVERED
64202	ESSEN HYPERTEN-DEL W P/P

DIAGNOSES ALLOWED FOR FEMALES ONLY

64203 ESSEN HYPERTEN-ANTEPART
64204 ESSEN HYPERTEN-POSTPART
64210 RENAL HYPERTEN PREG-UNSP
64211 RENAL HYPERTEN PG-DELIV
64212 RENAL HYPERTEN-DEL P/P
64213 RENAL HYPERTEN-ANTEPART
64214 RENAL HYPERTEN-POSTPART
64220 OLD HYPERTEN PREG-UNSPEC
64221 OLD HYPERTEN NEC-DELIVER
64222 OLD HYPERTEN-DELIV W P/P
64223 OLD HYPERTEN NEC-ANTEPAR
64224 OLD HYPERTEN NEC-POSTPAR
64230 TRANS HYPERTEN PREG-UNSP
64231 TRANS HYPERTEN-DELIVERED
64232 TRANS HYPERTEN-DEL W P/P
64233 TRANS HYPERTEN-ANTEPART
64234 TRANS HYPERTEN-POSTPART
64240 MILD/NOS PREECLAMP-UNSP
64241 MILD/NOS PREECLAMP-DELIV
64242 MILD PREECLAMP-DEL W P/P
64243 MILD/NOS PREECLAMP-ANTEP
64244 MILD/NOS PREECLAMP-P/P
64250 SEVERE PREECLAMP-UNSPEC
64251 SEVERE PREECLAMP-DELIVER
64252 SEV PREECLAMP-DEL W P/P
64253 SEV PREECLAMP-ANTEPARTUM
64254 SEV PREECLAMP-POSTPARTUM
64260 ECLAMPSIA-UNSPECIFIED
64261 ECLAMPSIA-DELIVERED
64262 ECLAMPSIA-DELIV W P/P
64263 ECLAMPSIA-ANTEPARTUM
64264 ECLAMPSIA-POSTPARTUM
64270 TOX W OLD HYPERTEN-UNSP
64271 TOX W OLD HYPERTEN-DELIV
64272 TOX W OLD HYP-DEL W P/P
64273 TOX W OLD HYPER-ANTEPART
64274 TOX W OLD HYPER-POSTPART
64290 HYPERTEN PREG NOS-UNSPEC
64291 HYPERTENS NOS-DELIVERED
64292 HYPERTENS NOS-DEL W P/P
64293 HYPERTENS NOS-ANTEPARTUM
64294 HYPERTENS NOS-POSTPARTUM
64300 MILD HYPEREM GRAV-UNSPEC
64301 MILD HYPEREM GRAV-DELIV
64303 MILD HYPEREMESIS-ANTEPAR
64310 HYPEREM W METAB DIS-UNSP
64311 HYPEREM W METAB DIS-DEL
64313 HYPEREM W METAB-ANTEPART
64320 LATE VOMIT OF PREG-UNSP
64321 LATE VOMIT OF PREG-DELIV
64323 LATE VOMIT PREG-ANTEPART
64380 VOMIT COMPL PREG-UNSPEC
64381 VOMIT COMPL PREG-DELIVER
64383 VOMIT COMPL PREG-ANTEPAR
64390 VOMIT OF PREG NOS-UNSPEC
64391 VOMIT OF PREG NOS-DELIV
64393 VOMIT OF PG NOS-ANTEPART
64400 THREAT PREM LABOR-UNSPEC
64403 THRT PREM LABOR-ANTEPART
64410 THREAT LABOR NEC-UNSPEC
64413 THREAT LABOR NEC-ANTEPAR
64420 EARLY ONSET DELIV-UNSPEC
64421 EARLY ONSET DELIVERY-DEL
64500 PROLONGED PREG-UNSPEC
64501 PROLONGED PREG-DELIVERED
64503 PROLONGED PREG-ANTEPART
64600 PAPYRACEOUS FETUS-UNSPEC
64601 PAPYRACEOUS FETUS-DELIV
64603 PAPYRACEOUS FET-ANTEPAR
64610 EDEMA IN PREG-UNSPEC
64611 EDEMA IN PREG-DELIVERED
64612 EDEMA IN PREG-DEL W P/P
64613 EDEMA IN PREG-ANTEPARTUM
64614 EDEMA IN PREG-POSTPARTUM
64620 RENAL DIS PREG NOS-UNSP
64621 RENAL DIS NOS-DELIVERED
64622 RENAL DIS NOS-DEL W P/P
64623 RENAL DIS NOS-ANTEPARTUM
64624 RENAL DIS NOS-POSTPARTUM
64630 HABITUAL ABORTER-UNSPEC
64631 HABITUAL ABORTER-DELIVER
64633 HABITUAL ABORT-ANTEPART
64640 NEURITIS OF PREG-UNSPEC
64641 NEURITIS-DELIVERED
64642 NEURITIS-DELIVERED W P/P
64643 NEURITIS OF PREG-ANTEPAR
64644 NEURITIS OF PREG-POSTPAR
64650 BACTERIURIA PREG-UNSPEC
64651 ASYM BACTERIURIA-DELIVER
64652 ASY BACTERURIA-DEL W P/P
64653 ASY BACTERIURIA-ANTEPART
64654 ASY BACTERIURIA-POSTPART
64660 GU INFECT IN PREG-UNSPEC
64661 GU INFECTION-DELIVERED
64662 GU INFECTION-DELIV W P/P
64663 GU INFECTION-ANTEPARTUM
64664 GU INFECTION-POSTPARTUM
64670 LIVER DIS IN PREG-UNSPEC
64671 LIVER DISORDER-DELIVERED
64673 LIVER DISORDER-ANTEPART

DIAGNOSES ALLOWED FOR FEMALES ONLY

64680 PREG COMPL NEC-UNSPEC
64681 PREG COMPL NEC-DELIVERED
64682 PREG COMPL NEC-DEL W P/P
64683 PREG COMPL NEC-ANTEPART
64684 PREG COMPL NEC-POSTPART
64690 PREG COMPL NOS-UNSPEC
64691 PREG COMPL NOS-DELIVERED
64693 PREG COMPL NOS-ANTEPART
64700 SYPHILIS IN PREG-UNSPEC
64701 SYPHILIS-DELIVERED
64702 SYPHILIS-DELIVERED W P/P
64703 SYPHILIS-ANTEPARTUM
64704 SYPHILIS-POSTPARTUM
64710 GONORRHEA IN PREG-UNSPEC
64711 GONORRHEA-DELIVERED
64712 GONORRHEA-DELIVER W P/P
64713 GONORRHEA-ANTEPARTUM
64714 GONORRHEA-POSTPARTUM
64720 OTHER VD IN PREG-UNSPEC
64721 OTHER VD-DELIVERED
64722 OTHER VD-DELIVERED W P/P
64723 OTHER VD-ANTEPARTUM
64724 OTHER VD-POSTPARTUM
64730 TB IN PREG-UNSPECIFIED
64731 TUBERCULOSIS-DELIVERED
64732 TUBERCULOSIS-DELIV W P/P
64733 TUBERCULOSIS-ANTEPARTUM
64734 TUBERCULOSIS-POSTPARTUM
64740 MALARIA IN PREG-UNSPEC
64741 MALARIA-DELIVERED
64742 MALARIA-DELIVERED W P/P
64743 MALARIA-ANTEPARTUM
64744 MALARIA-POSTPARTUM
64750 RUBELLA IN PREG-UNSPEC
64751 RUBELLA-DELIVERED
64752 RUBELLA-DELIVERED W P/P
64753 RUBELLA-ANTEPARTUM
64754 RUBELLA-POSTPARTUM
64760 OTH VIRUS IN PREG-UNSPEC
64761 OTH VIRAL DIS-DELIVERED
64762 OTH VIRAL DIS-DEL W P/P
64763 OTH VIRAL DIS-ANTEPARTUM
64764 OTH VIRAL DIS-POSTPARTUM
64780 INF DIS IN PREG NEC-UNSP
64781 INFECT DIS NEC-DELIVERED
64782 INFECT DIS NEC-DEL W P/P
64783 INFECT DIS NEC-ANTEPART
64784 INFECT DIS NEC-POSTPART
64790 INFECT IN PREG NOS-UNSP
64791 INFECT NOS-DELIVERED
64792 INFECT NOS-DELIVER W P/P
64793 INFECT NOS-ANTEPARTUM
64794 INFECT NOS-POSTPARTUM
64800 DIABETES IN PREG-UNSPEC
64801 DIABETES-DELIVERED
64802 DIABETES-DELIVERED W P/P
64803 DIABETES-ANTEPARTUM
64804 DIABETES-POSTPARTUM
64810 THYROID DYSFUN PREG-UNSP
64811 THYROID DYSFUNC-DELIVER
64812 THYROID DYSFUN-DEL W P/P
64813 THYROID DYSFUNC-ANTEPART
64814 THYROID DYSFUNC-POSTPART
64820 ANEMIA IN PREG-UNSPEC
64821 ANEMIA-DELIVERED
64822 ANEMIA-DELIVERED W P/P
64823 ANEMIA-ANTEPARTUM
64824 ANEMIA-POSTPARTUM
64830 DRUG DEPEND PREG-UNSPEC
64831 DRUG DEPENDENCE-DELIVER
64832 DRUG DEPENDEN-DEL W P/P
64833 DRUG DEPENDENCE-ANTEPART
64834 DRUG DEPENDENCE-POSTPART
64840 MENTAL DIS PREG-UNSPEC
64841 MENTAL DISORDER-DELIVER
64842 MENTAL DIS-DELIV W P/P
64843 MENTAL DISORDER-ANTEPART
64844 MENTAL DISORDER-POSTPART
64850 CONGEN CV DIS PREG-UNSP
64851 CONGEN CV DIS-DELIVERED
64852 CONGEN CV DIS-DEL W P/P
64853 CONGEN CV DIS-ANTEPARTUM
64854 CONGEN CV DIS-POSTPARTUM
64860 CV DIS NEC PREG-UNSPEC
64861 CV DIS NEC PREG-DELIVER
64862 CV DIS NEC-DELIVER W P/P
64863 CV DIS NEC-ANTEPARTUM
64864 CV DIS NEC-POSTPARTUM
64870 BONE DISORD IN PREG-UNSP
64871 BONE DISORDER-DELIVERED
64872 BONE DISORDER-DEL W P/P
64873 BONE DISORDER-ANTEPARTUM
64874 BONE DISORDER-POSTPARTUM
64880 ABN GLUCOSE IN PREG-UNSP
64881 ABN GLUCOSE TOLER-DELIV
64882 ABN GLUCOSE-DELIV W P/P
64883 ABN GLUCOSE-ANTEPARTUM
64884 ABN GLUCOSE-POSTPARTUM
64890 OTH CURR COND PREG-UNSP
64891 OTH CURR COND-DELIVERED

DIAGNOSES ALLOWED FOR FEMALES ONLY

64892 OTH CURR COND-DEL W P/P
64893 OTH CURR COND-ANTEPARTUM
64894 OTH CURR COND-POSTPARTUM
650 NORMAL DELIVERY
65100 TWIN PREGNANCY-UNSPEC
65101 TWIN PREGNANCY-DELIVERED
65103 TWIN PREGNANCY-ANTEPART
65110 TRIPLET PREGNANCY-UNSPEC
65111 TRIPLET PREGNANCY-DELIV
65113 TRIPLET PREG-ANTEPARTUM
65120 QUADRUPLET PREG-UNSPEC
65121 QUADRUPLET PREG-DELIVER
65123 QUADRUPLET PREG-ANTEPART
65180 MULTI GESTAT NEC-UNSPEC
65181 MULTI GESTAT NEC-DELIVER
65183 MULTI GEST NEC-ANTEPART
65190 MULTI GESTAT NOS-UNSPEC
65191 MULT GESTATION NOS-DELIV
65193 MULTI GEST NOS-ANTEPART
65200 UNSTABLE LIE-UNSPECIFIED
65201 UNSTABLE LIE-DELIVERED
65203 UNSTABLE LIE-ANTEPARTUM
65210 CEPHALIC VERS NOS-UNSPEC
65211 CEPHALIC VERS NOS-DELIV
65213 CEPHAL VERS NOS-ANTEPART
65220 BREECH PRESENTAT-UNSPEC
65221 BREECH PRESENTAT-DELIVER
65223 BREECH PRESENT-ANTEPART
65230 TRANSV/OBLIQ LIE-UNSPEC
65231 TRANSVER/OBLIQ LIE-DELIV
65233 TRANSV/OBLIQ LIE-ANTEPAR
65240 FACE/BROW PRESENT-UNSPEC
65241 FACE/BROW PRESENT-DELIV
65243 FACE/BROW PRES-ANTEPART
65250 HIGH HEAD AT TERM-UNSPEC
65251 HIGH HEAD AT TERM-DELIV
65253 HIGH HEAD TERM-ANTEPART
65260 MULT GEST MALPRESEN-UNSP
65261 MULT GEST MALPRES-DELIV
65263 MULT GES MALPRES-ANTEPAR
65270 PROLAPSED ARM-UNSPEC
65271 PROLAPSED ARM-DELIVERED
65273 PROLAPSED ARM-ANTEPART
65280 MALPOSITION NEC-UNSPEC
65281 MALPOSITION NEC-DELIVER
65283 MALPOSITION NEC-ANTEPART
65290 MALPOSITION NOS-UNSPEC
65291 MALPOSITION NOS-DELIVER
65293 MALPOSITION NOS-ANTEPART
65300 PELVIC DEFORM NOS-UNSPEC
65301 PELVIC DEFORM NOS-DELIV
65303 PELV DEFORM NOS-ANTEPART
65310 CONTRACT PELV NOS-UNSPEC
65311 CONTRACT PELV NOS-DELIV
65313 CONTRAC PELV NOS-ANTEPAR
65320 INLET CONTRACTION-UNSPEC
65321 INLET CONTRACTION-DELIV
65323 INLET CONTRACT-ANTEPART
65330 OUTLET CONTRACTION-UNSP
65331 OUTLET CONTRACTION-DELIV
65333 OUTLET CONTRACT-ANTEPART
65340 FETOPELV DISPROP-UNSPEC
65341 FETOPELV DISPROPOR-DELIV
65343 FETOPEL DISPROP-ANTEPART
65350 FETAL DISPROP NOS-UNSPEC
65351 FETAL DISPROP NOS-DELIV
65353 FETAL DISPRO NOS-ANTEPAR
65360 HYDROCEPHAL FETUS-UNSPEC
65361 HYDROCEPH FETUS-DELIVER
65363 HYDROCEPH FETUS-ANTEPART
65370 OTH ABN FET DISPROP-UNSP
65371 OTH ABN FET DISPRO-DELIV
65373 OTH ABN FET DISPRO-ANTEP
65380 DISPROPORTION NEC-UNSPEC
65381 DISPROPORTION NEC-DELIV
65383 DISPROPOR NEC-ANTEPARTUM
65390 DISPROPORTION NOS-UNSPEC
65391 DISPROPORTION NOS-DELIV
65393 DISPROPOR NOS-ANTEPARTUM
65400 CONG ABN UTER PREG-UNSP
65401 CONGEN ABN UTERUS-DELIV
65402 CONG ABN UTER-DEL W P/P
65403 CONGEN ABN UTER-ANTEPART
65404 CONGEN ABN UTER-POSTPART
65410 UTER TUMOR IN PREG-UNSP
65411 UTERINE TUMOR-DELIVERED
65412 UTERINE TUMOR-DEL W P/P
65413 UTERINE TUMOR-ANTEPARTUM
65414 UTERINE TUMOR-POSTPARTUM
65420 PREV C-SECT NOS-UNSPEC
65421 PREV C-SECT NOS-DELIVER
65423 PREV C-SECT NOS-ANTEPART
65430 RETROVERT UTERUS-UNSPEC
65431 RETROVERT UTERUS-DELIVER
65432 RETROVERT UTER-DEL W P/P
65433 RETROVERT UTER-ANTEPART
65434 RETROVERT UTER-POSTPART
65440 ABN GRAV UTERUS NEC-UNSP
65441 ABN UTERUS NEC-DELIVERED
65442 ABN UTERUS NEC-DEL W P/P

DIAGNOSES ALLOWED FOR FEMALES ONLY

65443 ABN UTERUS NEC-ANTEPART
65444 ABN UTERUS NEC-POSTPART
65450 CERV INCOMPET PREG-UNSP
65451 CERVICAL INCOMPET-DELIV
65452 CERV INCOMPET-DEL W P/P
65453 CERV INCOMPET-ANTEPARTUM
65454 CERV INCOMPET-POSTPARTUM
65460 ABN CERVIX NEC PREG-UNSP
65461 ABN CERVIX NEC-DELIVERED
65462 ABN CERVIX NEC-DEL W P/P
65463 ABN CERVIX NEC-ANTEPART
65464 ABN CERVIX NEC-POSTPART
65470 ABN VAGINA IN PREG-UNSP
65471 ABNORM VAGINA-DELIVERED
65472 ABNORM VAGINA-DEL W P/P
65473 ABNORM VAGINA-ANTEPARTUM
65474 ABNORM VAGINA-POSTPARTUM
65480 ABN VULVA IN PREG-UNSPEC
65481 ABNORMAL VULVA-DELIVERED
65482 ABNORMAL VULVA-DEL W P/P
65483 ABNORMAL VULVA-ANTEPART
65484 ABNORMAL VULVA-POSTPART
65490 ABN PEL NOS IN PREG-UNSP
65491 ABN PELV ORG NOS-DELIVER
65492 ABN PELV NOS-DELIV W P/P
65493 ABN PELV ORG NOS-ANTEPAR
65494 ABN PELV ORG NOS-POSTPAR
65500 FETAL CNS MALFORM-UNSPEC
65501 FETAL CNS MALFORM-DELIV
65503 FETAL CNS MALFOR-ANTEPAR
65510 FETAL CHROMOS ABN-UNSPEC
65511 FETAL CHROMOSO ABN-DELIV
65513 FET CHROMO ABN-ANTEPART
65520 FAMIL HEREDIT DIS-UNSPEC
65521 FAMIL HEREDIT DIS-DELIV
65523 FAMIL HERED DIS-ANTEPART
65530 FET DAMG D/T VIRUS-UNSP
65531 FET DAMG D/T VIRUS-DELIV
65533 FET DAMG D/T VIRUS-ANTEP
65540 FET DAMG D/T DIS-UNSPEC
65541 FET DAMG D/T DIS-DELIVER
65543 FET DAMG D/T DIS-ANTEPAR
65550 FETAL DAMG D/T DRUG-UNSP
65551 FET DAMAG D/T DRUG-DELIV
65553 FET DAMG D/T DRUG-ANTEPA
65560 RADIAT FETAL DAMAG-UNSP
65561 RADIAT FETAL DAMAG-DELIV
65563 RADIAT FET DAMAG-ANTEPAR
65580 FETAL ABNORM NEC-UNSPEC
65581 FETAL ABNORM NEC-DELIVER
65583 FETAL ABNORM NEC-ANTEPAR
65590 FETAL ABNORM NOS-UNSPEC
65591 FETAL ABNORM NOS-DELIVER
65593 FETAL ABNORM NOS-ANTEPAR
65600 FETAL-MATERNAL HEM-UNSP
65601 FETAL-MATERNAL HEM-DELIV
65603 FETAL-MATERN HEM-ANTEPAR
65610 RH ISOIMMUNIZATION-UNSP
65611 RH ISOIMMUNIZAT-DELIVER
65613 RH ISOIMMUNIZAT-ANTEPART
65620 ABO ISOIMMUNIZATION-UNSP
65621 ABO ISOIMMUNIZAT-DELIVER
65623 ABO ISOIMMUNIZAT-ANTEPAR
65630 FETAL DISTRESS-UNSPEC
65631 FETAL DISTRESS-DELIVERED
65633 FETAL DISTRESS-ANTEPART
65640 INTRAUTERINE DEATH-UNSP
65641 INTRAUTER DEATH-DELIVER
65643 INTRAUTER DEATH-ANTEPART
65650 POOR FETAL GROWTH-UNSPEC
65651 POOR FETAL GROWTH-DELIV
65653 POOR FETAL GRTH-ANTEPART
65660 EXCESS FETAL GRTH-UNSPEC
65661 EXCESS FETAL GRTH-DELIV
65663 EXCESS FET GRTH-ANTEPART
65670 OTH PLACENT COND-UNSPEC
65671 OTH PLACENT COND-DELIVER
65673 OTH PLACENT COND-ANTEPAR
65680 FET/PLAC PROB NEC-UNSPEC
65681 FET/PLAC PROB NEC-DELIV
65683 FET/PLAC PROB NEC-ANTEPA
65690 FET/PLAC PROB NOS-UNSPEC
65691 FET/PLAC PROB NOS-DELIV
65693 FET/PLAC PROB NOS-ANTEPA
65700 POLYHYDRAMNIOS-UNSPEC
65701 POLYHYDRAMNIOS-DELIVERED
65703 POLYHYDRAMNIOS-ANTEPART
65800 OLIGOHYDRAMNIOS-UNSPEC
65801 OLIGOHYDRAMNIOS-DELIVER
65803 OLIGOHYDRAMNIOS-ANTEPAR
65810 PREM RUPT MEMBRAN-UNSPEC
65811 PREM RUPT MEMBRAN-DELIV
65813 PREM RUPT MEMB-ANTEPART
65820 PROLONG RUPT MEMB-UNSPEC
65821 PROLONG RUPT MEMB-DELIV
65823 PROLONG RUP MEMB-ANTEPAR
65830 ARTIFIC RUPT MEMBR-UNSP
65831 ARTIFIC RUPT MEMBR-DELIV
65833 ARTIF RUPT MEMB-ANTEPART
65840 AMNIOTIC INFECTION-UNSP

DIAGNOSES ALLOWED FOR FEMALES ONLY

65841 AMNIOTIC INFECTION-DELIV
65843 AMNIOTIC INFECT-ANTEPART
65880 AMNIOTIC PROB NEC-UNSPEC
65881 AMNIOTIC PROB NEC-DELIV
65883 AMNION PROB NEC-ANTEPART
65890 AMNIOTIC PROB NOS-UNSPEC
65891 AMNIOTIC PROB NOS-DELIV
65893 AMNION PROB NOS-ANTEPART
65900 FAIL MECHAN INDUCT-UNSP
65901 FAIL MECH INDUCT-DELIVER
65903 FAIL MECH INDUCT-ANTEPAR
65910 FAIL INDUCTION NOS-UNSP
65911 FAIL INDUCTION NOS-DELIV
65913 FAIL INDUCT NOS-ANTEPART
65920 PYREXIA IN LABOR-UNSPEC
65921 PYREXIA IN LABOR-DELIVER
65923 PYREXIA IN LABOR-ANTEPAR
65930 SEPTICEMIA IN LABOR-UNSP
65931 SEPTICEM IN LABOR-DELIV
65933 SEPTICEM IN LABOR-ANTEPA
65940 GRAND MULTIPARITY-UNSPEC
65941 GRAND MULTIPARITY-DELIV
65943 GRAND MULTIPARITY-ANTEPA
65950 ELDERLY PRIMIGRAVID-UNSP
65951 ELDERLY PRIMIGRAVIDA-DEL
65953 ELDER PRIMIGRAVID-ANTEPA
65980 COMPLIC LABOR NEC-UNSP
65981 COMPLIC LABOR NEC-DELIV
65983 COMPL LABOR NEC-ANTEPART
65990 COMPLIC LABOR NOS-UNSP
65991 COMPLIC LABOR NOS-DELIV
65993 COMPL LABOR NOS-ANTEPART
66000 OBSTRUCT/FET MALPOS-UNSP
66001 OBSTRUC/FET MALPOS-DELIV
66003 OBSTRUC/FET MALPOS-ANTEP
66010 BONY PELV OBSTRUC-UNSPEC
66011 BONY PELV OBSTRUCT-DELIV
66013 BONY PELV OBSTRUC-ANTEPA
66020 ABN PELV TISS OBSTR-UNSP
66021 ABN PELV TIS OBSTR-DELIV
66023 ABN PELV TIS OBSTR-ANTEP
66030 PERSIST OCCIPITPOST-UNSP
66031 PERSIST OCCIPTPOST-DELIV
66033 PERSIST OCCIPTPOST-ANTEP
66040 SHOULDER DYSTOCIA-UNSPEC
66041 SHOULDER DYSTOCIA-DELIV
66043 SHOULDER DYSTOCIA-ANTEPA
66050 LOCKED TWINS-UNSPECIFIED
66051 LOCKED TWINS-DELIVERED
66053 LOCKED TWINS-ANTEPARTUM
66060 FAIL TRIAL LAB NOS-UNSP
66061 FAIL TRIAL LAB NOS-DELIV
66063 FAIL TRIAL LAB NOS-ANTEP
66070 FAILED FORCEP NOS-UNSPEC
66071 FAILED FORCEPS NOS-DELIV
66073 FAIL FORCEPS NOS-ANTEPAR
66080 OBSTRUC LABOR NEC-UNSPEC
66081 OBSTRUCT LABOR NEC-DELIV
66083 OBSTRUC LABOR NEC-ANTEPA
66090 OBSTRUC LABOR NOS-UNSPEC
66091 OBSTRUCT LABOR NOS-DELIV
66093 OBSTRUC LABOR NOS-ANTEPA
66100 PRIM UTERINE INERT-UNSP
66101 PRIM UTERINE INERT-DELIV
66103 PRIM UTER INERT-ANTEPART
66110 SEC UTERINE INERT-UNSPEC
66111 SEC UTERINE INERT-DELIV
66113 SEC UTERINE INERT-ANTEPA
66120 UTERINE INERTIA NEC-UNSP
66121 UTERINE INERT NEC-DELIV
66123 UTERINE INERT NEC-ANTEPA
66130 PRECIPITATE LABOR-UNSPEC
66131 PRECIPITATE LABOR-DELIV
66133 PRECIPITATE LABOR-ANTEPA
66140 UTER DYSTOCIA NOS-UNSPEC
66141 UTER DYSTOCIA NOS-DELIV
66143 UTER DYSTOCIA NOS-ANTEPA
66190 ABNORMAL LABOR NOS-UNSP
66191 ABNORMAL LABOR NOS-DELIV
66193 ABNORM LABOR NOS-ANTEPAR
66200 PROLONGED 1ST STAGE-UNSP
66201 PROLONG 1ST STAGE-DELIV
66203 PROLONG 1ST STAGE-ANTEPA
66210 PROLONGED LABOR NOS-UNSP
66211 PROLONG LABOR NOS-DELIV
66213 PROLONG LABOR NOS-ANTEPA
66220 PROLONGED 2ND STAGE-UNSP
66221 PROLONG 2ND STAGE-DELIV
66223 PROLONG 2ND STAGE-ANTEPA
66230 DELAY DEL 2ND TWIN-UNSP
66231 DELAY DEL 2ND TWIN-DELIV
66233 DELAY DEL 2 TWIN-ANTEPAR
66300 CORD PROLAPSE-UNSPEC
66301 CORD PROLAPSE-DELIVERED
66303 CORD PROLAPSE-ANTEPARTUM
66310 CORD AROUND NECK-UNSPEC
66311 CORD AROUND NECK-DELIVER
66313 CORD AROUND NECK-ANTEPAR
66320 CORD COMPRESS NEC-UNSPEC
66321 CORD COMPRESS NEC-DELIV

DIAGNOSES ALLOWED FOR FEMALES ONLY

66323 CORD COMPRES NEC-ANTEPAR
66330 CORD ENTANGLE NEC-UNSPEC
66331 CORD ENTANGLE NEC-DELIV
66333 CORD ENTANGL NEC-ANTEPAR
66340 SHORT CORD-UNSPECIFIED
66341 SHORT CORD-DELIVERED
66343 SHORT CORD-ANTEPARTUM
66350 VASA PREVIA-UNSPECIFIED
66351 VASA PREVIA-DELIVERED
66353 VASA PREVIA-ANTEPARTUM
66360 VASC LESION CORD-UNSPEC
66361 VASC LESION CORD-DELIVER
66363 VASC LESION CORD-ANTEPAR
66380 CORD COMPLICAT NEC-UNSP
66381 CORD COMPLICAT NEC-DELIV
66383 CORD COMPL NEC-ANTEPART
66390 CORD COMPLICAT NOS-UNSP
66391 CORD COMPLICAT NOS-DELIV
66393 CORD COMPL NOS-ANTEPART
66400 DEL W 1 DEG LACERAT-UNSP
66401 DEL W 1 DEG LACERAT-DEL
66404 DEL W 1 DEG LAC-POSTPART
66410 DEL W 2 DEG LACERAT-UNSP
66411 DEL W 2 DEG LACERAT-DEL
66414 DEL W 2 DEG LAC-POSTPART
66420 DEL W 3 DEG LACERAT-UNSP
66421 DEL W 3 DEG LACERAT-DEL
66424 DEL W 3 DEG LAC-POSTPART
66430 DEL W 4 DEG LACERAT-UNSP
66431 DEL W 4 DEG LACERAT-DEL
66434 DEL W 4 DEG LAC-POSTPART
66440 OB PERINEAL LAC NOS-UNSP
66441 OB PERINEAL LAC NOS-DEL
66444 PERINEAL LAC NOS-POSTPAR
66450 OB PERINEAL HEMATOM-UNSP
66451 OB PERINEAL HEMATOMA-DEL
66454 PERIN HEMATOMA-POSTPART
66480 OB PERIN TRAUM NEC-UNSP
66481 OB PERINEAL TRAU NEC-DEL
66484 PERIN TRAUM NEC-POSTPART
66490 OB PERIN TRAUM NOS-UNSP
66491 OB PERINEAL TRAU NOS-DEL
66494 PERIN TRAUM NOS-POSTPART
66500 PRELABOR RUPT UTER-UNSP
66501 PRELABOR RUPT UTERUS-DEL
66503 PRELAB RUPT UTER-ANTEPAR
66510 RUPTURE UTERUS NOS-UNSP
66511 RUPTURE UTERUS NOS-DELIV
66512 RUPT UTER NOS-DEL W P/P
66514 RUPT UTERUS NOS-POSTPART
66520 INVERSION OF UTERUS-UNSP
66522 INVERS UTERUS-DEL W P/P
66524 INVERS UTERUS-POSTPART
66530 LACERAT OF CERVIX-UNSPEC
66531 LACERAT OF CERVIX-DELIV
66534 LACER OF CERVIX-POSTPART
66540 HIGH VAGINAL LACER-UNSP
66541 HIGH VAGINAL LACER-DELIV
66544 HIGH VAGINAL LAC-POSTPAR
66550 OB INJ PELV ORG NEC-UNSP
66551 OB INJ PELV ORG NEC-DEL
66554 INJ PELV ORG NEC-POSTPAR
66560 DAMAGE TO PELVIC JT-UNSP
66561 DAMAGE TO PELVIC JT-DEL
66564 DAMAGE PELVIC JT-POSTPAR
66570 OB PELVIC HEMATOMA-UNSP
66571 OB PELVIC HEMATOMA-DELIV
66572 PELVIC HEMATOM-DEL W PP
66574 PELVIC HEMATOMA-POSTPART
66580 OB TRAUMA NEC-UNSPEC
66581 OB TRAUMA NEC-DELIVERED
66582 OB TRAUMA NEC-DEL W P/P
66583 OB TRAUMA NEC-ANTEPARTUM
66584 OB TRAUMA NEC-POSTPARTUM
66590 OB TRAUMA NOS-UNSPEC
66591 OB TRAUMA NOS-DELIVERED
66592 OB TRAUMA NOS-DEL W P/P
66593 OB TRAUMA NOS-ANTEPARTUM
66594 OB TRAUMA NOS-POSTPARTUM
66600 THIRD-STAGE HEM-UNSPEC
66602 THRD-STAGE HEM-DEL W P/P
66604 THIRD-STAGE HEM-POSTPART
66610 POSTPARTUM HEM NEC-UNSP
66612 POSTPA HEM NEC-DEL W P/P
66614 POSTPART HEM NEC-POSTPAR
66620 DELAY P/PART HEM-UNSPEC
66622 DELAY P/P HEM-DEL W P/P
66624 DELAY P/PART HEM-POSTPAR
66630 POSTPART COAGUL DEF-UNSP
66632 P/P COAG DEF-DEL W P/P
66634 POSTPART COAG DEF-POSTPA
66700 RETAIN PLACENTA NOS-UNSP
66702 RETND PLAC NOS-DEL W P/P
66704 RETAIN PLAC NOS-POSTPART
66710 RETAIN PROD CONCEPT-UNSP
66712 RET PROD CONC-DEL W P/P
66714 RET PROD CONCEPT-POSTPAR
66800 PULM COMPL IN DEL-UNSPEC
66801 PULM COMPL IN DEL-DELIV
66802 PULM COMPLIC-DEL W P/P

DIAGNOSES ALLOWED FOR FEMALES ONLY

66803 PULM COMPLICAT-ANTEPART
66804 PULM COMPLICAT-POSTPART
66810 HEART COMPL IN DEL-UNSP
66811 HEART COMPL IN DEL-DELIV
66812 HEART COMPL-DEL W P/P
66813 HEART COMPLIC-ANTEPART
66814 HEART COMPLIC-POSTPART
66820 CNS COMPL LABOR/DEL-UNSP
66821 CNS COMPL LAB/DEL-DELIV
66822 CNS COMPLIC-DEL W P/P
66823 CNS COMPL IN DEL-ANTEPAR
66824 CNS COMPL IN DEL-POSTPAR
66880 ANESTH COMP DEL NEC-UNSP
66881 ANESTH COMPL NEC-DELIVER
66882 ANESTH COMPL NEC-DEL P/P
66883 ANESTH COMPL ANTEPARTUM
66884 ANESTH COMPL-POSTPARTUM
66890 ANESTH COMP DEL NOS-UNSP
66891 ANESTH COMPL NOS-DELIVER
66892 ANESTH COMPL NOS-DEL P/P
66893 ANESTH COMPL-ANTEPARTUM
66894 ANESTH COMPL-POSTPARTUM
66900 MATERNAL DISTRESS-UNSPEC
66901 MATERNAL DISTRESS-DELIV
66902 MATERN DISTRES-DEL W P/P
66903 MATERN DISTRESS-ANTEPAR
66904 MATERN DISTRESS-POSTPART
66910 OBSTETRIC SHOCK-UNSPEC
66911 OBSTETRIC SHOCK-DELIVER
66912 OBSTET SHOCK-DELIV W P/P
66913 OBSTETRIC SHOCK-ANTEPAR
66914 OBSTETRIC SHOCK-POSTPART
66920 MATERN HYPOTENS SYN-UNSP
66921 MATERN HYPOTEN SYN-DELIV
66922 MATERN HYPOTEN-DEL W P/P
66923 MATERN HYPOTENS-ANTEPAR
66924 MATERN HYPOTENS-POSTPART
66930 AC REN FAIL W DELIV-UNSP
66932 AC REN FAIL-DELIV W P/P
66934 AC RENAL FAILURE-POSTPAR
66940 OTH OB SURG COMPL-UNSPEC
66941 OTH OB COMPL-DELIVERED
66942 OTH OB COMPL-DELIV W P/P
66944 OTH OB SURG COMPL-POSTPA
66950 FORCEP DELIV NOS-UNSPEC
66951 FORCEP DELIV NOS-DELIVER
66960 BREECH EXTR NOS-UNSPEC
66961 BREECH EXTR NOS-DELIVER
66970 CESAREAN DELIV NOS-UNSP
66971 CESAREAN DELIVERY NOS
66980 COMPL LAB/DELIV NEC-UNSP
66981 COMP LAB/DELIV NEC-DELIV
66982 COMPL DEL NEC-DEL W P/P
66983 COMPL DELIV NEC-ANTEPAR
66984 COMPL DELIV NEC-POSTPART
66990 COMPL LAB/DELIV NOS-UNSP
66991 COMP LAB/DELIV NOS-DELIV
66992 COMPL DEL NOS-DEL W P/P
66993 COMPL DELIV NOS-ANTEPAR
66994 COMPL DELIV NOS-POSTPART
67000 MAJOR PUERP INFECT-UNSP
67002 MAJOR PUERP INF-DEL P/P
67004 MAJOR PUERP INF-POSTPART
67100 VARIC VEIN LEG PREG-UNSP
67101 VARICOSE VEIN LEG-DELIV
67102 VARIC VEIN LEG-DEL W P/P
67103 VARIC VEIN LEG-ANTEPART
67104 VARIC VEIN LEG-POSTPART
67110 VARIC VULVA PREG-UNSPEC
67111 VARICOSE VULVA-DELIVERED
67112 VARICOSE VULVA-DEL W P/P
67113 VARICOSE VULVA-ANTEPART
67114 VARICOSE VULVA-POSTPART
67120 THROMBOPHLEB PREG-UNSPEC
67121 THROMBOPHLEBITIS-DELIVER
67122 THROMBOPHLEB-DELIV W P/P
67123 THROMBOPHLEBIT-ANTEPART
67124 THROMBOPHLEBIT-POSTPART
67130 DEEP THROMB ANTEPAR-UNSP
67131 DEEP THROM ANTEPAR-DELIV
67133 DEEP VEIN THROMB-ANTEPAR
67140 DEEP THROMB POSTPAR-UNSP
67142 THROMB POSTPAR-DEL W P/P
67144 DEEP VEIN THROMB-POSTPAR
67150 THROMBOSIS NEC PREG-UNSP
67151 THROMBOSIS NEC-DELIVERED
67152 THROMB NEC-DELIV W P/P
67153 THROMBOSIS NEC-ANTEPART
67154 THROMBOSIS NEC-POSTPART
67180 VEN COMPL PREG NEC-UNSP
67181 VENOUS COMPL NEC-DELIVER
67182 VEN COMP NEC-DELIV W P/P
67183 VENOUS COMPL NEC-ANTEPAR
67184 VENOUS COMPL NEC-POSTPAR
67190 VEN COMPL PREG NOS-UNSP
67191 VENOUS COMPL NOS-DELIVER
67192 VEN COMP NOS-DELIV W P/P
67193 VENOUS COMPL NOS-ANTEPAR
67194 VENOUS COMPL NOS-POSTPAR
67200 PUERPERAL PYREXIA-UNSPEC

DIAGNOSES ALLOWED FOR FEMALES ONLY

67202 PUERP PYREXIA-DEL W P/P
67204 PUERP PYREXIA-POSTPARTUM
67300 OB AIR EMBOLISM-UNSPEC
67301 OB AIR EMBOLISM-DELIVER
67302 OB AIR EMBOL-DELIV W P/P
67303 OB AIR EMBOLISM-ANTEPART
67304 OB AIR EMBOLISM-POSTPART
67310 AMNIOTIC EMBOLISM-UNSPEC
67311 AMNIOTIC EMBOLISM-DELIV
67312 AMNIOT EMBOL-DELIV W P/P
67313 AMNIOTIC EMBOL-ANTEPART
67314 AMNIOTIC EMBOL-POSTPART
67320 OB PULM EMBOL NOS-UNSPEC
67321 PULM EMBOL NOS-DELIVERED
67322 PULM EMBOL NOS-DEL W P/P
67323 PULM EMBOL NOS-ANTEPART
67324 PULM EMBOL NOS-POSTPART
67330 OB PYEMIC EMBOL-UNSPEC
67331 OB PYEMIC EMBOL-DELIVER
67332 OB PYEM EMBOL-DEL W P/P
67333 OB PYEMIC EMBOL-ANTEPART
67334 OB PYEMIC EMBOL-POSTPART
67380 OB PULMON EMBOL NEC-UNSP
67381 PULMON EMBOL NEC-DELIVER
67382 PULM EMBOL NEC-DEL W P/P
67383 PULMON EMBOL NEC-ANTEPAR
67384 PULMON EMBOL NEC-POSTPAR
67400 PUERP CEREBVASC DIS-UNSP
67401 PUERP CEREBVAS DIS-DELIV
67402 CEREBVAS DIS-DELIV W P/P
67403 CEREBROVASC DIS-ANTEPART
67404 CEREBROVASC DIS-POSTPART
67410 DISRUPT C-SECT WND-UNSP
67412 DISRUPT C-SECT-DEL W P/P
67414 DISRUPT C-SECT-POSTPART
67420 DISRUPT PERINEUM-UNSPEC
67422 DISRUPT PERIN-DEL W P/P
67424 DISRUPT PERINEUM-POSTPAR
67430 OB SURG COMPL NEC-UNSPEC
67432 OB SURG COMPL-DEL W P/P
67434 OB SURG COMP NEC-POSTPAR
67440 PLACENTAL POLYP-UNSPEC
67442 PLACENT POLYP-DEL W P/P
67444 PLACENTAL POLYP-POSTPART
67480 PUERP COMPL NEC-UNSPEC
67482 PUERP COMP NEC-DEL W P/P
67484 PUERP COMPL NEC-POSTPART
67490 PUERP COMPL NOS-UNSPEC
67492 PUERP COMP NOS-DEL W P/P
67494 PUERP COMPL NOS-POSTPART
67500 INFECT NIPPLE PREG-UNSP
67501 INFECT NIPPLE-DELIVERED
67502 INFECT NIPPLE-DEL W P/P
67503 INFECT NIPPLE-ANTEPARTUM
67504 INFECT NIPPLE-POSTPARTUM
67510 BREAST ABSCESS PREG-UNSP
67511 BREAST ABSCESS-DELIVERED
67512 BREAST ABSCESS-DEL W P/P
67513 BREAST ABSCESS-ANTEPART
67514 BREAST ABSCESS-POSTPART
67520 MASTITIS IN PREG-UNSPEC
67521 MASTITIS-DELIVERED
67522 MASTITIS-DELIV W P/P
67523 MASTITIS-ANTEPARTUM
67524 MASTITIS-POSTPARTUM
67580 BREAST INF PREG NEC-UNSP
67581 BREAST INFECT NEC-DELIV
67582 BREAST INF NEC-DEL W P/P
67583 BREAST INF NEC-ANTEPART
67584 BREAST INF NEC-POSTPART
67590 BREAST INF PREG NOS-UNSP
67591 BREAST INFECT NOS-DELIV
67592 BREAST INF NOS-DEL W P/P
67593 BREAST INF NOS-ANTEPART
67594 BREAST INF NOS-POSTPART
67600 RETRACT NIPPLE PREG-UNSP
67601 RETRACTED NIPPLE-DELIVER
67602 RETRACT NIPPLE-DEL W P/P
67603 RETRACT NIPPLE-ANTEPART
67604 RETRACT NIPPLE-POSTPART
67610 CRACKED NIPPLE PREG-UNSP
67611 CRACKED NIPPLE-DELIVERED
67612 CRACKED NIPPLE-DEL W P/P
67613 CRACKED NIPPLE-ANTEPART
67614 CRACKED NIPPLE-POSTPART
67620 BREAST ENGORGE-UNSPEC
67621 BREAST ENGORGE-DELIVERED
67622 BREAST ENGORGE-DEL W P/P
67623 BREAST ENGORGE-ANTEPART
67624 BREAST ENGORGE-POSTPART
67630 BREAST DIS PREG NEC-UNSP
67631 BREAST DIS NEC-DELIVERED
67632 BREAST DIS NEC-DEL W P/P
67633 BREAST DIS NEC-ANTEPART
67634 BREAST DIS NEC-POSTPART
67640 LACTATION FAIL-UNSPEC
67641 LACTATION FAIL-DELIVERED
67642 LACTATION FAIL-DEL W P/P
67643 LACTATION FAIL-ANTEPART
67644 LACTATION FAIL-POSTPART

DIAGNOSES ALLOWED FOR FEMALES ONLY

67650 SUPPR LACTATION-UNSPEC
67651 SUPPR LACTATION-DELIVER
67652 SUPPR LACTAT-DEL W P/P
67653 SUPPR LACTATION-ANTEPAR
67654 SUPPR LACTATION-POSTPART
67660 GALACTORRHEA PREG-UNSPEC
67661 GALACTORRHEA-DELIVERED
67662 GALACTORRHEA-DEL W P/P
67663 GALACTORRHEA-ANTEPARTUM
67664 GALACTORRHEA-POSTPARTUM
67680 LACTATION DIS NEC-UNSPEC
67681 LACTATION DIS NEC-DELIV
67682 LACTAT DIS NEC-DEL W P/P
67683 LACTAT DIS NEC-ANTEPART
67684 LACTAT DIS NEC-POSTPART
67690 LACTATION DIS NOS-UNSPEC
67691 LACTATION DIS NOS-DELIV
67692 LACTAT DIS NOS-DEL W P/P
67693 LACTAT DIS NOS-ANTEPART
67694 LACTAT DIS NOS-POSTPART
71630 CLIMACT ARTHRITIS-UNSPEC
71631 CLIMACT ARTHRITIS-SHLDER
71632 CLIMACT ARTHRITIS-UP/ARM
71633 CLIMACT ARTHRIT-FOREARM
71634 CLIMACT ARTHRITIS-HAND
71635 CLIMACT ARTHRITIS-PELVIS
71636 CLIMACT ARTHRITIS-L/LEG
71637 CLIMACT ARTHRITIS-ANKLE
71638 CLIMACT ARTHRITIS NEC
71639 CLIMACT ARTHRITIS-MULT
7520 ANOMALIES OF OVARIES
75210 TUBAL/BROAD LIG ANOM NOS
75211 EMBRYONIC CYST OF ADNEXA
75219 TUBAL/BROAD LIG ANOM NEC
7522 DOUBLING OF UTERUS
7523 UTERINE ANOMALY NEC
75240 CERVIX/FEM GEN ANOM NOS
75241 EMBRYON CYST FEM GEN NEC
75242 IMPERFORATE HYMEN
75249 CERVIX/FEM GEN ANOM NEC
7923 ABN FIND-AMNIOTIC FLUID
7950 ABN PAP SMEAR-CERVIX
8674 UTERUS INJURY-CLOSED
8675 UTERUS INJURY-OPEN
8784 OPEN WOUND OF VULVA
8785 OPEN WOUND VULVA-COMPL
8786 OPEN WOUND OF VAGINA
8787 OPEN WOUND VAGINA-COMPL
90255 INJURY UTERINE ARTERY
90256 INJURY UTERINE VEIN
90281 INJURY OVARIAN ARTERY
90282 INJURY OVARIAN VEIN
9391 FOREIGN BODY UTERUS
9392 FOREIGN BDY VULVA/VAGINA
9474 BURN OF VAGINA & UTERUS
99632 MALFUNCTION IUD
V1040 HX-FEMALE GENIT MALG NOS
V1041 HX-CERVICAL MALIGNANCY
V1042 HX-UTERUS MALIGNANCY NEC
V1043 HX OF OVARIAN MALIGNANCY
V1044 HX-FEMALE GENIT MALG NEC
V220 SUPERVIS NORMAL 1ST PREG
V221 SUPERVIS OTH NORMAL PREG
V222 PREG STATE, INCIDENTAL
V230 PREG W HX OF INFERTILITY
V231 PREG W HX-TROPHOBLAS DIS
V232 PREG W HX OF ABORTION
V233 GRAND MULTIPARITY
V234 PREG W POOR OBSTETRIC HX
V235 PREG W POOR REPRODUCT HX
V238 SUPRV HIGH-RISK PREG NEC
V239 SUPRV HIGH-RISK PREG NOS
V240 POSTPART CARE AFTER DEL
V241 POSTPART CARE-LACTATION
V242 ROUT POSTPART FOLLOW-UP
V2501 PRESCRIP-ORAL CONTRACEPT
V251 INSERTION OF IUD
V253 MENSTRUAL EXTRACTION
V2541 CONTRACEPT PILL SURVEILL
V2542 IUD SURVEILLANCE
V261 ARTIFICIAL INSEMINATION
V270 DELIVER-SINGLE LIVEBORN
V271 DELIVER-SINGLE STILLBORN
V272 DELIVER-TWINS, BOTH LIVE
V273 DEL-TWINS, 1 NB, 1 SB
V274 DELIVER-TWINS, BOTH SB
V275 DEL-MULT BIRTH, ALL LIVE
V276 DEL-MULT BRTH, SOME LIVE
V277 DEL-MULT BIRTH, ALL SB
V279 OUTCOME OF DELIVERY NOS
V280 SCREENING-CHROMOSOM ANOM
V281 SCREEN-ALPHAFETOPROTEIN
V282 SCREEN BY AMNIOCENT NEC
V283 SCREEN-FETAL MALFORM
V284 SCREEN-FETAL RETARDATION
V285 SCREEN-ISOIMMUNIZATION
V288 ANTENATAL SCREENING NEC
V289 ANTENATAL SCREENING NOS
V455 PRESENCE OF IUD
V524 FITTING BREAST PROSTHES

DIAGNOSES ALLOWED FOR FEMALES ONLY

V616	ILLEGITIMATE PREGNANCY
V617	UNWANTED PREGNANCY NEC
V723	GYNECOLOGIC EXAMINATION
V724	PREG EXAM-PREG UNCONFIRM
V762	SCREEN MAL NEOP-CERVIX

PROCEDURES ALLOWED FOR FEMALES ONLY

650 OOPHOROTOMY
6511 OVARIAN ASPIRAT BIOPSY
6512 OVARIAN BIOPSY NEC
6519 OVARIAN DX PROCEDURE NEC
6521 OVARIAN CYST MARSUPIALIZ
6522 OVARIAN WEDGE RESECTION
6529 LOCAL DESTR OVA LES NEC
653 UNILATERAL OOPHORECTOMY
654 UNILAT SALPINGO-OOPHOREC
6551 REMOVE BOTH OVARIES
6552 REMOVE SOLITARY OVARY
6561 REMOVE BOTH TUBES & OVAR
6562 REMOVE SOLITARY TUBE/OVA
6571 SIMPLE SUTURE OF OVARY
6572 OVARIAN REIMPLANTATION
6573 SALPINGO-OOPHOROPLASTY
6579 REPAIR OF OVARY NEC
658 TUBO-OVARIAN ADHESIOLYS
6591 ASPIRATION OF OVARY
6592 TRANSPLANTATION OF OVARY
6593 MANUAL RUPT OVARIAN CYST
6594 OVARIAN DENERVATION
6595 OVARIAN TORSION RELEASE
6599 OVARIAN OPERATION NEC
660 SALPINGOTOMY
6611 FALLOPIAN TUBE BIOPSY
6619 FALLOP TUBE DX PROC NEC
6621 BILAT ENDOSC CRUSH TUBE
6622 BILAT ENDOSC DIVIS TUBE
6629 BILAT ENDOS OCC TUBE NEC
6631 BILAT TUBAL CRUSHING NEC
6632 BILAT TUBAL DIVISION NEC
6639 BILAT TUBAL DESTRUCT NEC
664 TOTAL UNILAT SALPINGECT
6651 REMOVE BOTH FALLOP TUBES
6652 REMOVE SOLITARY FAL TUBE
6661 DESTROY FALLOP TUBE LES
6662 REMOV TUBE & ECTOP PREG
6663 BILAT PART SALPINGEC NOS
6669 PARTIAL SALPINGECTOM NEC
6671 SIMPL SUTURE FALLOP TUBE
6672 SALPINGO-OOPHOROSTOMY
6673 SALPINGO-SALPINGOSTOMY
6674 SALPINGO-UTEROSTOMY
6679 FALLOP TUBE REPAIR NEC
668 FALLOPIAN TUBE INSUFFLAT
6691 FALLOPIAN TUBE ASPIRAT
6692 UNILAT FALLOP TUBE DESTR
6693 IMPL FALLOP TUBE PROSTH
6694 REMOV FALLOP TUBE PROSTH
6695 BLOW THERAPEUT INTO TUBE
6696 FALLOPIAN TUBE DILATION
6697 BURY FIMBRIAE IN UTERUS
6699 FALLOPIAN TUBE OP NEC
670 CERVICAL CANAL DILATION
6711 ENDOCERVICAL BIOPSY
6712 CERVICAL BIOPSY NEC
6719 CERVICAL DX PROCEDUR NEC
672 CONIZATION OF CERVIX
6731 CERVICAL CYST MARSUPIAL
6732 CERVICAL LES CAUTERIZAT
6733 CERVICAL LES CRYOTHERAPY
6739 CERVICAL LES DESTRUC NEC
674 AMPUTATION OF CERVIX
675 INT CERVICAL OS REPAIR
6761 SUTURE CERVICAL LACERAT
6762 CERVICAL FISTULA REPAIR
6769 CERVICAL REPAIR NEC
680 HYSTEROTOMY
6811 DIGITAL EXAM OF UTERUS
6812 HYSTEROSCOPY
6813 UTERINE BIOPSY
6814 UTERINE LIGAMENT BIOPSY
6819 UTERUS/ADNEX DX PROC NEC
6821 ENDOMET SYNECHIAE DIVIS
6822 INCISION UTERINE SEPTUM
6829 UTERINE LES DESTRUCT NEC
683 SUBTOT ABD HYSTERECTOMY
684 TOTAL ABD HYSTERECTOMY
685 VAGINAL HYSTERECTOMY
686 RADICAL ABD HYSTERECTOMY
687 RADICAL VAG HYSTERECTOMY
688 PELVIC EVISCERATION
6901 D & C FOR PREG TERMINAT
6902 D & C POST DELIVERY
6909 D & C NEC
6911 REMOVE INTRALIG ECT PREG
6919 DESTRUC UTER SUPPORT NEC
6921 INTERPOSIT OP UTERIN LIG
6922 UTERINE SUSPENSION NEC
6923 VAG REPAIR INVERS UTERUS
6929 UTERUS/ADNEXA REPAIR NEC
693 PARACERV UTERINE DENERV
6941 SUTURE UTERINE LACERAT
6942 CLOSURE UTERINE FISTULA
6949 UTERINE REPAIR NEC
6951 ASPIRAT CURET-PREG TERMI
6952 ASPIRAT CURET-POST DELIV
6959 ASPIR CURETT UTERUS NEC
696 MENSTRUAL EXTRACTION

PROCEDURES ALLOWED FOR FEMALES ONLY

697	INSERTION OF IUD
6991	INSERT UTERINE DEVICE
6992	ARTIFICIAL INSEMINATION
6993	INSERTION OF LAMINARIA
6994	MAN REPLACE INVERT UTER
6995	INCISION OF CERVIX
6996	REMOVE CERVICAL CERCLAGE
6997	REMOVE PENETRAT CERV FB
6998	UTERINE SUPPORT OP NEC
6999	UTERINE OPERATION NEC
700	CULDOCENTESIS
7011	HYMENOTOMY
7012	CULDOTOMY
7013	INTRALUM VAG ADHESIOLYS
7014	VAGINOTOMY NEC
7021	VAGINOSCOPY
7022	CULDOSCOPY
7023	CUL-DE-SAC BIOPSY
7024	VAGINAL BIOPSY
7029	VAGIN/CUL-DE-SAC DX NEC
7031	HYMENECTOMY
7032	EXCIS CUL-DE-SAC LESION
7033	EXCISION VAGINAL LESION
704	VAGINAL OBLITERATION
7050	CYSTOCEL/RECTOCEL REPAIR
7051	CYSTOCELE REPAIR
7052	RECTOCELE REPAIR
7061	VAGINAL CONSTRUCTION
7062	VAGINAL RECONSTRUCTION
7071	SUTURE VAGINA LACERATION
7072	REPAIR COLOVAGIN FISTULA
7073	REPAIR RECTOVAG FISTULA
7074	REP VAGINOENT FISTUL NEC
7075	REPAIR VAG FISTULA NEC
7076	HYMENORRHAPHY
7077	VAGINAL SUSPENS & FIXAT
7079	VAGINAL REPAIR NEC
708	VAGINAL VAULT OBLITERAT
7091	VAGINAL OPERATION NEC
7092	CUL-DE-SAC OPERATION NEC
7101	VULVAR ADHESIOLYSIS
7109	INCIS VULVA/PERINEUM NEC
7111	VULVAR BIOPSY
7119	VULVAR DIAGNOS PROC NEC
7121	PERCUTAN BARTHOLIN ASPIR
7122	INCISE BARTHOLIN'S GLAND
7123	BARTHOLIN GLAND MARSUP
7124	DESTRUC BARTHOLIN GLAND
7129	BARTHOLIN'S GLAND OP NEC
713	LOCAL VULVAR EXCIS NEC
714	OPERATIONS ON CLITORIS
715	RADICAL VULVECTOMY
7161	UNILATERAL VULVECTOMY
7162	BILATERAL VULVECTOMY
7171	SUTURE VULVAR LACERATION
7172	REPAIR VULVAR FISTULA
7179	VULVAR/PERIN REPAIR NEC
718	OTHER VULVAR OPERATIONS
719	OTHER FEMALE GENITAL OPS
720	LOW FORCEPS OPERATION
721	LOW FORCEPS W EPISIOTOMY
7221	MID FORCEPS W EPISIOTOMY
7229	MID FORCEPS OP NEC
7231	HIGH FORCEPS W EPISIOT
7239	HIGH FORCEPS OP NEC
724	FORCEPS ROTAT FETAL HEAD
7251	PART BRCH EXTRAC W FORCP
7252	PART BREECH EXTRACT NEC
7253	TOT BRCH EXTRAC W FORCEP
7254	TOT BREECH EXTRAC NEC
726	FORCEPS-AFTERCOMING HEAD
7271	VACUUM EXT DEL W EPISIOT
7279	VACUUM EXTRACT DEL NEC
728	INSTRUMENT DELIVERY NEC
729	INSTRUMENT DELIVERY NOS
7301	INDUCT LABOR-RUPT MEMB
7309	ARTIF RUPT MEMBRANES NEC
731	SURG INDUCT LABOR NEC
7321	INT/COMB VERSION NO EXTR
7322	INT/COMB VERSION W EXTR
733	FAILED FORCEPS
734	MEDICAL INDUCTION LABOR
7351	MANUAL ROTAT FETAL HEAD
7359	MANUAL ASSIST DELIV NEC
736	EPISIOTOMY
738	FETAL OPS-FACILITATE DEL
7391	EXT VERSION-ASSIST DELIV
7392	REPLACE PROLAPSED CORD
7393	INCIS CX TO ASSIST DELIV
7394	PUBIOTOMY TO ASSIST DEL
7399	OPS ASSISTING DELIV NEC
740	CLASSICAL C-SECTION
741	LOW CERVICAL C-SECTION
742	EXTRAPERITONEAL C-SECT
743	REMOV INTRAPERIT FETUS
744	CESAREAN SECTION NEC
7491	HYSTEROTOMY TO TERMIN PG
7499	CESAREAN SECTION NOS
750	INTRA-AMNION INJ FOR AB
751	DIAGNOSTIC AMNIOCENTESIS

PROCEDURES ALLOWED FOR FEMALES ONLY

752	INTRAUTERINE TRANSFUSION
7531	AMNIOSCOPY
7532	FETAL EKG
7533	FETAL BLOOD SAMPLE/BX
7534	FETAL MONITORING NOS
7535	DX PROC FETUS/AMNION NEC
7536	CORRECTION FETAL DEFECT
754	MANUAL REMOVAL-PLACENTA
7550	REPAIR OB LAC UTERUS NOS
7551	REPAIR OB LACERAT CERVIX
7552	REPAIR OB LAC CORP UTERI
7561	REPAIR OB LAC BLAD/URETH
7562	REPAIR OB LAC RECT/ANUS
7569	REPAIR OB LACERATION NEC
757	MANUAL EXPLOR UTERUS P/P
758	OB TAMPONADE UTERUS/VAG
7591	EVAC OB INC HEMAT PERIN
7592	EVAC OB HEMAT VULVA/VAG
7593	SURG CORR INVERT UTERUS
7594	MAN REPLAC INVERT UTERUS
7599	OBSTETRIC OPERATION NEC
8781	X-RAY OF GRAVID UTERUS
8782	GAS HYSTEROSALPINGOGRAM
8783	DYE HYSTEROSALPINGOGRAM
8784	PERCUTANEOUS HYSTEROGRAM
8785	TUBE & UTERUS X-RAY NEC
8789	FEMALE GENITAL X-RAY NEC
8846	CONTRAST PLACENTOGRAM
8878	DX ULTRASOUND-GRAV UTER
8926	GYNECOLOGIC EXAMINATION
9141	BACT SMEAR-FEMALE GENIT
9142	CULTURE-FEMALE GENITAL
9143	C & S-FEMALE GENITAL
9144	PARASITOLOGY-FEMALE GEN
9145	TOXICOLOGY-FEMALE GENIT
9146	CELL BLK/PAP-FEMALE GEN
9149	MICRO EXAM-FEMAL GEN NEC
9217	PLACENTAL SCAN
9614	VAGINAL PACKING
9615	VAGINAL MOLD INSERTION
9616	OTHER VAGINAL DILATION
9617	VAG DIAPHRAGM INSERTION
9618	OTH VAGIN PESSARY INSERT
9644	VAGINAL DOUCHE
9724	REPLACE VAG DIAPHRAGM
9725	REPLACE VAGINAL PESSARY
9726	REPLACE VAG/VULV PACKING
9771	REMOVAL IUD
9772	REMOV INTRAUTERINE PACK
9773	REMOV VAGINAL DIAPHRAGM
9774	REMOVAL OTH VAG PESSARY
9775	REMOV VAG/VULV PACKING
9816	REMOV INTRALUM UTER FB
9817	REMOV INTRALUM VAG FB
9823	REMOVAL VULVAR FB

DIAGNOSES ALLOWED FOR MALES ONLY

01640 TB EPIDIDYMIS-UNSPEC
01641 TB EPIDIDYMIS-NO EXAM
01642 TB EPIDIDYMIS-EXAM UNKN
01643 TB EPIDIDYMIS-MICRO DX
01644 TB EPIDIDYMIS-CULT DX
01645 TB EPIDIDYMIS-HISTO DX
01646 TB EPIDIDYMIS-OTH TEST
01650 TB MALE GENIT NEC-UNSPEC
01651 TB MALE GEN NEC-NO EXAM
01652 TB MALE GEN NEC-EX UNKN
01653 TB MALE GEN NEC-MICRO DX
01654 TB MALE GEN NEC-CULT DX
01655 TB MALE GEN NEC-HISTO DX
01656 TB MALE GEN NEC-OTH TEST
05413 HERPETIC INFECT OF PENIS
0720 MUMPS ORCHITIS
09812 GC PROSTATITIS (ACUTE)
09813 GC ORCHITIS (ACUTE)
09814 GC SEM VESICULIT (ACUTE)
09832 GC PROSTATITIS, CHRONIC
09833 GC ORCHITIS, CHRONIC
09834 GC SEM VESICULITIS, CHR
13103 TRICHOMONAL PROSTATITIS
1750 MAL NEO MALE NIPPLE
1759 MAL NEO MALE BREAST NEC
185 MALIGN NEOPL PROSTATE
1860 MAL NEO UNDESCEND TESTIS
1869 MALIG NEO TESTIS NEC
1871 MALIGN NEOPL PREPUCE
1872 MALIG NEO GLANS PENIS
1873 MALIG NEO PENIS BODY
1874 MALIG NEO PENIS NOS
1875 MALIG NEO EPIDIDYMIS
1876 MAL NEO SPERMATIC CORD
1877 MALIGN NEOPL SCROTUM
1878 MAL NEO MALE GENITAL NEC
1879 MAL NEO MALE GENITAL NOS
2144 LIPOMA SPERMATIC CORD
2220 BENIGN NEOPLASM TESTIS
2221 BENIGN NEOPLASM PENIS
2222 BENIGN NEOPLASM PROSTATE
2223 BENIGN NEO EPIDIDYMIS
2224 BENIGN NEOPLASM SCROTUM
2228 BEN NEO MALE GENITAL NEC
2229 BEN NEO MALE GENITAL NOS
2334 CA IN SITU PROSTATE
2335 CA IN SITU PENIS
2336 CA IN SITU MALE GEN NEC
2364 UNC BEHAV NEO TESTIS
2365 UNC BEHAV NEO PROSTATE
2366 UNC BEHAV NEO MALE NEC
2570 TESTICULAR HYPERFUNCTION
2571 POSTABLAT TESTIC HYPOFUN
2572 TESTICULAR HYPOFUNC NEC
2578 TESTICULAR DYSFUNCT NEC
2579 TESTICULAR DYSFUNCT NOS
30274 INHIBITED MALE ORGASM
30275 PREMATURE EJACULATION
4564 SCROTAL VARICES
600 HYPERPLASIA OF PROSTATE
6010 ACUTE PROSTATITIS
6011 CHRONIC PROSTATITIS
6012 ABSCESS OF PROSTATE
6013 PROSTATOCYSTITIS
6014 PROSTATITIS IN OTH DIS
6018 PROSTATIC INFLAM DIS NEC
6019 PROSTATITIS NOS
6020 CALCULUS OF PROSTATE
6021 PROSTATIC CONGEST/HEMORR
6022 ATROPHY OF PROSTATE
6028 PROSTATIC DISORDERS NEC
6029 PROSTATIC DISORDER NOS
6040 ORCHITIS WITH ABSCESS
60490 ORCHITIS/EPIDIDYMIT NOS
60491 ORCHITIS IN OTH DISEASE
60499 ORCHITIS/EPIDIDYMIT NEC
605 REDUN PREPUCE & PHIMOSIS
6060 AZOOSPERMIA
6061 OLIGOSPERMIA
6068 MALE INFERTILITY NEC
6069 MALE INFERTILITY NOS
6070 LEUKOPLAKIA OF PENIS
6071 BALANOPOSTHITIS
6072 INFLAM DIS, PENIS NEC
6073 PRIAPISM
60781 BALANITIS XEROTICA OBLIT
60782 VASCULAR DISORDER, PENIS
60783 EDEMA OF PENIS
60784 IMPOTENCE, ORGANIC ORIGN
60789 DISORDER OF PENIS NEC
6079 DISORDER OF PENIS NOS
6080 SEMINAL VESICULITIS
6081 SPERMATOCELE
6082 TORSION OF TESTIS
6083 ATROPHY OF TESTIS
6084 MALE GEN INFLAM DIS NEC
60881 MALE GEN DIS IN OTH DIS
60883 MALE GEN VASCUL DIS NEC
60884 CHYLOCELE, TUNIC VAGINAL
60885 STRICTURE, MALE GEN ORGN

DIAGNOSES ALLOWED FOR MALES ONLY

60886	EDEMA, MALE GENITAL ORGN
60889	MALE GENITAL DIS NEC
6089	MALE GENITAL DIS NOS
7525	UNDESCENDED TESTICLE
7526	MALE HYPOSPADIAS/EPISPAD
7587	KLINEFELTER'S SYNDROME
7922	ABN FINDINGS-SEMEN
8780	OPEN WOUND OF PENIS
8781	OPEN WOUND PENIS-COMPL
8782	OPN WOUND SCROTUM/TESTES
8783	OPN WND SCROT/TEST-COMPL
9393	FOREIGN BODY PENIS
V1045	HX-MALE GENIT MALIG NOS
V1046	HX-PROSTATIC MALIGNANCY
V1047	HX-TESTICULAR MALIGNANCY
V1049	HX-MALE GENIT MALIG NEC
V502	ROUTINE CIRCUMCISION

PROCEDURES ALLOWED FOR MALES ONLY

600 INCISION OF PROSTATE
6011 PROSTATIC NEEDLE BIOPSY
6012 PROSTATIC BIOPSY NEC
6013 PERCUT SEMINAL VES BIOPS
6014 SEMINAL VES BIOPSY NEC
6015 PERIPROSTATIC BIOPSY
6018 PROSTATIC DX PROCED NEC
6019 SEMIN VES DX PROCED NEC
602 TRANSURETHRAL PROSTATECT
603 SUPRAPUBIC PROSTATECTOMY
604 RETROPUBIC PROSTATECTOMY
605 RADICAL PROSTATECTOMY
6061 LOS EXCIS PROSTATIC LES
6062 PERINEAL PROSTATECTOMY
6069 PROSTATECTOMY NEC
6071 PERCUT SEMIN VES ASPIRAT
6072 SEMINAL VESICLE INCISION
6073 SEMINAL VESICLE EXCISION
6079 SEMINAL VESICLE OP NEC
6081 PERIPROSTATIC INCISION
6082 PERIPROSTATIC EXCISION
6091 PERCUT PROSTATIC ASPIRAT
6092 INJECTION INTO PROSTATE
6093 REPAIR OF PROSTATE
6094 CONTROL POSTOP PROST HEM
6099 PROSTATIC OPERATION NEC
610 SCROTUM & TUNICA I & D
6111 SCROTUM & TUNICA BIOPSY
6119 SCROT/TUNICA DX PROC NEC
612 EXCISION OF HYDROCELE
613 SCROTAL LES DESTRUCTION
6141 SUTURE SCROTAL LACERAT
6142 SCROTAL FISTULA REPAIR
6149 SCROTUM/TUNIC REPAIR NEC
6191 PERCUT TUNICA ASPIRATION
6192 EXCISION TUNICA LES NEC
6199 SCROTUM & TUNICA OP NEC
620 INCISION OF TESTES
6211 PERCUT TESTICULAR BIOPSY
6212 TESTICULAR BIOPSY NEC
6219 TESTES DX PROCEDURE NEC
622 TESTICULAR LES DESTRUCT
623 UNILATERAL ORCHIECTOMY
6241 REMOVE BOTH TESTES
6242 REMOVE SOLITARY TESTIS
625 ORCHIOPEXY
6261 SUTURE TESTICULAR LACER
6269 TESTICULAR REPAIR NEC
627 INSERT TESTICULAR PROSTH
6291 ASPIRATION OF TESTES
6292 INJECTION INTO TESTES
6299 TESTICULAR OPERATION NEC
6301 SPERMATIC CORD/VAS BIOPS
6309 SPERMAT CORD/VAS DX NEC
631 EXC SPERMATIC VARICOCELE
632 EXCISE EPIDIDYMIS CYST
633 EXCISE CORD/EPID LES NEC
634 EPIDIDYMECTOMY
6351 SUTURE CORD & EPID LACER
6352 REDUCTION TORSION TESTES
6353 TRANSPLANT SPERMAT CORD
6359 CORD & EPIDID REPAIR NEC
636 VASOTOMY
6370 MALE STERILIZATION NOS
6371 LIGATION OF VAS DEFERENS
6372 SPERMATIC CORD LIGATION
6373 VASECTOMY
6381 SUTURE VAS & EPIDID LAC
6382 POSTOP VAS RECONSTRUCT
6383 EPIDIDYMOVASOSTOMY
6384 REMOVAL VAS LIGATURE
6385 REMOV VAS DEFERENS VALVE
6389 VAS & EPIDIDY REPAIR NEC
6391 SPERMATOCELE ASPIRATION
6392 EPIDIDYMOTOMY
6393 SPERMATIC CORD INCISION
6394 SPERM CORD ADHESIOLYSIS
6395 INSERT VALVE IN VAS DEF
6399 CORD/EPID/VAS OPS NEC
640 CIRCUMCISION
6411 PENILE BIOPSY
6419 PENILE DIAGNOST PROC NEC
642 LOCAL EXCIS PENILE LES
643 AMPUTATION OF PENIS
6441 SUTURE PENILE LACERATION
6442 RELEASE OF CHORDEE
6443 CONSTRUCTION OF PENIS
6444 RECONSTRUCTION OF PENIS
6445 REPLANTATION OF PENIS
6449 PENILE REPAIR NEC
645 SEX TRANSFORMAT OP NEC
6491 DORSAL/LAT SLIT PREPUCE
6492 INCISION OF PENIS
6493 DIVISION OF PENILE ADHES
6494 FIT EXT PENILE PROSTHES
6495 INS NONINFL PENIS PROSTH
6496 REMOVE INT PENILE PROSTH
6497 INS INFLATE PENIS PROSTH
6498 PENILE OPERATION NEC
6499 MALE GENITAL OP NEC

PROCEDURES ALLOWED FOR MALES ONLY

8791	CONTR SEMIN VESICULOGRAM
8792	PROSTAT/SEM VES XRAY NEC
8793	CONTRAST EPIDIDYMOGRAM
8794	CONTRAST VASOGRAM
8795	EPIDIDYMIS/VAS X-RAY NEC
8799	MALE GENITAL X-RAY NEC
9824	REMOVAL SCROTAL/PENIS FB
9994	PROSTATIC MASSAGE
9995	STRETCHING OF FORESKIN
9996	SPERM COLLECTION

MANIFESTATIONS NOT ALLOWED AS PRINCIPAL DIAGNOSIS

3207	MENING IN OTH BACT DIS
3210	CRYPTOCOCCAL MENINGITIS
3211	MENING IN OTH FUNGAL DIS
3212	MENING IN OTH VIRAL DIS
3213	TRYPANOSOMIASIS MENINGIT
3214	MENINGIT D/T SARCOIDOSIS
3218	MENING IN OTH NONBAC DIS
3230	ENCEPHALIT IN VIRAL DIS
3231	RICKETTSIAL ENCEPHALITIS
3232	PROTOZOAL ENCEPHALITIS
3234	OTH ENCEPHALIT D/T INFEC
3236	POSTINFECT ENCEPHALITIS
3237	TOXIC ENCEPHALITIS
3302	CEREB DEGEN IN LIPIDOSIS
3303	CERB DEG CHLD IN OTH DIS
3317	CEREB DEGEN IN OTH DIS
3344	CEREBEL ATAX IN OTH DIS
3362	COMB DEG CORD IN OTH DIS
3363	MYELOPATHY IN OTH DIS
3371	AUT NEUROPTHY IN OTH DIS
3571	NEURPTHY IN COL VASC DIS
3572	NEUROPATHY IN DIABETES
3573	NEUROPATHY IN MALIG DIS
3574	NEUROPATHY IN OTHER DIS
3581	MYASTHENIA IN OTH DIS
3595	MYOPATHY IN ENDOCRIN DIS
3596	INFL MYOPATHY IN OTH DIS
36201	DIABETIC RETINOPATHY NOS
36202	PROLIF DIAB RETINOPATHY
36271	RET DYSTRPH IN LIPIDOSES
36272	RET DYSTRPH IN SYST DIS
36411	CHR IRIDOCYL IN OTH DIS
36541	GLAUC W CHAMB ANGLE ANOM
36542	GLAUCOMA W IRIS ANOMALY
36543	GLAUC W ANT SEG ANOM NEC
36544	GLAUCOMA W SYSTEMIC SYND
36641	DIABETIC CATARACT
36642	TETANIC CATARACT
36643	MYOTONIC CATARACT
36644	CATARACT W SYNDROME NEC
37044	KERATITIS IN EXANTHEMA
37105	PHTHISICAL CORNEA
37215	PARASITIC CONJUNCTIVITIS
37231	ROSACEA CONJUNCTIVITIS
37233	MUCOCUTAN DIS CONJUNCTIV
3734	INFECT DERM LID W DEFORM
3735	INFEC DERMATITIS LID NEC
3736	PARASITIC INFEST EYELID
37451	XANTHELASMA
37613	PARASITE INFEST, ORBIT
37621	THYROTOXIC EXOPHTHALMOS
37622	EXOPHTHALM OPHTHALMOPLEG
38013	AC INFECT EXTERN EAR NEC
38015	CHR MYCOT OTITIS EXTERNA
38202	AC SUPP OM IN OTH DIS
4200	AC PERICARDIT IN OTH DIS
4211	AC ENDOCARDIT IN OTH DIS
4220	AC MYOCARDIT IN OTH DIS
42491	ENDOCARDITIS IN OTH DIS
4257	METABOLIC CARDIOMYOPATHY
4258	CARDIOMYOPATH IN OTH DIS
44381	ANGIOPATHY IN OTHER DIS
45620	BLEED ESOPH VAR OTH DIS
45621	ESOPH VARICE OTH DIS NOS
4841	PNEUM W CYTOMEG INCL DIS
4843	PNEUMONIA IN WHOOP COUGH
4845	PNEUMONIA IN ANTHRAX
4846	PNEUM IN ASPERGILLOSIS
4847	PNEUM IN OTH SYS MYCOSES
4848	PNEUM IN INFECT DIS NEC
5161	IDIO PULM HEMOSIDEROSIS
5171	RHEUMATIC PNEUMONIA
5172	SYST SCLEROSIS LUNG DIS
5178	LUNG INVOLV IN OTH DIS
5670	PERITONITIS IN INFEC DIS
5731	HEPATITIS IN VIRAL DIS
5732	HEPATITIS IN OTH INF DIS
58081	AC NEPHRITIS IN OTH DIS
58181	NEPHROTIC SYN IN OTH DIS
58281	CHR NEPHRITIS IN OTH DIS
58381	NEPHRITIS NOS IN OTH DIS
59081	PYELONEPHRIT IN OTH DIS
5954	CYSTITIS IN OTH DIS
59801	URETH STRICT:OTH INFECT
6014	PROSTATITIS IN OTH DIS
60491	ORCHITIS IN OTH DISEASE
60881	MALE GEN DIS IN OTH DIS
61611	VAGINITIS IN OTH DISEASE
61651	VULVAR ULCER IN OTH DIS
6281	INFERTIL-PITUITARY ORIG
71110	REITER ARTHRITIS-UNSPEC
71111	REITER ARTHRITIS-SHLDER
71112	REITER ARTHRITIS-UP/ARM
71113	REITER ARTHRITIS-FOREARM
71114	REITER ARTHRITIS-HAND
71115	REITER ARTHRITIS-PELVIS
71116	REITER ARTHRITIS-L/LEG
71117	REITER ARTHRITIS-ANKLE
71118	REITER ARTHRITIS NEC
71119	REITER ARTHRITIS-MULT

MANIFESTATIONS NOT ALLOWED AS PRINCIPAL DIAGNOSIS

71120 BEHCET ARTHRITIS-UNSPEC
71121 BEHCET ARTHRITIS-SHLDER
71122 BEHCET ARTHRITIS-UP/ARM
71123 BEHCET ARTHRITIS-FOREARM
71124 BEHCET ARTHRITIS-HAND
71125 BEHCET ARTHRITIS-PELVIS
71126 BEHCET ARTHRITIS-L/LEG
71127 BEHCET ARTHRITIS-ANKLE
71128 BEHCET ARTHRITIS NEC
71129 BEHCET ARTHRITIS-MULT
71130 DYSENTER ARTHRIT-UNSPEC
71131 DYSENTER ARTHRIT-SHLDER
71132 DYSENTER ARTHRIT-UP/ARM
71133 DYSENTER ARTHRIT-FOREARM
71134 DYSENTER ARTHRIT-HAND
71135 DYSENTER ARTHRIT-PELVIS
71136 DYSENTER ARTHRIT-L/LEG
71137 DYSENTER ARTHRIT-ANKLE
71138 DYSENTER ARTHRIT NEC
71139 DYSENTER ARTHRIT-MULT
71140 BACT ARTHRITIS-UNSPEC
71141 BACT ARTHRITIS-SHLDER
71142 BACT ARTHRITIS-UP/ARM
71143 BACT ARTHRITIS-FOREARM
71144 BACT ARTHRITIS-HAND
71145 BACT ARTHRITIS-PELVIS
71146 BACT ARTHRITIS-L/LEG
71147 BACT ARTHRITIS-ANKLE
71148 BACT ARTHRITIS NEC
71149 BACT ARTHRITIS-MULT
71150 VIRAL ARTHRITIS-UNSPEC
71151 VIRAL ARTHRITIS-SHLDER
71152 VIRAL ARTHRITIS-UP/ARM
71153 VIRAL ARTHRITIS-FOREARM
71154 VIRAL ARTHRITIS-HAND
71155 VIRAL ARTHRITIS-PELVIS
71156 VIRAL ARTHRITIS-L/LEG
71157 VIRAL ARTHRITIS-ANKLE
71158 VIRAL ARTHRITIS NEC
71159 VIRAL ARTHRITIS-MULT
71160 MYCOTIC ARTHRITIS-UNSPEC
71161 MYCOTIC ARTHRITIS-SHLDER
71162 MYCOTIC ARTHRITIS-UP/ARM
71163 MYCOTIC ARTHRIT-FOREARM
71164 MYCOTIC ARTHRITIS-HAND
71165 MYCOTIC ARTHRITIS-PELVIS
71166 MYCOTIC ARTHRITIS-L/LEG
71167 MYCOTIC ARTHRITIS-ANKLE
71168 MYCOTIC ARTHRITIS NEC
71169 MYCOTIC ARTHRITIS-MULT
71170 HELMINTH ARTHRIT-UNSPEC
71171 HELMINTH ARTHRIT-SHLDER
71172 HELMINTH ARTHRIT-UP/ARM
71173 HELMINTH ARTHRIT-FOREARM
71174 HELMINTH ARTHRIT-HAND
71175 HELMINTH ARTHRIT-PELVIS
71176 HELMINTH ARTHRIT-L/LEG
71177 HELMINTH ARTHRIT-ANKLE
71178 HELMINTH ARTHRIT NEC
71179 HELMINTH ARTHRIT-MULT
71180 INF ARTHRITIS NEC-UNSPEC
71181 INF ARTHRITIS NEC-SHLDER
71182 INF ARTHRITIS NEC-UP/ARM
71183 INF ARTHRIT NEC-FOREARM
71184 INF ARTHRITIS NEC-HAND
71185 INF ARTHRITIS NEC-PELVIS
71186 INF ARTHRITIS NEC-L/LEG
71187 INF ARTHRITIS NEC-ANKLE
71188 INF ARTHRIT NEC-OTH SITE
71189 INF ARTHRITIS NEC-MULT
71210 DICALC PHOS CRYST-UNSPEC
71211 DICALC PHOS CRYST-SHLDER
71212 DICALC PHOS CRYST-UP/ARM
71213 DICALC PHOS CRYS-FOREARM
71214 DICALC PHOS CRYST-HAND
71215 DICALC PHOS CRYST-PELVIS
71216 DICALC PHOS CRYST-L/LEG
71217 DICALC PHOS CRYST-ANKLE
71218 DICALC PHOS CRY-SITE NEC
71219 DICALC PHOS CRYST-MULT
71220 PYROPHOSPH CRYST-UNSPEC
71221 PYROPHOSPH CRYST-SHLDER
71222 PYROPHOSPH CRYST-UP/ARM
71223 PYROPHOSPH CRYST-FOREARM
71224 PYROPHOSPH CRYST-HAND
71225 PYROPHOSPH CRYST-PELVIS
71226 PYROPHOSPH CRYST-L/LEG
71227 PYROPHOSPH CRYST-ANKLE
71228 PYROPHOS CRYST-SITE NEC
71229 PYROPHOS CRYST-MULT
71230 CHONDROCALCIN NOS-UNSPEC
71231 CHONDROCALCIN NOS-SHLDER
71232 CHONDROCALCIN NOS-UP/ARM
71233 CHONDROCALC NOS-FOREARM
71234 CHONDROCALCIN NOS-HAND
71235 CHONDROCALCIN NOS-PELVIS
71236 CHONDROCALCIN NOS-L/LEG
71237 CHONDROCALCIN NOS-ANKLE
71238 CHONDROCALC NOS-OTH SITE
71239 CHONDROCALCIN NOS-MULT

MANIFESTATIONS NOT ALLOWED AS PRINCIPAL DIAGNOSIS

7130 ARTHROP W ENDOCR/MET DIS
7131 ARTHROP W NONINF GI DIS
7132 ARTHROPATH W HEMATOL DIS
7133 ARTHROPATHY W SKIN DIS
7134 ARTHROPATHY W RESP DIS
7135 ARTHROPATHY W NERVE DIS
7136 ARTHROP W HYPERSEN REACT
7137 ARTHROP W SYSTEM DIS NEC
7138 ARTHROP W OTH DIS NEC
72081 SPONDYLOPATHY IN OTH DIS
72701 SYNOVITIS IN OTH DIS
73070 POLIO OSTEOPATHY-UNSPEC
73071 POLIO OSTEOPATHY-SHLDER
73072 POLIO OSTEOPATHY-UP/ARM
73073 POLIO OSTEOPATHY-FOREARM
73074 POLIO OSTEOPATHY-HAND
73075 POLIO OSTEOPATHY-PELVIS
73076 POLIO OSTEOPATHY-L/LEG
73077 POLIO OSTEOPATHY-ANKLE
73078 POLIO OSTEOPATHY NEC
73079 POLIO OSTEOPATHY-MULT
73080 BONE INFECT NEC-UNSPEC
73081 BONE INFECT NEC-SHLDER
73082 BONE INFECT NEC-UP/ARM
73083 BONE INFECT NEC-FOREARM
73084 BONE INFECT NEC-HAND
73085 BONE INFECT NEC-PELVIS
73086 BONE INFECT NEC-L/LEG
73087 BONE INFECT NEC-ANKLE
73088 BONE INFECT NEC-OTH SITE
73089 BONE INFECT NEC-MULT
7311 OSTEITIS DEF IN OTH DIS
7318 BONE INVOLV IN OTH DIS
73740 SPIN CURV NOS IN OTH DIS
73741 KYPHOSIS IN OTH DIS
73742 LORDOSIS IN OTH DIS
73743 SCOLIOSIS IN OTH DIS
7740 PERINAT JAUND-HERED ANEM
77431 NEONAT JAUND IN OTH DIS
7745 PERINATAL JAUNDICE NEC

NON-SPECIFIC PRINCIPAL DIAGNOSES

00320 LOCAL SALMONELLA INF NOS
01590 TB BONE/JOINT NOS-UNSPEC
01591 TB BONE/JT NOS-NO EXAM
01592 TB BONE/JT NOS-EXAM UNKN
01593 TB BONE/JT NOS-MICRO DX
01594 TB BONE/JT NOS-CULT DX
01595 TB BONE/JT NOS-HISTO DX
01596 TB BONE/JT NOS-OTH TEST
0369 MENINGOCOCCAL INFECT NOS
0399 ACTINOMYCOSIS NOS
0528 VARICELLA COMPLICAT NOS
05310 H ZOSTER NERV SYST NOS
0538 H ZOSTER COMPLICATED NOS
05440 HERPES SIMPLEX EYE NOS
0548 H SIMPLEX COMPLICAT NOS
0558 MEASLES COMPLICATION NOS
05600 RUBELLA NERVE COMPL NOS
0568 RUBELLA COMPLICATION NOS
0728 MUMPS COMPLICATION NOS
0738 ORNITHOSIS COMPLICAT NOS
07420 COXSACKIE CARDITIS NOS
0979 SYPHILIS NOS
09810 GC (ACUTE) UPPER GU NOS
09830 CHR GC UPPER GU NOS
0999 VENEREAL DISEASE NOS
1009 LEPTOSPIROSIS NOS
1109 DERMATOPHYTOSIS SITE NOS
1129 CANDIDIASIS SITE NOS
1149 COCCIDIOIDOMYCOSIS NOS
1279 INTEST HELMINTHIASIS NOS
129 INTESTIN PARASITISM NOS
1309 TOXOPLASMOSIS NOS
13100 UROGENITAL TRICHOMON NOS
1319 TRICHOMONIASIS NOS
1329 PEDICULOSIS NOS
1369 INFECT/PARASITE DIS NOS
1370 LATE EFFECT TB, RESP/NOS
1371 LATE EFFECT CNS TB
1372 LATE EFFECT GU TB
1373 LATE EFF BONE & JOINT TB
1374 LATE EFFECT TB NEC
138 LATE EFFECT ACUTE POLIO
1390 LATE EFF VIRAL ENCEPHAL
1391 LATE EFFECT OF TRACHOMA
1398 LATE EFF INFECT DIS NEC
1409 MAL NEO LIP/VERMIL NOS
1419 MALIG NEO TONGUE NOS
1429 MAL NEO SALIVARY NOS
1439 MALIG NEO GUM NOS
1449 MAL NEO MOUTH FLOOR NOS
1469 MALIG NEO OROPHARYNX NOS
1479 MAL NEO NASOPHARYNX NOS
1509 MAL NEO ESOPHAGUS NOS
1519 MALIG NEOPL STOMACH NOS
1529 MAL NEO SMALL BOWEL NOS
1539 MALIGNANT NEO COLON NOS
1543 MALIGNANT NEO ANUS NOS
1579 MALIG NEO PANCREAS NOS
1589 MAL NEO PERITONEUM NOS
1590 MALIG NEO INTESTINE NOS
1609 MAL NEO ACCESS SINUS NOS
1619 MALIGNANT NEO LARYNX NOS
1629 MAL NEO BRONCH/LUNG NOS
1639 MALIG NEOPL PLEURA NOS
1649 MAL NEO MEDIASTINUM NOS
1709 MALIG NEOPL BONE NOS
1719 MAL NEO SOFT TISSUE NOS
1729 MALIG MELANOMA SKIN NOS
1739 MALIG NEO SKIN NOS
1749 MALIGN NEOPL BREAST NOS
179 MALIG NEOPL UTERUS NOS
1809 MAL NEO CERVIX UTERI NOS
1839 MAL NEO ADNEXA NOS
1874 MALIG NEO PENIS NOS
1879 MAL NEO MALE GENITAL NOS
1889 MALIG NEO BLADDER NOS
1899 MAL NEO URINARY NOS
1909 MALIGN NEOPL EYE NOS
1929 MAL NEO NERVOUS SYST NOS
1949 MAL NEO ENDOCRINE NOS
1969 MAL NEO LYMPH NODE NOS
1991 MALIGNANT NEOPLASM NOS
2049 LYMPHOID LEUKEMIA NOS
2059 MYELOID LEUKEMIA NOS
2069 MONOCYTIC LEUKEMIA NOS
2089 LEUKEMIA-UNSPEC CELL NOS
2129 BENIGN NEO RESP SYS NOS
2139 BENIGN NEO BONE NOS
2149 LIPOMA NOS
2159 BEN NEO SOFT TISSUE NOS
2169 BENIGN NEOPLASM SKIN NOS
2189 UTERINE LEIOMYOMA NOS
2199 BENIGN NEO UTERUS NOS
2229 BEN NEO MALE GENITAL NOS
2239 BENIGN NEO URINARY NOS
2249 BENIGN NEOPLASM EYE NOS
2259 BENIGN NEO NERV SYS NOS
2279 BENIGN NEO ENDOCRINE NOS
22800 HEMANGIOMA NOS
2299 BENIGN NEOPLASM NOS

NON-SPECIFIC PRINCIPAL DIAGNOSES

2306	CA IN SITU ANUS NOS
2319	CA IN SITU RESP SYS NOS
2329	CA IN SITU SKIN NOS
2349	CA IN SITU NOS
23690	UNC BEHAV NEO URINAR NOS
2390	DIGESTIVE NEOPLASM NOS
2391	RESPIRATORY NEOPLASM NOS
2392	BONE/SKIN NEOPLASM NOS
2393	BREAST NEOPLASM NOS
2394	BLADDER NEOPLASM NOS
2396	BRAIN NEOPLASM NOS
2397	ENDOCRINE/NERV NEO NOS
2398	NEOPLASM NOS, SITE NEC
2399	NEOPLASM NOS
2469	DISORDER OF THYROID NOS
2519	PANCREATIC DISORDER NOS
2529	PARATHYROID DISORDER NOS
2539	PITUITARY DISORDER NOS
2549	DISEASE OF THYMUS NOS
2569	OVARIAN DYSFUNCTION NOS
2579	TESTICULAR DYSFUNCT NOS
2589	POLYGLANDUL DYSFUNC NOS
2681	RICKETS, LATE EFFECT
2709	DIS AMINO-ACID METAB NOS
2719	DIS CARBOHYDR METAB NOS
2729	LIPOID METABOL DIS NOS
2739	DIS PLAS PROTEIN MET NOS
2759	DIS MINERAL METABOL NOS
2779	METABOLISM DISORDER NOS
2793	IMMUNITY DEFICIENCY NOS
2799	IMMUNE MECHANISM DIS NOS
28950	SPLEEN DISEASE NOS
30510	TOBACCO ABUSE-UNSPEC
30511	TOBACCO ABUSE-CONTINUOUS
30512	TOBACCO ABUSE-EPISODIC
30513	TOBACCO ABUSE-IN REMISS
3249	CNS ABSCESS NOS
326	LATE EFF CNS ABSCESS
3309	CEREB DEGEN IN CHILD NOS
3319	CEREB DEGENERATION NOS
3349	SPINOCEREBELLAR DIS NOS
3359	ANT HORN CELL DIS NOS
3419	CNS DEMYELINATION NOS
3439	CEREBRAL PALSY NOS
3449	PARALYSIS NOS
3469	MIGRAINE NOS
3489	BRAIN CONDITION NOS
3499	CNS DISORDER NOS
3509	TRIGEMINAL NERVE DIS NOS
3519	FACIAL NERVE DIS NOS
3529	CRANIAL NERVE DIS NOS
3539	NERV ROOT/PLEXUS DIS NOS
3569	IDIO PERIPH NEURPTHY NOS
3579	INFLAM/TOX NEUROPTHY NOS
3589	MYONEURAL DISORDERS NOS
3599	MYOPATHY NOS
3609	DISORDER OF GLOBE NOS
3619	RETINAL DETACHMENT NOS
3629	RETINAL DISORDER NOS
3639	CHOROIDAL DISORDER NOS
3649	IRIS/CILIARY DIS NOS
3659	GLAUCOMA NOS
3669	CATARACT NOS
3679	REFRACTION DISORDER NOS
3689	VISUAL DISTURBANCE NOS
36900	BOTH EYES BLIND-WHO DEF
36901	TOT IMPAIRMENT-BOTH EYES
36902	ONE EYE-NEAR TOT/OTH-NOS
36903	ONE EYE-NEAR TOT/OTH-TOT
36904	NEAR-TOT IMPAIR-BOTH EYE
36905	ONE EYE-PROFOUND/OTH-NOS
36906	ONE EYE-PROFOUND/OTH-TOT
36907	ONE EYE-PRFND/OTH-NR TOT
36908	PROFOUND IMPAIR BOTH EYE
36910	BLINDNESS/LOW VISION
36911	1 EYE-SEV/OTH-BLIND NOS
36912	ONE EYE-SEVERE/OTH-TOTAL
36913	ONE EYE-SEV/OTH-NEAR TOT
36914	ONE EYE-SEV/OTH-PRFND
36915	ONE EYE-MOD/OTH-BLIND
36916	ONE EYE-MODERATE/OTH-TOT
36917	ONE EYE-MOD/OTH-NEAR TOT
36918	ONE EYE-MOD/OTH-PROFOUND
36920	LOW VISION, 2 EYES NOS
36921	ONE EYE-SEVERE/OTH-NOS
36922	SEVERE IMPAIR-BOTH EYES
36923	ONE EYE-MODERATE/OTH-NOS
36924	ONE EYE-MODERATE/OTH-SEV
36925	MODERATE IMPAIR-BOTH EYE
3693	BLINDNESS NOS, BOTH EYES
3694	LEGAL BLINDNESS-USA DEF
36960	BLINDNESS, ONE EYE
36961	ONE EYE-TOTAL/OTH-UNKNWN
36962	ONE EYE-TOT/OTH-NEAR NOR
36963	ONE EYE-TOTAL/OTH-NORMAL
36964	ONE EYE-NEAR TOT/OTH-NOS
36965	NEAR-TOT IMP/NEAR-NORMAL
36966	NEAR-TOTAL IMPAIR/NORMAL
36967	ONE EYE-PRFOUND/OTH-UNKN
36968	PROFND IMPAIR/NEAR NORM

NON-SPECIFIC PRINCIPAL DIAGNOSES

36969	PROFOUND IMPAIR/NORMAL
36970	LOW VISION, ONE EYE
36971	ONE EYE-SEVERE/OTH-UNKNW
36972	ONE EYE-SEV/OTH-NR NORM
36973	ONE EYE-SEVERE/OTH-NORM
36974	ONE EYE-MOD/OTHER-UNKNWN
36975	ONE EYE-MOD/OTH-NR NORM
36976	ONE EYE-MOD/OTH NORMAL
3698	VISUAL LOSS, ONE EYE NOS
3699	VISUAL LOSS NOS
3709	KERATITIS NOS
3719	CORNEAL DISORDER NOS
3729	CONJUNCTIVA DISORDER NOS
3739	INFLAMMATION EYELID NOS
3749	DISORDER OF EYELID NOS
3759	LACRIMAL SYST DIS NOS
3769	ORBITAL DISORDER NOS
3779	OPTIC NERVE DISORDER NOS
3789	EYE MOVEMNT DISORDER NOS
3809	DIS EXTERNAL EAR NOS
3819	EUSTACHIAN TUBE DIS NOS
3829	OTITIS MEDIA NOS
3839	MASTOIDITIS NOS
3849	DIS TYMPANIC MEMB NOS
3859	DIS MID EAR/MASTOID NOS
3879	OTOSCLEROSIS NOS
38800	DEGEN/VASCUL DIS EAR NOS
38810	NOISE EFFECT-EAR/NOS
38830	TINNITUS NOS
38840	ABN AUDITORY PERCEPT NOS
38860	OTORRHEA NOS
38870	OTALGIA NOS
3889	DISORDER OF EAR NOS
38900	CONDUCT HEARING LOSS NOS
38910	SENSORNEUR HEAR LOSS NOS
3897	DEAF MUTISM NEC
3899	HEARING LOSS NOS
4109	MYOCARDIAL INFARCT NOS
412	OLD MYOCARDIAL INFARCT
4149	CHR ISCHEMIC HRT DIS NOS
4179	PULMON CIRCULAT DIS NOS
42650	BUNDLE BRANCH BLOCK NOS
4275	CARDIAC ARREST
4279	CARDIAC DYSRHYTHMIA NOS
4289	HEART FAILURE NOS
4299	HEART DISEASE NOS
4329	INTRACRANIAL HEMORR NOS
4339	PRECEREB OCCLUSION NOS
436	CVA
4379	CEREBROVASC DISEASE NOS
438	LATE EFF CEREBROVASC DIS
4419	AORTIC ANEURYSM NOS
4429	ANEURYSM NOS
4449	ARTERIAL EMBOLISM NOS
4479	ARTERIAL DISEASE NOS
4519	THROMBOPHLEBITIS NOS
4539	VENOUS THROMBOSIS NOS
4579	NONINFECT LYMPH DIS NOS
4599	CIRCULATORY DISEASE NOS
4619	ACUTE SINUSITIS NOS
4749	CHR T & A DIS NOS
4919	CHRONIC BRONCHITIS NOS
5169	ALVEOL PNEUMONOPATHY NOS
5199	RESP SYSTEM DISEASE NOS
5209	TOOTH DEVEL/ERUP DIS NOS
5219	HARD TISS DIS TEETH NOS
5239	GINGIV/PERIODONT DIS NOS
5249	DENTOFACIAL ANOMALY NOS
5259	DENTAL DISORDER NOS
5269	JAW DISEASE NOS
5279	SALIVARY GLAND DIS NOS
5299	TONGUE DISORDER NOS
5309	ESOPHAGEAL DISORDER NOS
5379	GASTRODUODENAL DIS NOS
5539	HERNIA NOS
5649	FUNCT DIS INTESTINE NOS
5679	PERITONITIS NOS
5689	PERITONEAL DISORDER NOS
5699	INTESTINAL DISORDER NOS
5739	LIVER DISORDER NOS
5759	DIS OF GALLBLADDER NOS
5769	DIS OF BILIARY TRACT NOS
5779	PANCREATIC DISEASE NOS
5799	INTEST MALABSORPTION NOS
5889	IMPAIRED RENAL FUNCT NOS
5890	UNILATERAL SMALL KIDNEY
5891	BILATERAL SMALL KIDNEYS
5899	SMALL KIDNEY NOS
5909	INFECTION OF KIDNEY NOS
5959	CYSTITIS NOS
5969	BLADDER DISORDER NOS
5989	URETHRAL STRICTURE NOS
5999	URINARY TRACT DIS NOS
6019	PROSTATITIS NOS
6029	PROSTATIC DISORDER NOS
6089	MALE GENITAL DIS NOS
6109	BENIGN MAMM DYSPLAS NOS
6169	FEMALE GEN INFLAM NOS
6179	ENDOMETRIOSIS NOS
6184	UTERVAGINAL PROLAPSE NOS

NON-SPECIFIC PRINCIPAL DIAGNOSES

6189 GENITAL PROLAPSE NOS
6199 FEM GENITAL FISTULA NOS
6209 NONINFL DIS OVA/ADNX NOS
6219 DISORDER OF UTERUS NOS
6229 NONINFLAM DIS CERVIX NOS
6239 NONINFLAM DIS VAGINA NOS
6249 NONINFLAM DIS VULVA NOS
6269 MENSTRUAL DISORDER NOS
6279 MENOPAUSAL DISORDER NOS
6339 ECTOPIC PREGNANCY NOS
64090 HEMORR EARLY PREG-UNSPEC
64091 HEM EARLY PREG-DELIVERED
64093 HEM EARLY PREG-ANTEPART
64100 PLACENTA PREVIA-UNSPEC
64110 PLACENTA PREV HEM-UNSPEC
64120 PREM SEPAR PLACEN-UNSPEC
64130 COAG DEF HEMORR-UNSPEC
64180 ANTEPART HEM NEC-UNSPEC
64190 ANTEPART HEM NOS-UNSPEC
64191 ANTEPARTUM HEM NOS-DELIV
64193 ANTEPART HEM NOS-ANTEPAR
64200 ESSEN HYPERTEN PREG-UNSP
64210 RENAL HYPERTEN PREG-UNSP
64220 OLD HYPERTEN PREG-UNSPEC
64230 TRANS HYPERTEN PREG-UNSP
64240 MILD/NOS PREECLAMP-UNSP
64250 SEVERE PREECLAMP-UNSPEC
64260 ECLAMPSIA-UNSPECIFIED
64270 TOX W OLD HYPERTEN-UNSP
64290 HYPERTEN PREG NOS-UNSPEC
64300 MILD HYPEREM GRAV-UNSPEC
64310 HYPEREM W METAB DIS-UNSP
64320 LATE VOMIT OF PREG-UNSP
64380 VOMIT COMPL PREG-UNSPEC
64390 VOMIT OF PREG NOS-UNSPEC
64400 THREAT PREM LABOR-UNSPEC
64410 THREAT LABOR NEC-UNSPEC
64420 EARLY ONSET DELIV-UNSPEC
64500 PROLONGED PREG-UNSPEC
64600 PAPYRACEOUS FETUS-UNSPEC
64610 EDEMA IN PREG-UNSPEC
64620 RENAL DIS PREG NOS-UNSP
64630 HABITUAL ABORTER-UNSPEC
64640 NEURITIS OF PREG-UNSPEC
64650 BACTERIURIA PREG-UNSPEC
64660 GU INFECT IN PREG-UNSPEC
64670 LIVER DIS IN PREG-UNSPEC
64680 PREG COMPL NEC-UNSPEC
64690 PREG COMPL NOS-UNSPEC
64700 SYPHILIS IN PREG-UNSPEC
64710 GONORRHEA IN PREG-UNSPEC
64720 OTHER VD IN PREG-UNSPEC
64730 TB IN PREG-UNSPECIFIED
64740 MALARIA IN PREG-UNSPEC
64750 RUBELLA IN PREG-UNSPEC
64760 OTH VIRUS IN PREG-UNSPEC
64780 INF DIS IN PREG NEC-UNSP
64790 INFECT IN PREG NOS-UNSP
64791 INFECT NOS-DELIVERED
64792 INFECT NOS-DELIVER W P/P
64793 INFECT NOS-ANTEPARTUM
64794 INFECT NOS-POSTPARTUM
64800 DIABETES IN PREG-UNSPEC
64810 THYROID DYSFUN PREG-UNSP
64820 ANEMIA IN PREG-UNSPEC
64830 DRUG DEPEND PREG-UNSPEC
64840 MENTAL DIS PREG-UNSPEC
64850 CONGEN CV DIS PREG-UNSP
64860 CV DIS NEC PREG-UNSPEC
64870 BONE DISORD IN PREG-UNSP
64880 ABN GLUCOSE IN PREG-UNSP
64890 OTH CURR COND PREG-UNSP
65100 TWIN PREGNANCY-UNSPEC
65110 TRIPLET PREGNANCY-UNSPEC
65120 QUADRUPLET PREG-UNSPEC
65180 MULTI GESTAT NEC-UNSPEC
65190 MULTI GESTAT NOS-UNSPEC
65191 MULT GESTATION NOS-DELIV
65193 MULTI GEST NOS-ANTEPART
65200 UNSTABLE LIE-UNSPECIFIED
65210 CEPHALIC VERS NOS-UNSPEC
65220 BREECH PRESENTAT-UNSPEC
65230 TRANSV/OBLIQ LIE-UNSPEC
65240 FACE/BROW PRESENT-UNSPEC
65250 HIGH HEAD AT TERM-UNSPEC
65260 MULT GEST MALPRESEN-UNSP
65270 PROLAPSED ARM-UNSPEC
65280 MALPOSITION NEC-UNSPEC
65290 MALPOSITION NOS-UNSPEC
65291 MALPOSITION NOS-DELIVER
65293 MALPOSITION NOS-ANTEPART
65300 PELVIC DEFORM NOS-UNSPEC
65310 CONTRACT PELV NOS-UNSPEC
65320 INLET CONTRACTION-UNSPEC
65330 OUTLET CONTRACTION-UNSP
65340 FETOPELV DISPROP-UNSPEC
65350 FETAL DISPROP NOS-UNSPEC
65360 HYDROCEPHAL FETUS-UNSPEC
65370 OTH ABN FET DISPROP-UNSP
65380 DISPROPORTION NEC-UNSPEC

NON-SPECIFIC PRINCIPAL DIAGNOSES

65390 DISPROPORTION NOS-UNSPEC
65391 DISPROPORTION NOS-DELIV
65393 DISPROPOR NOS-ANTEPARTUM
65400 CONG ABN UTER PREG-UNSP
65410 UTER TUMOR IN PREG-UNSP
65420 PREV C-SECT NOS-UNSPEC
65430 RETROVERT UTERUS-UNSPEC
65440 ABN GRAV UTERUS NEC-UNSP
65450 CERV INCOMPET PREG-UNSP
65460 ABN CERVIX NEC PREG-UNSP
65470 ABN VAGINA IN PREG-UNSP
65480 ABN VULVA IN PREG-UNSPEC
65490 ABN PEL NOS IN PREG-UNSP
65491 ABN PELV ORG NOS-DELIVER
65492 ABN PELV NOS-DELIV W P/P
65493 ABN PELV ORG NOS-ANTEPAR
65494 ABN PELV ORG NOS-POSTPAR
65500 FETAL CNS MALFORM-UNSPEC
65510 FETAL CHROMOS ABN-UNSPEC
65520 FAMIL HEREDIT DIS-UNSPEC
65530 FET DAMG D/T VIRUS-UNSP
65540 FET DAMG D/T DIS-UNSPEC
65550 FETAL DAMG D/T DRUG-UNSP
65560 RADIAT FETAL DAMAG-UNSP
65580 FETAL ABNORM NEC-UNSPEC
65590 FETAL ABNORM NOS-UNSPEC
65591 FETAL ABNORM NOS-DELIVER
65593 FETAL ABNORM NOS-ANTEPAR
65600 FETAL-MATERNAL HEM-UNSP
65610 RH ISOIMMUNIZATION-UNSP
65620 ABO ISOIMMUNIZATION-UNSP
65630 FETAL DISTRESS-UNSPEC
65640 INTRAUTERINE DEATH-UNSP
65650 POOR FETAL GROWTH-UNSPEC
65660 EXCESS FETAL GRTH-UNSPEC
65670 OTH PLACENT COND-UNSPEC
65680 FET/PLAC PROB NEC-UNSPEC
65690 FET/PLAC PROB NOS-UNSPEC
65700 POLYHYDRAMNIOS-UNSPEC
65800 OLIGOHYDRAMNIOS-UNSPEC
65810 PREM RUPT MEMBRAN-UNSPEC
65820 PROLONG RUPT MEMB-UNSPEC
65830 ARTIFIC RUPT MEMBR-UNSP
65840 AMNIOTIC INFECTION-UNSP
65880 AMNIOTIC PROB NEC-UNSPEC
65890 AMNIOTIC PROB NOS-UNSPEC
65891 AMNIOTIC PROB NOS-DELIV
65893 AMNION PROB NOS-ANTEPART
65900 FAIL MECHAN INDUCT-UNSP
65910 FAIL INDUCTION NOS-UNSP
65920 PYREXIA IN LABOR-UNSPEC
65930 SEPTICEMIA IN LABOR-UNSP
65940 GRAND MULTIPARITY-UNSPEC
65950 ELDERLY PRIMIGRAVID-UNSP
65980 COMPLIC LABOR NEC-UNSP
65990 COMPLIC LABOR NOS-UNSP
65991 COMPLIC LABOR NOS-DELIV
65993 COMPL LABOR NOS-ANTEPART
66000 OBSTRUCT/FET MALPOS-UNSP
66010 BONY PELV OBSTRUC-UNSPEC
66020 ABN PELV TISS OBSTR-UNSP
66030 PERSIST OCCIPITPOST-UNSP
66040 SHOULDER DYSTOCIA-UNSPEC
66050 LOCKED TWINS-UNSPECIFIED
66060 FAIL TRIAL LAB NOS-UNSP
66070 FAILED FORCEP NOS-UNSPEC
66080 OBSTRUC LABOR NEC-UNSPEC
66090 OBSTRUC LABOR NOS-UNSPEC
66100 PRIM UTERINE INERT-UNSP
66110 SEC UTERINE INERT-UNSPEC
66120 UTERINE INERTIA NEC-UNSP
66130 PRECIPITATE LABOR-UNSPEC
66140 UTER DYSTOCIA NOS-UNSPEC
66190 ABNORMAL LABOR NOS-UNSP
66191 ABNORMAL LABOR NOS-DELIV
66193 ABNORM LABOR NOS-ANTEPAR
66200 PROLONGED 1ST STAGE-UNSP
66210 PROLONGED LABOR NOS-UNSP
66220 PROLONGED 2ND STAGE-UNSP
66230 DELAY DEL 2ND TWIN-UNSP
66300 CORD PROLAPSE-UNSPEC
66310 CORD AROUND NECK-UNSPEC
66320 CORD COMPRESS NEC-UNSPEC
66330 CORD ENTANGLE NEC-UNSPEC
66340 SHORT CORD-UNSPECIFIED
66350 VASA PREVIA-UNSPECIFIED
66360 VASC LESION CORD-UNSPEC
66380 CORD COMPLICAT NEC-UNSP
66390 CORD COMPLICAT NOS-UNSP
66391 CORD COMPLICAT NOS-DELIV
66393 CORD COMPL NOS-ANTEPART
66400 DEL W 1 DEG LACERAT-UNSP
66410 DEL W 2 DEG LACERAT-UNSP
66420 DEL W 3 DEG LACERAT-UNSP
66430 DEL W 4 DEG LACERAT-UNSP
66440 OB PERINEAL LAC NOS-UNSP
66441 OB PERINEAL LAC NOS-DEL
66444 PERINEAL LAC NOS-POSTPAR
66450 OB PERINEAL HEMATOM-UNSP
66480 OB PERIN TRAUM NEC-UNSP

NON-SPECIFIC PRINCIPAL DIAGNONES

66490 OB PERIN TRAUM NOS-UNSP
66491 OB PERINEAL TRAU NOS-DEL
66494 PERIN TRAUM NOS-POSTPART
66500 PRELABOR RUPT UTER-UNSP
66510 RUPTURE UTERUS NOS-UNSP
66520 INVERSION OF UTERUS-UNSP
66530 LACERAT OF CERVIX-UNSPEC
66540 HIGH VAGINAL LACER-UNSP
66550 OB INJ PELV ORG NEC-UNSP
66560 DAMAGE TO PELVIC JT-UNSP
66570 OB PELVIC HEMATOMA-UNSP
66580 OB TRAUMA NEC-UNSPEC
66590 OB TRAUMA NOS-UNSPEC
66591 OB TRAUMA NOS-DELIVERED
66592 OB TRAUMA NOS-DEL W P/P
66593 OB TRAUMA NOS-ANTEPARTUM
66594 OB TRAUMA NOS-POSTPARTUM
66600 THIRD-STAGE HEM-UNSPEC
66610 POSTPARTUM HEM NEC-UNSP
66620 DELAY P/PART HEM-UNSPEC
66630 POSTPART COAGUL DEF-UNSP
66700 RETAIN PLACENTA NOS-UNSP
66710 RETAIN PROD CONCEPT-UNSP
66800 PULM COMPL IN DEL-UNSPEC
66810 HEART COMPL IN DEL-UNSP
66820 CNS COMPL LABOR/DEL-UNSP
66880 ANESTH COMP DEL NEC-UNSP
66890 ANESTH COMP DEL NOS-UNSP
66891 ANESTH COMPL NOS-DELIVER
66892 ANESTH COMPL NOS-DEL P/P
66893 ANESTH COMPL-ANTEPARTUM
66894 ANESTH COMPL-POSTPARTUM
66900 MATERNAL DISTRESS-UNSPEC
66910 OBSTETRIC SHOCK-UNSPEC
66920 MATERN HYPOTENS SYN-UNSP
66930 AC REN FAIL W DELIV-UNSP
66940 OTH OB SURG COMPL-UNSPEC
66950 FORCEP DELIV NOS-UNSPEC
66960 BREECH EXTR NOS-UNSPEC
66970 CESAREAN DELIV NOS-UNSP
66980 COMPL LAB/DELIV NEC-UNSP
66990 COMPL LAB/DELIV NOS-UNSP
66991 COMP LAB/DELIV NOS-DELIV
66992 COMPL DEL NOS-DEL W P/P
66993 COMPL DELIV NOS-ANTEPAR
66994 COMPL DELIV NOS-POSTPART
67000 MAJOR PUERP INFECT-UNSP
67100 VARIC VEIN LEG PREG-UNSP
67110 VARIC VULVA PREG-UNSPEC
67120 THROMBOPHLEB PREG-UNSPEC
67130 DEEP THROMB ANTEPAR-UNSP
67140 DEEP THROMB POSTPAR-UNSP
67150 THROMBOSIS NEC PREG-UNSP
67180 VEN COMPL PREG NEC-UNSP
67190 VEN COMPL PREG NOS-UNSP
67191 VENOUS COMPL NOS-DELIVER
67192 VEN COMP NOS-DELIV W P/P
67193 VENOUS COMPL NOS-ANTEPAR
67194 VENOUS COMPL NOS-POSTPAR
67200 PUERPERAL PYREXIA-UNSPEC
67300 OB AIR EMBOLISM-UNSPEC
67310 AMNIOTIC EMBOLISM-UNSPEC
67320 OB PULM EMBOL NOS-UNSPEC
67330 OB PYEMIC EMBOL-UNSPEC
67380 OB PULMON EMBOL NEC-UNSP
67400 PUERP CEREBVASC DIS-UNSP
67410 DISRUPT C-SECT WND-UNSP
67420 DISRUPT PERINEUM-UNSPEC
67430 OB SURG COMPL NEC-UNSPEC
67440 PLACENTAL POLYP-UNSPEC
67480 PUERP COMPL NEC-UNSPEC
67490 PUERP COMPL NOS-UNSPEC
67492 PUERP COMP NOS-DEL W P/P
67494 PUERP COMPL NOS-POSTPART
67500 INFECT NIPPLE PREG-UNSP
67510 BREAST ABSCESS PREG-UNSP
67520 MASTITIS IN PREG-UNSPEC
67580 BREAST INF PREG NEC-UNSP
67590 BREAST INF PREG NOS-UNSP
67600 RETRACT NIPPLE PREG-UNSP
67610 CRACKED NIPPLE PREG-UNSP
67620 BREAST ENGORGE-UNSPEC
67630 BREAST DIS PREG NEC-UNSP
67640 LACTATION FAIL-UNSPEC
67650 SUPPR LACTATION-UNSPEC
67660 GALACTORRHEA PREG-UNSPEC
67680 LACTATION DIS NEC-UNSPEC
67690 LACTATION DIS NOS-UNSPEC
67691 LACTATION DIS NOS-DELIV
67692 LACTAT DIS NOS-DEL W P/P
67693 LACTAT DIS NOS-ANTEPART
67694 LACTAT DIS NOS-POSTPART
6809 CARBUNCLE NOS
6819 CELLULITIS OF DIGIT NOS
6829 CELLULITIS NOS
6869 LOCAL SKIN INFECTION NOS
6949 BULLOUS DERMATOSES NOS
7019 SKIN HYPERTRO/ATROPH NOS
7049 HAIR DISEASE NOS
7059 SWEAT GLAND DISORDER NOS

NON-SPECIFIC PRINCIPAL DIAGNOSES

7069	SEBACEOUS GLAND DIS NOS
7079	CHRONIC SKIN ULCER NOS
7149	INFLAMM POLYARTHROP NOS
71590	OSTEOARTHROS NOS-UNSPEC
7179	INT DERANGEMENT KNEE NOS
71849	JT CONTRACTURE-MULT JTS
71850	ANKYLOSIS-UNSPEC
72230	SCHMORL'S NODES NOS
72270	DISC DIS W MYELOPATH NOS
72280	POSTLAMINECTOMY SYND NOS
72290	DISC DIS NEC/NOS-UNSPEC
7239	NECK DISORDER/SYMPT NOS
7244	LUMBOSACRAL NEURITIS NOS
7289	MUSCLE/LIGAMENT DIS NOS
73000	AC OSTEOMYELITIS-UNSPEC
73010	CHR OSTEOMYELITIS-UNSP
73020	OSTEOMYELITIS NOS-UNSPEC
73030	PERIOSTITIS-UNSPEC
73090	BONE INFEC NOS-UNSP SITE
73091	BONE INFECT NOS-SHLDER
73092	BONE INFECT NOS-UP/ARM
73093	BONE INFECT NOS-FOREARM
73094	BONE INFECT NOS-HAND
73095	BONE INFECT NOS-PELVIS
73096	BONE INFECT NOS-L/LEG
73097	BONE INFECT NOS-ANKLE
73098	BONE INFECT NOS-OTH SITE
73099	BONE INFECT NOS-MULT
73340	ASEPT NECROSIS BONE NOS
73390	BONE & CARTILAGE DIS NOS
7359	ACQ DEFORMITY OF TOE NOS
73600	FOREARM DEFORMITY NOS
73620	ACQ FINGER DEFORMITY NOS
73630	ACQ HIP DEFORMITY NOS
73670	ACQ ANKLE-FOOT DEF NOS
7369	ACQ LIMB DEFORMITY NOS
7389	ACQ DEFORMITY NOS
74100	SPIN BIF W HYDROCEPH NOS
74190	SPINA BIFIDA
7429	NERVOUS SYSTEM ANOM NOS
7439	EYE ANOMALY NOS
7449	CONG FACE/NECK ANOM NOS
7459	SEPTAL CLOSURE ANOM NOS
7469	CONG HEART ANOMALY NOS
7489	RESPIRATORY ANOMALY NOS
74900	CLEFT PALATE NOS
74910	CLEFT LIP NOS
7509	UPPER GI ANOMALY NOS
7519	ANOM DIGESTIVE SYST NOS
7529	GENITAL ORGAN ANOM NOS
7539	URINARY ANOMALY NOS
7559	CONGEN LIMB ANOMALY NOS
7579	INTEGUMENT ANOMALY NOS
7599	CONGENITAL ANOMALY NOS
7600	MATERN HYPERTEN AFF NB
7601	MATERN URINE DIS AFF NB
7602	MATERNAL INFEC AFF NB
7603	MATERN CARDIORESP AFF NB
7604	MATERN NUTRIT DIS AFF NB
7605	MATERNAL INJURY AFF NB
7606	SURG OP ON MOTHER AFF NB
76070	NOXIOUS SUBST NOS AFF NB
76072	MATERNAL NARCOTIC AFF NB
76073	MATERNAL HALLUCIN AFF NB
76074	MATERNAL ANTI-INF AFF NB
76079	NOXIOUS SUBST NEC AFF NB
7608	MATERNAL COND NEC AFF NB
7609	MATERNAL COND NOS AFF NB
7610	INCOMPETNT CERVIX AFF NB
7611	PREMAT RUPT MEMB AFF NB
7612	OLIGOHYDRAMNIOS AFF NB
7613	POLYHYDRAMNIOS AFF NB
7614	ECTOPIC PREGNANCY AFF NB
7615	MULT PREGNANCY AFF NB
7616	MATERNAL DEATH AFF NB
7617	ANTEPART MALPRES AFF NB
7618	MATERN COMPL NEC AFF NB
7619	MATERN COMPL NOS AFF NB
7629	ABN AMNION NOS AFF NB
7630	BREECH DEL/EXTRAC AFF NB
7631	MALPOS/DISPRO NEC AFF NB
7632	FORCEPS DELIVERY AFF NB
7633	VACUUM EXTRAC DEL AFF NB
7634	CESAREAN DELIVERY AFF NB
7635	MAT ANESTH/ANALG AFF NB
7636	PRECIPITATE DEL AFF NB
7637	ABN UTERINE CONTR AFF NB
7638	COMPL DELIV NEC AFF NB
7639	COMPL DELIV NOS AFF NB
7679	BIRTH TRAUMA NOS
7689	BIRTH ASPHYXIA NOS
7709	NB RESPIRATORY COND NOS
7729	NEONATAL HEMORRHAGE NOS
7759	TRANSIENT MET DIS NB NOS
7769	NB HEMATOLOGICAL DIS NOS
7779	PERINAT GI SYS DIS NOS
7789	NB INTEGUMENT COND NOS
7799	PERINATAL CONDITION NOS
7807	MALAISE AND FATIGUE
7809	GENERAL SYMPTOMS NEC

NON-SPECIFIC PRINCIPAL DIAGNOSES

7825 CYANOSIS
78261 PALLOR
78262 FLUSHING
7901 ELEVATED SEDIMENT RATE
7904 ELEV TRANSAMINASE/LDH
7905 ABN SERUM ENZY LEVEL NEC
7906 ABN BLOOD CHEMISTRY NEC
7909 ABN BLOOD FINDINGS NEC
7929 ABN FIND-BODY SUBST NEC
7939 ABN FIND-BODY STRUCT NEC
7954 ABN HISTOLOGIC FIND NEC
7964 ABN CLINICAL FINDING NEC
7969 ABNORMAL FINDINGS NEC
7993 DEBILITY NOS
7998 ILL-DEFINE CONDITION NEC
7999 UNKN CAUSE MORB/MORT NEC
8290 FRACTURE NOS-CLOSED
8291 FRACTURE NOS-OPEN
8398 DISLOCATION NEC-CLOSED
8399 DISLOCATION NEC-OPEN
8409 SPRAIN SHOULDER/ARM NOS
8419 SPRAIN ELBOW/FOREARM NOS
8439 SPRAIN HIP & THIGH NOS
8469 SPRAIN SACROILIAC NOS
8479 SPRAIN OF BACK NOS
8489 SPRAIN NOS
8678 PELVIC ORGAN INJ NOS-CL
8679 PELVIC ORGAN INJ NOS-OPN
86800 INTRA-ABDOM INJ NOS-CLOS
86810 INTRA-ABDOM INJ NOS-OPEN
9009 INJ HEAD/NECK VESSEL NOS
9019 INJ THORACIC VESSEL NOS
9029 INJ ABDOMINAL VESSEL NOS
9039 INJURY ARM VESSEL NOS
9048 INJURY LEG VESSEL NOS
9049 BLOOD VESSEL INJURY NOS
9050 LATE EFFEC SKULL/FACE FX
9051 LATE EFF SPINE/TRUNK FX
9052 LATE EFFECT ARM FX
9053 LATE EFF FEMORAL NECK FX
9054 LATE EFFECT LEG FX
9055 LATE EFFECT FRACTURE NEC
9056 LATE EFFECT DISLOCATION
9057 LATE EFFEC SPRAIN/STRAIN
9058 LATE EFFEC TENDON INJURY
9059 LATE EFF TRAUMAT AMPUTAT
9060 LT EFF OPN WND HEAD/TRNK
9061 LATE EFF OPEN WND EXTREM
9062 LATE EFF SUPERFICIAL INJ
9063 LATE EFFECT OF CONTUSION
9064 LATE EFFECT OF CRUSHING
9065 LATE EFF HEAD/NECK BURN
9066 LATE EFF WRIST/HAND BURN
9067 LATE EFF BURN EXTREM NEC
9068 LATE EFFECT OF BURNS NEC
9069 LATE EFFECT OF BURN NOS
9070 LT EFF INTRACRANIAL INJ
9071 LATE EFF CRAN NERVE INJ
9072 LATE EFF SPINAL CORD INJ
9073 LT EFF NERV INJ TRNK NEC
9074 LT EFF NERV INJ SHLD/ARM
9075 LT EFF NERV INJ PELV/LEG
9079 LATE EFF NERVE INJ NEC
9080 LATE EFF INT INJUR CHEST
9081 LATE EFF INT INJ ABDOMEN
9082 LATE EFF INT INJURY NEC
9083 LATE EFF INJ PERIPH VESS
9084 LT EFF INJ THOR/ABD VESS
9085 LATE EFF FB IN ORIFICE
9086 LATE EFF COMPLIC TRAUMA
9089 LATE EFFECT INJURY NOS
9090 LATE EFF DRUG POISONING
9091 LATE EFF NONMED SUBSTANC
9092 LATE EFFECT OF RADIATION
9093 LATE EFF SURG/MED COMPL
9094 LATE EFF CERT EXT CAUSE
9099 LATE EFF EXTER CAUSE NEC
9219 CONTUSION OF EYE NOS
9229 CONTUSION TRUNK NOS
9239 CONTUSION UPPER LIMB NOS
9249 CONTUSION NOS
9269 CRUSHING INJ TRUNK NOS
9279 CRUSHING INJURY ARM NOS
9289 CRUSHING INJURY LEG NOS
9299 CRUSHING INJURY NOS
9349 FB RESPIRATORY TREE NOS
9399 FOREIGN BDY GU TRACT NOS
94100 BURN NOS HEAD-UNSPEC
94101 BURN NOS EAR
94102 BURN NOS EYE
94103 BURN NOS LIP
94104 BURN NOS CHIN
94105 BURN NOS NOSE
94106 BURN NOS SCALP
94107 BURN NOS FACE NEC
94108 BURN NOS NECK
94109 BURN NOS HEAD-MULT
94200 BURN NOS TRUNK-UNSPEC
94201 BURN NOS BREAST
94202 BURN NOS CHEST WALL

NON-SPECIFIC PRINCIPAL DIAGNOSES

94203 BURN NOS ABDOMINAL WALL
94204 BURN NOS BACK
94205 BURN NOS GENITALIA
94209 BURN NOS TRUNK NEC
94300 BURN NOS ARM-UNSPEC
94301 BURN NOS FOREARM
94302 BURN NOS ELBOW
94303 BURN NOS UPPER ARM
94304 BURN NOS AXILLA
94305 BURN NOS SHOULDER
94306 BURN NOS SCAPULA
94309 BURN NOS ARM-MULTIPLE
94400 BURN NOS HAND-UNSPEC
94401 BURN NOS FINGER
94402 BURN NOS THUMB
94403 BURN NOS MULT FINGERS
94404 BURN NOS FINGER W THUMB
94405 BURN NOS PALM
94406 BURN NOS BACK OF HAND
94407 BURN NOS WRIST
94408 BURN NOS HAND-MULTIPLE
94500 BURN NOS LEG-UNSPEC
94501 BURN NOS TOE
94502 BURN NOS FOOT
94503 BURN NOS ANKLE
94504 BURN NOS LOWER LEG
94505 BURN NOS KNEE
94506 BURN NOS THIGH
94509 BURN NOS LEG-MULTIPLE
9460 BURN NOS MULTIPLE SITE
9479 BURN INTERNAL ORGAN NOS
9490 BURN NOS
9491 1ST DEGREE BURN NOS
9492 2ND DEGREE BURN NOS
9493 3RD DEGREE BURN NOS
9494 DEEP 3RD DEG BURN NOS
9495 3RD BURN W LOSS-SITE NOS
9519 INJURY CRANIAL NERVE NOS
9529 SPINAL CORD INJURY NOS
9539 INJ NERVE ROOT/PLEX NOS
9549 INJURY TRUNK NERVE NOS
9559 INJ NERVE SHLDR/ARM NOS
9569 INJ NERVE PELV/LEG NOS
9579 INJURY TO NERVE NOS
9599 INJURY-SITE NOS
9609 POISONING-ANTIBIOTIC NOS
9639 POISONING-SYSTEM AGT NOS
9649 POISONING-BLOOD AGT NOS
9659 POIS-ANALGES/ANTIPYR NOS
9679 POIS-SEDATIVE/HYPNOT NOS
9699 POISON-PSYCHOTROPIC NOS
9709 POIS-CNS STIMULANT NOS
9739 POISONING-GI AGENT NOS
9769 POIS-SKIN/MEMBR AGNT NOS
9779 POISON-MEDICINAL AGT NOS
9809 TOXIC EFFECT ALCOHOL NOS
9849 TOX EFF LEAD COMPND NOS
9859 TOXIC EFFECT METAL NOS
9889 TOX EFF NOXIOUS FOOD NOS
9899 TOX EFF NONMED SUBST NOS
9929 HEAT EFFECT NOS
9939 EFFECT AIR PRESSURE NOS
99600 MALFUNC CARD DEV/GRF NOS
99630 MALFUNC GU DEV/GRAFT NOS
99690 COMP REATTACH EXTREM NOS
99760 LATE AMPUTAT COMPLIC NOS
9989 SURGICAL COMPLICAT NOS

QUESTIONABLE ADMISSIONS - PRINCIPAL DIAGNOSIS ONLY

25000	DIABETES UNCOMPL ADULT
25001	DIABETES UNCOMPL JUVEN
2780	OBESITY
3804	IMPACTED CERUMEN
4011	BENIGN HYPERTENSION
4262	LEFT BB HEMIBLOCK
4263	LEFT BB BLOCK NEC
4264	RT BUNDLE BRANCH BLOCK
7958	POS SRL/VRL HL3
7962	ELEV BL PRES W/O HYPERTN
9999	COMPLIC MED CARE NEC/NOS
V533	ADJUST CARDIAC PACEMAKER

UNACCEPTABLE PRINCIPAL DIAGNOSES

7981 INSTANTANEOUS DEATH
7982 DEATH WITHIN 24 HR SYMPT
7989 UNATTENDED DEATH
V010 CHOLERA CONTACT
V011 TUBERCULOSIS CONTACT
V012 POLIOMYELITIS CONTACT
V013 SMALLPOX CONTACT
V014 RUBELLA CONTACT
V015 RABIES CONTACT
V016 VENEREAL DIS CONTACT
V017 VIRAL DIS CONTACT NEC
V018 COMMUNIC DIS CONTACT NEC
V019 COMMUNIC DIS CONTACT NOS
V020 CHOLERA CARRIER
V021 TYPHOID CARRIER
V022 AMEBIASIS CARRIER
V023 GI PATHOGEN CARRIER NEC
V024 DIPHTHERIA CARRIER
V025 BACTERIA DIS CARRIER NEC
V026 VIRAL HEPATITIS CARRIER
V027 GONORRHEA CARRIER
V028 VENEREAL DIS CARRIER NEC
V029 CARRIER NEC
V030 VACCIN FOR CHOLERA
V031 VACC-TYPHOID-PARATYPHOID
V032 VACCIN FOR TUBERCULOSIS
V033 VACCIN FOR PLAGUE
V034 VACCIN FOR TULAREMIA
V035 VACCIN FOR DIPHTHERIA
V036 VACCIN FOR PERTUSSIS
V037 TETANUS TOXOID INOCULAT
V038 VACCIN FOR BACT DIS NEC
V039 VACCIN FOR BACT DIS NOS
V040 VACCIN FOR POLIOMYELITIS
V041 VACCIN FOR SMALLPOX
V042 VACCIN FOR MEASLES
V043 VACCIN FOR RUBELLA
V044 VACCIN FOR YELLOW FEVER
V045 VACCIN FOR RABIES
V046 VACCIN FOR MUMPS
V047 VACCIN FOR COMMON COLD
V048 VACCIN FOR INFLUENZA
V050 ARBOVIRUS ENCEPH VACCIN
V051 VACC ARBOVIRAL DIS NEC
V052 VACCIN FOR LEISHMANIASIS
V058 VACCIN FOR DISEASE NEC
V059 VACCIN FOR SINGL DIS NOS
V060 VACCIN FOR CHOLERA + TAB
V061 VACCIN FOR DTP
V062 VACCIN FOR DTP + TAB
V063 VACCIN FOR DTP + POLIO
V064 VAC-MEASLE-MUMPS-RUBELLA
V068 VAC-DIS COMBINATIONS NEC
V069 VAC-DIS COMBINATIONS NOS
V071 DESENSITIZA TO ALLERGENS
V072 PROPHYLACT IMMUNOTHERAPY
V073 PROPHYL CHEMOTHERAPY NEC
V079 PROPHYLACTIC MEASURE NOS
V1000 HX OF GI MALIGNANCY NOS
V1001 HX OF TONGUE MALIGNANCY
V1002 HX-ORAL/PHARYNX MALG NEC
V1003 HX-ESOPHAGEAL MALIGNANCY
V1004 HX OF GASTRIC MALIGNANCY
V1005 HX OF COLONIC MALIGNANCY
V1006 HX-RECTAL & ANAL MALIGN
V1007 HX OF LIVER MALIGNANCY
V1009 HX OF GI MALIGNANCY NEC
V1011 HX-BRONCHOGENIC MALIGNAN
V1012 HX-TRACHEAL MALIGNANCY
V1020 HX-RESP ORG MALIGNAN NOS
V1021 HX-LARYNGEAL MALIGNANCY
V1022 HX-NOSE/EAR/SINUS MALIG
V1029 HX-INTRATHORACIC MAL NEC
V103 HX OF BREAST MALIGNANCY
V1040 HX-FEMALE GENIT MALG NOS
V1041 HX-CERVICAL MALIGNANCY
V1042 HX-UTERUS MALIGNANCY NEC
V1043 HX OF OVARIAN MALIGNANCY
V1044 HX-FEMALE GENIT MALG NEC
V1045 HX-MALE GENIT MALIG NOS
V1046 HX-PROSTATIC MALIGNANCY
V1047 HX-TESTICULAR MALIGNANCY
V1049 HX-MALE GENIT MALIG NEC
V1050 HX-URINARY MALIGNAN NOS
V1051 HX OF BLADDER MALIGNANCY
V1052 HX OF KIDNEY MALIGNANCY
V1059 HX-URINARY MALIGNAN NEC
V1060 HX OF LEUKEMIA NOS
V1061 HX OF LYMPHOID LEUKEMIA
V1062 HX OF MYELOID LEUKEMIA
V1063 HX OF MONOCYTIC LEUKEMIA
V1069 HX OF LEUKEMIA NEC
V1071 HX-LYMPHOSARCOMA
V1072 HX-HODGKIN'S DISEASE
V1079 HX-LYMPHATIC MALIGN NEC
V1081 HX OF BONE MALIGNANCY
V1082 HX-MALIG SKIN MELANOMA
V1083 HX-SKIN MALIGNANCY NEC
V1084 HX OF EYE MALIGNANCY
V1085 HX OF BRAIN MALIGNANCY

UNACCEPTABLE PRINCIPAL DIAGNOSES

V1086 HX-MALIGN NERVE SYST NEC
V1087 HX OF THYROID MALIGNANCY
V1088 HX-ENDOCRINE MALIGN NEC
V1089 HX OF MALIGNANCY NEC
V109 HX OF MALIGNANCY NOS
V110 HX OF SCHIZOPHRENIA
V111 HX OF AFFECTIVE DISORDER
V112 HX OF NEUROSIS
V113 HX OF ALCOHOLISM
V118 HX-MENTAL DISORDER NEC
V119 HX-MENTAL DISORDER NOS
V120 HX-INFECT/PARASITIC DIS
V121 HX-NUTRITION DEFICIENCY
V122 HX-ENDOCR/META/IMMUN DIS
V123 HX-BLOOD DISEASES
V124 HX-NERV SYS/SENS ORG DIS
V125 HX-CIRCULATORY SYS DIS
V126 HX-RESPIRATORY SYS DIS
V127 HX OF GI DISEASE
V130 HX-URINARY SYSTEM DISORD
V131 HX-TROPHOBLASTIC DISEASE
V132 HX-GENITAL/OBSTETRIC DIS
V133 HX-SKIN/SUBCUTAN TIS DIS
V134 HX OF ARTHRITIS
V135 HX-MUSCULOSKELET DIS NEC
V136 HX-CONGENITAL MALFORM
V137 HX-PERINATAL PROBLEMS
V138 HX OF DISEASES NEC
V139 HX OF DISEASE NOS
V140 HX-PENICILLIN ALLERGY
V141 HX-ANTIBIOT ALLERGY NEC
V142 HX-SULFONAMIDES ALLERGY
V143 HX-ANTI-INFECT ALLERGY
V144 HX-ANESTHETIC ALLERGY
V145 HX-NARCOTIC ALLERGY
V146 HX-ANALGESIC ALLERGY
V147 HX-VACCINE ALLERGY
V148 HX-DRUG ALLERGY NEC
V149 HX-DRUG ALLERGY NOS
V150 HX OF ALLERGY NEC
V151 HX-MAJOR CARDIOVASC SURG
V152 HX-MAJOR ORGAN SURG NEC
V153 HX OF IRRADIATION
V154 HX-PSYCHOLOGICAL TRAUMA
V155 HX OF INJURY
V156 HX OF POISONING
V157 HX OF CONTRACEPTION
V1581 HX OF PAST NONCOMPLIANCE
V1589 HX-HEALTH HAZARDS NEC
V159 HX-HEALTH HAZARD NOS
V160 FAMILY HX-GI MALIGNANCY
V161 FM HX-TRACH/BRONCHOG MAL
V162 FAM HX-INTRATHORACIC MAL
V163 FAMILY HX-BREAST MALIG
V164 FAMILY HX-GENITAL MALIG
V165 FAMILY HX-URINARY MALIG
V166 FAMILY HX-LEUKEMIA
V167 FAM HX-LYMPH NEOPLAS NEC
V168 FAMILY HX-MALIGNANCY NEC
V169 FAMILY HX-MALIGNANCY NOS
V170 FAM HX-PSYCHIATRIC COND
V171 FAMILY HX-STROKE
V172 FAM HX-NEUROLOG DIS NEC
V173 FAM HX-ISCHEM HEART DIS
V174 FAM HX-CARDIOVAS DIS NEC
V175 FAMILY HX-ASTHMA
V176 FAM HX-CHR RESP COND NEC
V177 FAMILY HX-ARTHRITIS
V178 FAM HX-MUSCLOSKL DIS NEC
V180 FAM HX-DIABETES MELLITUS
V181 FM HX-ENDO/METAB DIS NEC
V182 FAMILY HX-ANEMIA
V183 FAM HX-BLOOD DISORD NEC
V184 FAM HX-MENTAL RETARDAT
V185 FAMILY HX-GI DISORDERS
V186 FAMILY HX-KIDNEY DISEASE
V187 FAMILY HX-GU DISEASE NEC
V188 FM HX-INFECT/PARASIT DIS
V190 FAMILY HX-BLINDNESS
V191 FAMILY HX-EYE DISORD NEC
V192 FAMILY HX-DEAFNESS
V193 FAMILY HX-EAR DISORD NEC
V194 FAMILY HX-SKIN CONDITION
V195 FAM HX-CONGEN ANOMALIES
V196 FAMILY HX-ALLERGIC DIS
V197 CONSANGUINITY
V198 FAMILY HX-CONDITION NEC
V201 CARE OF HEALTHY CHLD NEC
V202 ROUTIN CHILD HEALTH EXAM
V210 RAPID CHILDHOOD GROWTH
V211 PUBERTY
V212 ADOLESCENCE GROWTH NEC
V218 CONSTIT STATE IN DEV NEC
V219 CONSTIT STATE IN DEV NOS
V220 SUPERVIS NORMAL 1ST PREG
V221 SUPERVIS OTH NORMAL PREG
V222 PREG STATE, INCIDENTAL
V230 PREG W HX OF INFERTILITY
V231 PREG W HX-TROPHOBLAS DIS
V232 PREG W HX OF ABORTION

UNACCEPTABLE PRINCIPAL DIAGNOSES

V233	GRAND MULTIPARITY
V234	PREG W POOR OBSTETRIC HX
V235	PREG W POOR REPRODUCT HX
V238	SUPRV HIGH-RISK PREG NEC
V239	SUPRV HIGH-RISK PREG NOS
V241	POSTPART CARE-LACTATION
V242	ROUT POSTPART FOLLOW-UP
V2501	PRESCRIP-ORAL CONTRACEPT
V2502	INITIATE CONTRACEPT NEC
V2509	CONTRACEPTIVE MANGMT NEC
V251	INSERTION OF IUD
V2540	CONTRACEPT SURVEILL NOS
V2541	CONTRACEPT PILL SURVEILL
V2542	IUD SURVEILLANCE
V2549	CONTRACEPT SURVEILL NEC
V258	CONTRACEPTIVE MANGMT NEC
V259	CONTRACEPTIVE MANGMT NOS
V261	ARTIFICIAL INSEMINATION
V262	PROCREATIVE MGMT-INVEST
V263	GENETIC COUNSELING
V264	PROCREATIVE MGMT-COUNSEL
V268	PROCREATIVE MANGMT NEC
V269	PROCREATIVE MANGMT NOS
V270	DELIVER-SINGLE LIVEBORN
V271	DELIVER-SINGLE STILLBORN
V272	DELIVER-TWINS, BOTH LIVE
V273	DEL-TWINS, 1 NB, 1 SB
V274	DELIVER-TWINS, BOTH SB
V275	DEL-MULT BIRTH, ALL LIVE
V276	DEL-MULT BRTH, SOME LIVE
V277	DEL-MULT BIRTH, ALL SB
V279	OUTCOME OF DELIVERY NOS
V280	SCREENING-CHROMOSOM ANOM
V281	SCREEN-ALPHAFETOPROTEIN
V282	SCREEN BY AMNIOCENT NEC
V283	SCREEN-FETAL MALFORM
V284	SCREEN-FETAL RETARDATION
V285	SCREEN-ISOIMMUNIZATION
V288	ANTENATAL SCREENING NEC
V289	ANTENATAL SCREENING NOS
V302	SINGLE LIVEBORN-NONHOSP
V312	TWIN, MATE LB-NONHOSP
V322	TWIN, MATE SB-NONHOSP
V332	TWIN NOS-NONHOSP
V342	OTH MULTIPLE NB-NONHOSP
V352	OTH MULTIPLE SB-NONHOSP
V362	MULTIPLE NB/SB-NONHOSP
V372	MULT BIRTH NOS-NONHOSP
V390	LIVEBORN NOS-IN HOSP
V391	LIVEBORN NOS-BEFORE ADM
V392	LIVEBORN NOS-NONHOSP
V400	PROBLEMS WITH LEARNING
V401	PROB WITH COMMUNICATION
V402	MENTAL PROBLEMS NEC
V403	BEHAVIORAL PROBLEMS NEC
V409	MENTAL/BEHAVIOR PROB NOS
V410	PROBLEMS WITH SIGHT
V411	EYE PROBLEMS NEC
V412	PROBLEMS WITH HEARING
V413	EAR PROBLEMS NEC
V414	VOICE PRODUCTION PROBLEM
V415	SMELL AND TASTE PROBLEM
V416	PROBLEM W SWALLOWING
V417	SEXUAL FUNCTION PROBLEM
V418	PROBL W SPECIAL FUNC NEC
V419	PROBL W SPECIAL FUNC NOS
V420	KIDNEY TRANSPLANT STATUS
V421	HEART TRANSPLANT STATUS
V422	HEART VALVE TRANSPLANT
V423	SKIN TRANSPLANT STATUS
V424	BONE TRANSPLANT STATUS
V425	CORNEA TRANSPLANT STATUS
V426	LUNG TRANSPLANT STATUS
V427	LIVER TRANSPLANT STATUS
V428	TRANSPLANT STATUS NEC
V429	TRANSPLANT STATUS NOS
V430	EYE REPLACEMENT NEC
V431	LENS REPLACEMENT NEC
V432	HEART REPLACEMENT NEC
V433	HEART VALVE REPLAC NEC
V434	BLOOD VESSEL REPLAC NEC
V435	BLADDER REPLACEMENT NEC
V436	JOINT REPLACEMENT NEC
V437	LIMB REPLACEMENT NEC
V438	ORGAN REPLACEMENT NEC
V440	TRACHEOSTOMY STATUS
V441	GASTROSTOMY STATUS
V442	ILEOSTOMY STATUS
V443	COLOSTOMY STATUS
V444	ENTEROSTOMY STATUS NEC
V445	CYSTOSTOMY STATUS
V446	URINOSTOMY STATUS NEC
V447	ARTIFICIAL VAGINA STATUS
V448	ARTIF OPEN STATUS NEC
V449	ARTIF OPEN STATUS NOS
V450	CARDIAC PACEMAKER STATUS
V451	RENAL DIALYSIS STATUS
V452	VENTRICULAR SHUNT STATUS
V453	INTESTINAL BYPASS STATUS
V454	ARTHRODESIS STATUS

UNACCEPTABLE PRINCIPAL DIAGNOSES

V455 PRESENCE OF IUD
V456 POSTSURGICAL STATE, EYE
V4581 AORTOCORONARY BYPASS
V4589 POSTSURGICAL STATES NEC
V460 DEPENDENCE ON ASPIRATOR
V461 DEPENDENCE ON RESPIRATOR
V468 MACHINE DEPENDENCE NEC
V469 MACHINE DEPENDENCE NOS
V470 INTERN ORGAN DEFICIENCY
V471 MECH PROB W INTERNAL ORG
V472 CARDIORESPIRAT PROBL NEC
V473 DIGESTIVE PROBLEMS NEC
V474 URINARY PROBLEMS NEC
V475 GENITAL PROBLEMS NEC
V479 PROBL W INTERNAL ORG NOS
V480 DEFICIENCIES OF HEAD
V481 DEFICIENCIES NECK/TRUNK
V482 MECHANICAL PROB W HEAD
V483 MECH PROB W NECK & TRUNK
V484 SENSORY PROBLEM W HEAD
V485 SENSOR PROB W NECK/TRUNK
V486 DISFIGUREMENTS OF HEAD
V487 DISFIGUREMENT NECK/TRUNK
V488 PROB-HEAD/NECK/TRUNK NEC
V489 PROB-HEAD/NECK/TRUNK NOS
V490 DEFICIENCIES OF LIMBS
V491 MECHANICAL PROB W LIMBS
V492 MOTOR PROBLEMS W LIMBS
V493 SENSORY PROBLEMS W LIMBS
V494 DISFIGUREMENTS OF LIMBS
V495 LIMB PROBLEMS NEC
V498 PROBL INFLU HEALTH NEC
V499 PROBL INFLU HEALTH NOS
V503 EAR PIERCING
V508 ELECTIVE SURGERY NEC
V509 ELECTIVE SURGERY NOS
V529 FITTING PROSTHESIS NOS
V531 FIT CONTACT LENS/GLASSES
V532 ADJUSTMENT HEARING AID
V534 FIT ORTHODONTIC DEVICE
V535 FIT/ADJUST ILEOSTOMY
V536 FITTING URINARY DEVICES
V537 FIT ORTHOPEDIC DEVICES
V538 ADJUSTMENT OF WHEELCHAIR
V539 ADJUSTMNT DEVICE NEC/NOS
V548 ORTHOPEDIC AFTERCARE NEC
V549 ORTHOPEDIC AFTERCARE NOS
V559 ATTN TO ARTIF OPEN NOS
V570 BREATHING EXERCISES
•V571 PHYSICAL THERAPY NEC
•V572 OCCUP/VOCATION THERAPY
•V573 SPEECH THERAPY
V574 ORTHOPTIC TRAINING
V5781 ORTHOTIC TRAINING
•V5789 REHABILITATION PROC NEC
•V579 REHABILITATION PROC NOS
V582 BLOOD TRANSFUSION, NO DX
V583 ATTEN-SURG DRESSNG/SUTUR
V585 ORTHODONTICS AFTERCARE
V589 AFTERCARE NOS
V590 BLOOD DONOR
V599 ORG OR TISSUE DONOR NOS
V600 LACK OF HOUSING
V601 INADEQUATE HOUSING
V602 ECONOMIC PROBLEM
V603 PERSON LIVING ALONE
V604 NO FAMILY ABLE TO CARE
V605 HOLIDAY RELIEF CARE
V606 PERSON IN RESIDENT INST
V608 HOUSING/ECONO CIRCUM NEC
V609 HOUSING/ECONO CIRCUM NOS
V610 FAMILY DISRUPTION
V611 MARITAL PROBLEMS
V6120 PARENT-CHILD PROBLEM NOS
V6129 PARENT-CHILD PROBLEM NEC
V613 PROBLEM W AGED PARENT
V6141 ALCOHOLISM IN FAMILY
V6149 FAMILY HEALTH PROBL NEC
V615 MULTIPARITY
V616 ILLEGITIMATE PREGNANCY
V617 UNWANTED PREGNANCY NEC
V618 FAMILY CIRCUMSTANCES NEC
V619 FAMILY CIRCUMSTANCE NOS
V620 UNEMPLOYMENT
V621 ADVERSE EFF-WORK ENVIRON
V622 OCCUP CIRCUMSTANCES NEC
V623 EDUCATIONAL CIRCUMSTANCE
V624 SOCIAL MALADJUSTMENT
V625 LEGAL CIRCUMSTANCES
V626 REFUSAL OF TREATMENT
V6281 INTERPERSONAL PROBL NEC
V6282 BEREAVEMENT, UNCOMPLICAT
V6289 PSYCHOLOGICAL STRESS NEC
V629 PSYCHOSOCIAL CIRCUM NOS
V630 HOME REMOTE FROM HOSPITL
V631 NO MEDICAL SERV IN HOME
V632 WAIT ADM TO OTH FACILITY
V638 NO MED FACILITIES NEC
V639 NO MED FACILITIES NOS
V640 NO VACCIN/CONTRAINDICAT

UNACCEPTABLE PRINCIPAL DIAGNOSES

V641	NO PROC/CONTRAINDICATION
V642	NO PROC/PATIENT DECISION
V643	NO PROC FOR REASONS NEC
V651	PERSON CONSULT FOR ANOTH
V653	DIETARY SURVEIL/COUNSEL
V654	COUNSELING NEC
V655	PERSN W FEARED COMPLAINT
V658	REASON FOR CONSULT NEC
V659	REASON FOR CONSULT NOS
V660	SURGICAL CONVALESCENCE
V661	RADIOTHERAPY CONVALESCEN
V662	CHEMOTHERAPY CONVALESCEN
V663	MENTAL DIS CONVALESCENCE
V664	FRACTURE TREATMNT CONVAL
V665	CONVALESCENCE NEC
V666	COMB TREATMENT CONVALES
V669	CONVALESCENCE NOS
V679	FOLLOW-UP EXAM NOS
V680	ISSUE MEDICAL CERTIFICAT
V681	ISSUE REPEAT PRESCRIPT
V682	REQUEST EXPERT EVIDENCE
V6881	REFERRAL-NO EXAM/TREAT
V6889	ADMINISTRTVE ENCOUNT NEC
V689	ADMINISTRTVE ENCOUNT NOS
V700	ROUTINE MEDICAL EXAM
V701	PSYCH EXAM-AUTHORITY REQ
V702	GEN PSYCHIATRIC EXAM NEC
V703	MED EXAM NEC-ADMIN PURP
V704	EXAM-MEDICOLEGAL REASONS
V705	HEALTH EXAM-GROUP SURVEY
V706	HEALTH EXAM-POP SURVEY
V707	EXAM-CLINICAL RESEARCH
V708	GENERAL MEDICAL EXAM NEC
V709	GENERAL MEDICAL EXAM NOS
V719	OBSERV-SUSPECT COND NOS
V720	EYE & VISION EXAMINATION
V721	EAR & HEARING EXAM
V722	DENTAL EXAMINATION
V723	GYNECOLOGIC EXAMINATION
V724	PREG EXAM-PREG UNCONFIRM
V725	RADIOLOGICAL EXAM NEC
V726	LABORATORY EXAMINATION
V727	SKIN/SENSITIZATION TESTS
V728	EXAMINATION NEC
V729	EXAMINATION NOS
V730	SCREENING-POLIOMYELITIS
V731	SCREENING FOR SMALLPOX
V732	SCREENING FOR MEASLES
V733	SCREENING FOR RUBELLA
V734	SCREENING-YELLOW FEVER
V735	SCREENING-ARBOVIRUS DIS
V736	SCREENING FOR TRACHOMA
V738	SCREEN FOR VIRAL DIS NEC
V739	SCREEN FOR VIRAL DIS NOS
V740	SCREENING FOR CHOLERA
V741	SCREENING-PULMONARY TB
V742	SCREENING FOR LEPROSY
V743	SCREENING FOR DIPHTHERIA
V744	SCREEN-BACT CONJUNCTIVIT
V745	SCREEN FOR VENERAL DIS
V746	SCREENING FOR YAWS
V748	SCREEN-BACTERIAL DIS NEC
V749	SCREEN-BACTERIAL DIS NOS
V750	SCREEN-RICKETTSIAL DIS
V751	SCREENING FOR MALARIA
V752	SCREEN FOR LEISHMANIASIS
V753	SCREEN-TRYPANOSOMIASIS
V754	SCREEN-MYCOTIC INFECT
V755	SCREEN-SCHISTOSOMIASIS
V756	SCREEN FOR FILARIASIS
V757	SCREEN FOR HELMINTHIASIS
V758	SCREEN-PARASITIC DIS NEC
V759	SCREEN FOR INFEC DIS NOS
V760	SCREEN MAL NEOP-RESP ORG
V761	SCREEN MAL NEOP-BREAST
V762	SCREEN MAL NEOP-CERVIX
V763	SCREEN MAL NEOP-BLADDER
V7641	SCREEN MAL NEOP-RECTUM
V7642	SCREEN MAL NEOP-ORAL CAV
V7643	SCREEN MAL NEOP-SKIN
V7649	SCREEN MAL NEOP-SITE NEC
V768	SCREEN-NEOPLASM NEC
V769	SCREEN-NEOPLASM NOS
V770	SCREEN-THYROID DISORDER
V771	SCREEN-DIABETES MELLITUS
V772	SCREEN FOR MALNUTRITION
V773	SCREEN-PHENYLKETONURIA
V774	SCREEN FOR GALACTOSEMIA
V775	SCREENING FOR GOUT
V776	SCREEN-CYSTIC FIBROSIS
V777	SCREEN-INBORN ERR METAB
V778	SCREENING FOR OBESITY
V779	SCREEN-ENDOC/NUT/MET NEC
V780	SCREEN-IRON DEFIC ANEMIA
V781	SCREEN-DEFIC ANEMIA NEC
V782	SCREEN-SICKLE CELL DIS
V783	SCRN-HEMOGLOBINOPATH NEC
V788	SCREEN-BLOOD DIS NEC
V789	SCREEN-BLOOD DIS NOS
V790	SCREENING FOR DEPRESSION

UNACCEPTABLE PRINCIPAL DIAGNOSES

V791	SCREENING FOR ALCOHOLISM
V792	SCREEN-MENTAL RETARDAT
V793	SCREEN-DEVELOPMENT PROB
V798	SCREEN-MENTAL DIS NEC
V799	SCREEN-MENTAL DIS NOS
V800	SCREEN-NEUROLOGICAL COND
V801	SCREENING FOR GLAUCOMA
V802	SCREENING-EYE COND NEC
V803	SCREENING FOR EAR DIS
V810	SCRN-ISCHEMIC HEART DIS
V811	SCREEN FOR HYPERTENSION
V812	SCREEN-CARDIOVASC NEC
V813	SCREEN-BRONCH/EMPHYSEMA
V814	SCREEN-RESPIR COND NEC
V815	SCREEN FOR NEPHROPATHY
V816	SCREEN FOR GU COND NEC
V820	SCREEN FOR SKIN COND
V821	SCREEN-RHEUMATOID ARTHR
V822	SCREEN-RHEUMAT DIS NEC
V823	SCREEN-CONG HIP DISLOCAT
V824	POSTNAT SCREEN-CHROM ABN
V825	SCREEN-CONTAMINATION NEC
V826	MULTIPHASIC SCREENING
V828	SCREEN FOR CONDITION NEC
V829	SCREEN FOR CONDITION NOS

NON-SPECIFIC O.R. PROCEDURES

0650	SUBSTERN THYROIDECT NOS
0700	ADRENAL EXPLORATION NOS
0763	PART EXCIS PITUITARY NOS
0769	TOTAL EXC PITUITARY NOS
0780	THYMECTOMY NOS
2630	SIALOADENECTOMY NOS
3500	CLOSED VALVOTOMY NOS
3510	OPEN VALVULOPLASTY NOS
3520	REPLACE HEART VALVE NOS
3550	PROSTH REP HRT SEPTA NOS
3560	GRFT REPAIR HRT SEPT NOS
3570	HEART SEPTA REPAIR NOS
3610	AORTOCORONARY BYPASS NOS
3710	INCISION OF HEART NOS
3770	INSERT CARD PACEMAK NOS
3800	INCISION OF VESSEL NOS
3810	ENDARTERECTOMY NOS
3830	VESSEL RESECT/ANAST NOS
3840	VESSEL RESECT/REPLAC NOS
3850	VARICOSE V LIG-STRIP NOS
3860	EXCISION OF VESSEL NOS
3880	SURG VESSEL OCCLUS NEC
4040	RAD NECK DISSECTION NOS
4050	RAD NODE DISSECTION NOS
4210	ESOPHAGOSTOMY NOS
4240	ESOPHAGECTOMY NOS
4400	VAGOTOMY NOS
4440	SUTURE PEPTIC ULCER NOS
4500	INTESTINAL INCISION NOS
4590	INTESTINAL ANASTOM NOS
4610	COLOSTOMY NOS
4620	ILEOSTOMY NOS
4640	INTEST STOMA REVIS NOS
4650	INTEST STOMA CLOSURE NOS
4660	INTESTINAL FIXATION NOS
4680	INTRA-AB BOWEL MANIP NOS
5300	UNILAT ING HERN REP NOS
5310	BILAT ING HERNIA REP NOS
5640	URETERECTOMY NOS
7550	REPAIR OB LAC UTERUS NOS
7670	REDUCTION FACIAL FX NOS
7700	SEQUESTRECTOMY NOS
7720	WEDGE OSTEOTOMY NOS
7760	LOC EXC BONE LESION NOS
7770	EXCISE BONE FOR GRFT NOS
7780	OTH PART OSTECTOMY NOS
7790	TOTAL OSTECTOMY NOS
7800	BONE GRAFT NOS
7810	PERIOSTEAL SUTURE NOS
7820	EPIPHYSEAL STAPLING NOS
7830	OTH BONE LNGTH CHNGE NOS
7840	OTHER BONE REPAIR NOS
7850	INT FIX W/O FX REDUC NOS
7870	OSTEOCLASIS NOS
7880	OTHER BONE DX PROC NOS
7890	OTHER BONE OPERATION NOS
7910	CL FX REDUC-INT FIX NOS
7920	OPEN FX REDUCTION NOS
7930	OPN FX RED W INT FIX NOS
7940	CLS REDUC-SEP EPIPHY NOS
7950	OPEN RED-SEP EPIPHY NOS
7960	OPEN FX SITE DEBRIDE NOS
7980	OPEN REDUC-DISLOCAT NOS
7990	UNSPEC OP BONE INJ NOS
8000	ARTHROT & PROS REMOV NOS
8010	OTHER ARTHROTOMY NOS
8020	ARTHROSCOPY NOS
8040	JT STRUCTUR DIVISION NOS
8070	SYNOVECTOMY-SITE NOS
8080	L DESTRUCT JOINT LES NOS
8090	EXCISION OF JOINT NOS
8100	SPINAL FUSION NOS
8120	ARTHRODESIS NOS
8400	UPPER LIMB AMPUTAT NOS
8440	IMPLNT/FIT PROS LIMB NOS
8660	FREE SKIN GRAFT NOS
8670	PEDICLE GRAFT/FLAP NOS

NON-COVERED O.R. PROCEDURES

1171	KERATOMELEUSIS
2095	ELECMAG HEAR AID IMPLANT
375	HEART TRANSPLANTATION
3795	IMPLT CARDIODEFIB LEADS
3822	PERCUTANEOUS ANGIOSCOPY
5051	AUXILIARY LIVER TRANSPL
5059	LIVER TRANSPLANT NEC
5280	PANCREAT TRANSPLANT NOS
5283	PANCREATIC HETEROTRANSPL

OPEN BIOPSY PROCEDURES

0112	CEREBRAL MENINGES BX NEC
0114	OTHER BRAIN BIOPSY
0412	PERIPH NERVE BIOPSY NEC
0612	OTHER THYROID BIOPSY
0712	OTHER ADRENAL BIOPSY
3325	OTHER BRONCHIAL BIOPSY
3327	OTHER LUNG BIOPSY
3426	OTHER MEDIASTINAL BIOPSY
4133	SPLEEN BIOPSY NEC
4415	GASTRIC BIOPSY NEC
4515	SMALL BOWEL BIOPSY NEC
5012	LIVER BIOPSY NEC
5113	BILIARY TRACT BX NEC
5212	PANCREATIC BIOPSY NEC
5524	RENAL BIOPSY NEC
5633	URETERAL BIOPSY NEC
5734	BLADDER BIOPSY NEC
6012	PROSTATIC BIOPSY NEC
6014	SEMINAL VES BIOPSY NEC
6212	TESTICULAR BIOPSY NEC
8512	BREAST BIOPSY NEC

NON-OPEN BIOPSY PROCEDURES

0111	PERCUTAN MENINGEAL BX
0113	PERCUTANEOUS BRAIN BX
0411	PERCUTAN BX - PERIPH NERVE
0611	THYROID NEEDLE BIOPSY
0711	ADRENAL NEEDLE BIOPSY
3324	ENDOSCOPIC BRONCHIAL BX
3326	PERCUTANEOUS LUNG BIOPSY
3425	PERCUTAN MEDIASTINAL BX
4132	ASPIRAT BIOPSY OF SPLEEN
4414	BRUSH BIOPSY OF STOMACH
4514	SMALL BOWEL BRUSH BIOPSY
5011	PERCUTAN LIVER BIOPSY
5112	PERCUT BILIARY TRACT BX
5211	PANCREATIC NEEDLE BIOPSY
5523	PERCUTAN RENAL BIOPSY
5632	PERCUTAN URETERAL BIOPSY
5733	TRANSURETH BLADD BIOPSY
6011	PROSTATIC NEEDLE BIOPSY
6013	PERCUT SEMINAL VES BIOPSY
6211	PERCUT TESTICULAR BIOPSY
8511	PERCUTAN BREAST BIOPSY

MSP ALERT

80000 CLOSED SKULL VAULT FX
80001 CL SKULL VLT FX W/O COMA
80002 CL SKULL VLT FX-BRF COMA
80003 CL SKULL VLT FX-MOD COMA
80004 CL SKL VLT FX-PROLN COMA
80005 CL SKUL VLT FX-DEEP COMA
80006 CL SKULL VLT FX-COMA NOS
80009 CL SKL VLT FX-CONCUS NOS
80010 CL SKL VLT FX/CEREBR LAC
80011 CL SKULL VLT FX W/O COMA
80012 CL SKULL VLT FX-BRF COMA
80013 CL SKULL VLT FX-MOD COMA
80014 CL SKL VLT FX-PROLN COMA
80015 CL SKUL VLT FX-DEEP COMA
80016 CL SKULL VLT FX-COMA NOS
80019 CL SKL VLT FX-CONCUS NOS
80020 CL SKL VLT FX/MENING HEM
80021 CL SKULL VLT FX W/O HEM
80022 CL SKULL VLT FX-BRF COMA
80023 CL SKULL VLT FX-MOD COMA
80024 CL SKL VLT FX-PROLN COMA
80025 CL SKUL VLT FX-DEEP COMA
80026 CL SKULL VLT FX-COMA NOS
80029 CL SKL VLT FX-CONCUS NOS
80030 CL SKULL VLT FX/HEM NEC
80031 CL SKULL VLT FX W/O COMA
80032 CL SKULL VLT FX-BRF COMA
80033 CL SKULL VLT FX-MOD COMA
80034 CL SKL VLT FX-PROLN COMA
80035 CL SKUL VLT FX-DEEP COMA
80036 CL SKULL VLT FX-COMA NOS
80039 CL SKL VLT FX-CONCUS NOS
80040 CL SKL VLT FX/BR INJ NEC
80041 CL SKULL VLT FX W/O COMA
80042 CL SKULL VLT FX-BRF COMA
80043 CL SKULL VLT FX-MOD COMA
80044 CL SKL VLT FX-PROLN COMA
80045 CL SKUL VLT FX-DEEP COMA
80046 CL SKULL VLT FX-COMA NOS
80049 CL SKL VLT FX-CONCUS NOS
80050 OPN SKULL VAULT FRACTURE
80051 OPN SKUL VLT FX W/O COMA
80052 OPN SKUL VLT FX-BRF COMA
80053 OPN SKUL VLT FX-MOD COMA
80054 OPN SKL VLT FX-PROLN COM
80055 OPN SKL VLT FX-DEEP COMA
80056 OPN SKUL VLT FX-COMA NOS
80059 OP SKL VLT FX-CONCUS NOS
80060 OPN SKL VLT FX/CEREB LAC
80061 OPN SKUL VLT FX W/O COMA
80062 OPN SKUL VLT FX-BRF COMA
80063 OPN SKUL VLT FX-MOD COMA
80064 OPN SKL VLT FX-PROLN COM
80065 OPN SKL VLT FX-DEEP COMA
80066 OPN SKUL VLT FX-COMA NOS
80069 OP SKL VLT FX-CONCUS NOS

80070 OPN SKL VLT FX/MENIN HEM
80071 OPN SKUL VLT FX W/O COMA
80072 OPN SKUL VLT FX-BRF COMA
80073 OPN SKUL VLT FX-MOD COMA
80074 OPN SKL VLT FX-PROLN COM
80075 OPN SKL VLT FX-DEEP COMA
80076 OPN SKUL VLT FX-COMA NOS
80079 OP SKL VLT FX-CONCUS NOS
80080 OPN SKULL VLT FX/HEM NEC
80081 OPN SKUL VLT FX W/O COMA
80082 OPN SKUL VLT FX-BRF COMA
80083 OPN SKUL VLT FX-MOD COMA
80084 OPN SKL VLT FX-PROLN COM
80085 OPN SKL VLT FX-DEEP COMA
80086 OPN SKUL VLT FX-COMA NOS
80089 OP SKL VLT FX-CONCUS NOS
80090 OP SKL VLT FX/BR INJ NEC
80091 OPN SKUL VLT FX W/O COMA
80092 OPN SKUL VLT FX-BRF COMA
80093 OPN SKUL VLT FX-MOD COMA
80094 OPN SKL VLT FX-PROLN COM
80095 OP SKUL VLT FX-DEEP COMA
80096 OPN SKUL VOT FX-COMA NOS
80099 OP SKL VLT FX-CONCUS NOS
80100 CLOS SKULL BASE FRACTURE
80101 CL SKUL BASE FX W/O COMA
80102 CL SKUL BASE FX-BRF COMA
80103 CL SKUL BASE FX-MOD COMA
80104 CL SKL BASE FX-PROL COMA
80105 CL SKL BASE FX-DEEP COMA
80106 CL SKUL BASE FX-COMA NOS
80109 CL SKULL BASE FX-CONCUSS
80110 CL SKL BASE FX/CEREB LAC
80111 CL SKUL BASE FX W/O COMA
80112 CL SKUL BASE FX-BRF COMA
80113 CL SKUL BASE FX-MOD COMA
80114 CL SKL BASE FX-PROL COMA
80115 CL SKL BASE FX-DEEP COMA
80116 CL SKUL BASE FX-COMA NOS
80119 CL SKULL BASE FX-CONCUSS
80120 CL SKL BASE FX/MENIN HEM
80121 CL SKUL BASE FX W/O COMA
80122 CL SKUL BASE FX/BRF COMA
80123 CL SKUL BASE FX-MOD COMA
80124 CL SKL BASE FX-PROL COMA
80125 CL SKL BASE FX-DEEP COMA
80126 CL SKUL BASE FX-COMA NOS
80129 CL SKULL BASE FX-CONCUSS
80130 CL SKULL BASE FX/HEM NEC
80131 CL SKUL BASE FX W/O COMA
80132 CL SKUL BASE FX-BRF COMA
80133 CL SKUL BASE FX-MOD COMA
80134 CL SKL BASE FX-PROL COMA
80135 CL SKL BASE FX-DEEP COMA
80136 CL SKUL BASE FX-COMA NOS
80139 CL SKULL BASE FX-CONCUSS

MSP ALERT

80140 CL SK BASE FX/BR INJ NEC
80141 CL SKUL BASE FX W/O COMA
80142 CL SKUL BASE FX-BRF COMA
80143 CL SKUL BASE FX-MOD COMA
80144 CL SKL BASE FX-PROL COMA
80145 CL SKL BASE FX-DEEP COMA
80146 CL SKUL BASE FX-COMA NOS
80149 CL SKULL BASE FX-CONCUSS
80150 OPEN SKULL BASE FRACTURE
80151 OPN SKL BASE FX W/O COMA
80152 OPN SKL BASE FX-BRF COMA
80153 OPN SKL BASE FX-MOD COMA
80154 OP SKL BASE FX-PROL COMA
80155 OP SKL BASE FX-DEEP COMA
80156 OPN SKL BASE FX-COMA NOS
80159 OPN SKUL BASE FX-CONCUSS
80160 OP SKL BASE FX/CEREB LAC
80161 OPN SKL BASE FX W/O COMA
80162 OPN SKL BASE FX-BRF COMA
80163 OPN SKL BASE FX-MOD COMA
80164 OP SKL BASE FX-PROL COMA
80165 OP SKL BASE FX-DEEP COMA
80166 OPN SKL BASE FX-COMA NOS
80169 OPN SKUL BASE FX-CONCUSS
80170 OP SKL BASE FX/MENIN HEM
80171 OPN SKL BASE FX W/O COMA
80172 OPN SKL BASE FX-BRF COMA
80173 OPN SKL BASE FX-MOD COMA
80174 OP SKL BASE FX-PROL COMA
80175 OP SKL BASE FX-DEEP COMA
80176 OPN SKL BASE FX-COMA NOS
80179 OPN SKUL BASE FX-CONCUSS
80180 OPN SKUL BASE FX/HEM NEC
80181 OPN SKL BASE FX W/O COMA
80182 OPN SKL BASE FX-BRF COMA
80183 OPN SKL BASE FX-MOD COMA
80184 OP SKL BASE FX-PROL COMA
80185 OP SKL BASE FX-DEEP COMA
80186 OPN SKL BASE FX-COMA NOS
80189 OPN SKUL BASE FX-CONCUSS
80190 OP SK BASE FX/BR INJ NEC
80191 OP SKUL BASE FX W/O COMA
80192 OPN SKL BASE FX-BRF COMA
80193 OPN SKL BASE FX-MOD COMA
80194 OP SKL BASE FX-PROL COMA
80195 OP SKL BASE FX-DEEP COMA
80196 OPN SKL BASE FX-COMA NOS
80199 OPN SKUL BASE FX-CONCUSS
8020 NASAL BONE FX-CLOSED
8021 NASAL BONE FX-OPEN
80220 MANDIBLE FX NOS-CLOSED
80221 FX CONDYL PROC MANDIB-CL
80222 SUBCONDYLAR FX MANDIB-CL
80223 FX CORON PROC MANDIB-CL
80224 FX RAMUS NOS-CLOSED
80225 FX ANGLE OF JAW-CLOSED
80226 FX SYMPHY MANDIB BODY-CL
80227 FX ALVEOLAR BORD MAND-CL
80228 FX MANDIBLE BODY NEC-CL
80229 MULT FX MANDIBLE-CLOSED
80230 MANDIBLE FX NOS-OPEN
80231 FX CONDYL PROC MAND-OPEN
80232 SUBCONDYL FX MANDIB-OPEN
80233 FX CORON PROC MANDIB-OPN
80234 FX RAMUS NOS-OPEN
80235 FX ANGLE OF JAW-OPEN
80236 FX SYMPHY MANDIB BDY-OPN
80237 FX ALV BORD MAND BDY-OPN
80238 FX MANDIBLE BODY NEC-OPN
80239 MULT FX MANDIBLE-OPEN
8024 FX MALAR/MAXILLARY-CLOSE
8025 FX MALAR/MAXILLARY-OPEN
8026 FX ORBITAL FLOOR-CLOSED
8027 FX ORBITAL FLOOR-OPEN
8028 FX FACIAL BONE NEC-CLOSE
8029 FX FACIAL BONE NEC-OPEN
80300 CLOSE SKULL FRACTURE NEC
80301 CL SKULL FX NEC W/O COMA
80302 CL SKULL FX NEC-BRF COMA
80303 CL SKULL FX NEC-MOD COMA
80304 CL SKL FX NEC-PROLN COMA
80305 CL SKUL FX NEC-DEEP COMA
80306 CL SKULL FX NEC-COMA NOS
80309 CL SKULL FX NEC-CONCUSS
80310 CL SKL FX NEC/CEREBR LAC
80311 CL SKULL FX NEC W/O COMA
80312 CL SKULL FX NEC-BRF COMA
80313 CL SKULL FX NEC-MOD COMA
80314 CL SKL FX NEC-PROLN COMA
80315 CL SKUL FX NEC-DEEP COMA
80316 CL SKULL FX NEC-COMA NOS
80319 CL SKULL FX NEC-CONCUSS
80320 CL SKL FX NEC/MENING HEM
80321 CL SKULL FX NEC W/O COMA
80322 CL SKULL FX NEC-BRF COMA
80323 CL SKULL FX NEC-MOD COMA
80324 CL SKL FX NEC-PROLN COMA
80325 CL SKUL FX NEC-DEEP COMA
80326 CL SKULL FX NEC-COMA NOS
80329 CL SKULL FX NEC-CONCUSS
80330 CL SKULL FX NEC/HEM NEC
80331 CL SKULL FX NEC W/O COMA
80332 CL SKULL FX NEC-BRF COMA
80333 CL SKULL FX NEC-MOD COMA
80334 CL SKL FX NEC-PROLN COMA
80335 CL SKUL FX NEC-DEEP COMA
80336 CL SKULL FX NEC-COMA NOS
80339 CL SKULL FX NEC-CONCUSS
80340 CL SKL FX NEC/BR INJ NEC
80341 CL SKULL FX NEC W/O COMA
80342 CL SKULL FX NEC-BRF COMA
80343 CL SKULL FX NEC-MOD COMA

MSP ALERT

80344 CL SKL FX NEC-PROLN COMA
80345 CL SKUL FX NEC-DEEP COMA
80346 CL SKULL FX NEC-COMA NOS
80349 CL SKULL FX NEC-CONCUSS
80350 OPEN SKULL FRACTURE NEC
80351 OPN SKUL FX NEC W/O COMA
80352 OPN SKUL FX NEC-BRF COMA
80353 OPN SKUL FX NEC-MOD COMA
80354 OPN SKL FX NEC-PROL COMA
80355 OPN SKL FX NEC-DEEP COMA
80356 OPN SKUL FX NEC-COMA NOS
80359 OPN SKULL FX NEC-CONCUSS
80360 OPN SKL FX NEC/CEREB LAC
80361 OPN SKUL FX NEC W/O COMA
80362 OPN SKUL FX NEC-BRF COMA
80363 OPN SKUL FX NEC-MOD COMA
80364 OPN SKL FX NEC-PROLN COM
80365 OPN SKL FX NEC-DEEP COMA
80366 OPN SKUL FX NEC-COMA NOS
80369 OPN SKULL FX NEC-CONCUSS
80370 OPN SKL FX NEC/MENIN HEM
80371 OPN SKUL FX NEC W/O COMA
80372 OPN SKUL FX NEC-BRF COMA
80373 OPN SKUL FX NEC-MOD COMA
80374 OPN SKL FX NEC-PROL COMA
80375 OPN SKL FX NEC-DEEP COMA
80376 OPN SKUL FX NEC-COMA NOS
80379 OPN SKULL FX NEC-CONCUSS
80380 OPN SKULL FX NEC/HEM NEC
80381 OPN SKUL FX NEC W/O COMA
80382 OPN SKUL FX NEC-BRF COMA
80383 OPN SKUL FX NEC-MOD COMA
80384 OPN SKL FX NEC-PROL COMA
80385 OPN SKL FX NEC-DEEP COMA
80386 OPN SKUL FX NEC-COMA NOS
80389 OPN SKULL FX NEC-CONCUSS
80390 OP SKL FX NEC/BR INJ NEC
80391 OPN SKUL FX NEC W/O COMA
80392 OPN SKUL FX NEC-BRF COMA
80393 OPN SKUL FX NEC-MOD COMA
80394 OPN SKL FX NEC-PROL COMA
80395 OPN SKL FX NEC-DEEP COMA
80396 OPN SKUL FX NEC-COMA NOS
80399 OPN SKULL FX NEC-CONCUSS
80400 CL SKUL FX W OTH BONE FX
80401 CL SKL W OTH FX W/O COMA
80402 CL SKL W OTH FX-BRF COMA
80403 CL SKL W OTH FX-MOD COMA
80404 CL SKL/OTH FX-PROLN COMA
80405 CL SKUL/OTH FX-DEEP COMA
80406 CL SKL W OTH FX-COMA NOS
80409 CL SKUL W OTH FX-CONCUSS
80410 CL SK W OTH FX/CEREB LAC
80411 CL SKL W OTH FX W/O COMA
80412 CL SKL W OTH FX-BRF COMA
80413 CL SKL W OTH FX-MOD COMA
80414 CL SKL/OTH FX-PROLN COMA
80415 CL SKUL/OTH FX-DEEP COMA
80416 CL SKL W OTH FX-COMA NOS
80419 CL SKUL W OTH FX-CONCUSS
80420 CL SKL/OTH FX/MENING HEM
80421 CL SKL W OTH FX W/O COMA
80422 CL SKL W OTH FX-BRF COMA
80423 CL SKL W OTH FX-MOD COMA
80424 CL SKL/OTH FX-PROLN COMA
80425 CL SKUL/OTH FX-DEEP COMA
80426 CL SKL W OTH FX-COMA NOS
80429 CL SKUL W OTH FX-CONCUSS
80430 CL SKUL W OTH FX/HEM NEC
80431 CL SKL W OTH FX W/O COMA
80432 CL SKL W OTH FX-BRF COMA
80433 CL SKL W OTH FX-MOD COMA
80434 CL SKL/OTH FX-PROLN COMA
80435 CL SKUL/OTH FX-DEEP COMA
80436 CL SKL W OTH FX-COMA NOS
80439 CL SKUL W OTH FX-CONCUSS
80440 CL SKL/OTH FX/BR INJ NEC
80441 CL SKL W OTH FX W/O COMA
80442 CL SKL W OTH FX-BRF COMA
80443 CL SKL W OTH FX-MOD COMA
80444 CL SKL/OTH FX-PROLN COMA
80445 CL SKUL/OTH FX-DEEP COMA
80446 CL SKL W OTH FX-COMA NOS
80449 CL SKUL W OTH FX-CONCUSS
80450 OPN SKULL FX/OTH BONE FX
80451 OPN SKUL/OTH FX W/O COMA
80452 OPN SKUL/OTH FX-BRF COMA
80453 OPN SKUL/OTH FX-MOD COMA
80454 OPN SKL/OTH FX-PROL COMA
80455 OPN SKL/OTH FX-DEEP COMA
80456 OPN SKUL/OTH FX-COMA NOS
80459 OPN SKULL/OTH FX-CONCUSS
80460 OPN SKL/OTH FX/CEREB LAC
80461 OPN SKUL/OTH FX W/O COMA
80462 OPN SKUL/OTH FX-BRF COMA
80463 OPN SKUL/OTH FX-MOD COMA
80464 OPN SKL/OTH FX-PROL COMA
80465 OPN SKL/OTH FX-DEEP COMA
80466 OPN SKUL/OTH FX-COMA NOS
80469 OPN SKULL/OTH FX-CONCUSS
80470 OPN SKL/OTH FX/MENIN HEM
80471 OPN SKUL/OTH FX W/O COMA
80472 OPN SKUL/OTH FX-BRF COMA
80473 OPN SKUL/OTH FX-MOD COMA
80474 OPN SKL/OTH FX-PROL COMA
80475 OPN SKL/OTH FX-DEEP COMA
80476 OPN SKUL/OTH FX-COMA NOS
80479 OPN SKULL/OTH FX-CONCUSS
80480 OPN SKL W OTH FX/HEM NEC
80481 OPN SKUL/OTH FX W/O COMA
80482 OPN SKUL/OTH FX-BRF COMA
80483 OPN SKUL/OTH FX-MOD COMA

MSP ALERT

80484 OPN SKL/OTH FX-PROL COMA
80485 OPN SKL/OTH FX-DEEP COMA
80486 OPN SKUL/OTH FX-COMA NOS
80489 OPN SKULL/OTH FX-CONCUSS
80490 OP SKL/OTH FX/BR INJ NEC
80491 OPN SKUL/OTH FX W/O COMA
80492 OPN SKUL/OTH FX-BRF COMA
80493 OPN SKUL/OTH FX-MOD COMA
80494 OPN SKL/OTH FX-PROL COMA
80495 OPN SKL/OTH FX-DEEP COMA
80496 OPN SKUL/OTH FX-COMA NOS
80499 OPN SKULL/OTH FX-CONCUSS
80500 FX CERVICAL VERT NOS-CL
80501 FX C1 VERTEBRA-CLOSED
80502 FX C2 VERTEBRA-CLOSED
80503 FX C3 VERTEBRA-CLOSED
80504 FX C4 VERTEBRA-CLOSED
80505 FX C5 VERTEBRA-CLOSED
80506 FX C6 VERTEBRA-CLOSED
80507 FX C7 VERTEBRA-CLOSED
80508 FX MULT CERVICAL VERT-CL
80510 FX CERVICAL VERT NOS-OPN
80511 FX C1 VERTEBRA-OPEN
80512 FX C2 VERTEBRA-OPEN
80513 FX C3 VERTEBRA-OPEN
80514 FX C4 VERTEBRA-OPEN
80515 FX C5 VERTEBRA-OPEN
80516 FX C6 VERTEBRA-OPEN
80517 FX C7 VERTEBRA-OPEN
80518 FX MLT CERVICAL VERT-OPN
8052 FX DORSAL VERTEBRA-CLOSE
8053 FX DORSAL VERTEBRA-OPEN
8054 FX LUMBAR VERTEBRA-CLOSE
8055 FX LUMBAR VERTEBRA-OPEN
8056 FX SACRUM/COCCYX-CLOSED
8057 FX SACRUM/COCCYX-OPEN
8058 VERTEBRAL FX NOS-CLOSED
8059 VERTEBRAL FX NOS-OPEN
80600 C1-C4 FX-CL/CORD INJ NOS
80601 C1-C4 FX-CL/COM CORD LES
80602 C1-C4 FX-CL/ANT CORD SYN
80603 C1-C4 FX-CL/CEN CORD SYN
80604 C1-C4 FX-CL/CORD INJ NEC
80605 C5-C7 FX-CL/CORD INJ NOS
80606 C5-C7 FX-CL/COM CORD LES
80607 C5-C7 FX-CL/ANT CORD SYN
80608 C5-C7 FX-CL/CEN CORD SYN
80609 C5-C7 FX-CL/CORD INJ NEC
80610 C1-C4 FX-OP/CORD INJ NOS
80611 C1-C4 FX-OP/COM CORD LES
80612 C1-C4 FX-OP/ANT CORD SYN
80613 C1-C4 FX-OP/CEN CORD SYN
80614 C1-C4 FX-OP/CORD INJ NEC
80615 C5-C7 FX-OP/CORD INJ NOS
80616 C5-C7 FX-OP/COM CORD LES
80617 C5-C7 FX-OP/ANT CORD SYN
80618 C5-C7 FX-OP/CEN CORD SYN
80619 C5-C7 FX-OP/CORD INJ NEC
80620 T1-T6 FX-CL/CORD INJ NOS
80621 T1-T6 FX-CL/COM CORD LES
80622 T1-T6 FX-CL/ANT CORD SYN
80623 T1-T6 FX-CL/CEN CORD SYN
80624 T1-T6 FX-CL/CORD INJ NEC
80625 T7-T12 FX-CL/CRD INJ NOS
80626 T7-T12 FX-CL/COM CRD LES
80627 T7-T12 FX-CL/ANT CRD SYN
80628 T7-T12 FX-CL/CEN CRD SYN
80629 T7-T12 FX-CL/CRD INJ NEC
80630 T1-T6 FX-OP/CORD INJ NOS
80631 T1-T6 FX-OP/COM CORD LES
80632 T1-T6 FX-OP/ANT CORD SYN
80633 T1-T6 FX-OP/CEN CORD SYN
80634 T1-T6 FX-OP/CORD INJ NEC
80635 T7-T12 FX-OP/CRD INJ NOS
80636 T7-T12 FX-OP/COM CRD LES
80637 T7-T12 FX-OP/ANT CRD SYN
80638 T7-T12 FX-OP/CEN CRD SYN
80639 T7-T12 FX-OP/CRD INJ NEC
8064 CL LUMBAR FX W CORD INJ
8065 OPN LUMBAR FX W CORD INJ
80660 FX SACRUM-CL/CRD INJ NOS
80661 FX SACR-CL/CAUDA EQU LES
80662 FX SACR-CL/CAUDA INJ NEC
80669 FX SACRUM-CL/CRD INJ NEC
80670 FX SACRUM-OP/CRD INJ NOS
80671 FX SACR-OP/CAUDA EQU LES
80672 FX SACR-OP/CAUDA INJ NEC
80679 FX SACRUM-OP/CRD INJ NEC
8068 VERT FX NOS-CL W CRD INJ
8069 VERT FX NOS-OP W CRD INJ
80700 FRACTURE RIB NOS-CLOSED
80701 FRACTURE ONE RIB-CLOSED
80702 FRACTURE TWO RIBS-CLOSED
80703 FRACTURE THREE RIBS-CLOS
80704 FRACTURE FOUR RIBS-CLOSE
80705 FRACTURE FIVE RIBS-CLOSE
80706 FRACTURE SIX RIBS-CLOSED
80707 FRACTURE SEVEN RIBS-CLOS
80708 FX EIGHT/MORE RIB-CLOSED
80709 FX MULT RIBS NOS-CLOSED
80710 FRACTURE RIB NOS-OPEN
80711 FRACTURE ONE RIB-OPEN
80712 FRACTURE TWO RIBS-OPEN
80713 FRACTURE THREE RIBS-OPEN
80714 FRACTURE FOUR RIBS-OPEN
80715 FRACTURE FIVE RIBS-OPEN
80716 FRACTURE SIX RIBS-OPEN
80717 FRACTURE SEVEN RIBS-OPEN
80718 FX EIGHT/MORE RIBS-OPEN
80719 FX MULT RIBS NOS-OPEN
8072 FRACTURE OF STERNUM-CLOS
8073 FRACTURE OF STERNUM-OPEN

MSP ALERT

8074 FLAIL CHEST
8075 FX LARYNX/TRACHEA-CLOSED
8076 FX LARYNX/TRACHEA-OPEN
81000 FX CLAVICLE NOS-CLOSED
81001 FX CLAVICL, STERN END-CL
81002 FX CLAVICLE SHAFT-CLOSED
81003 FX CLAVICL, ACROM END-CL
81010 FX CLAVICLE NOS-OPEN
81011 FX CLAVIC, STERN END-OPN
81012 FX CLAVICLE SHAFT-OPEN
81013 FX CLAVIC, ACROM END-OPN
81100 FX SCAPULA NOS-CLOSED
81101 FX SCAPUL, ACROM PROC-CL
81102 FX SCAPUL, CORAC PROC-CL
81103 FX SCAP, GLEN CAV/NCK-CL
81109 FX SCAPULA NEC-CLOSED
81110 FX SCAPULA NOS-OPEN
81111 FX SCAPUL, ACROM PROC-OP
81112 FX SCAPUL, CORAC PROC-OP
81113 FX SCAP, GLEN CAV/NCK-OP
81119 FX SCAPULA NEC-OPEN
8280 FX LEGS W ARM/RIB-CLOSED
8281 FX LEGS W ARM/RIB-OPEN
83900 DISLOC CERV VERT NOS-CL
83901 DISLOC 1ST CERV VERT-CL
83902 DISLOC 2ND CERV VERT-CL
83903 DISLOC 3RD CERV VERT-CL
83904 DISLOC 4TH CERV VERT-CL
83905 DISLOC 5TH CERV VERT-CL
83906 DISLOC 6TH CERV VERT-CL
83907 DISLOC 7TH CERV VERT-CL
83908 DISLOC MULT CERV VERT-CL
83910 DISLOC CERV VERT NOS-OPN
83911 DISLOC LST CERV VERT-OPN
83912 DISLOC 2ND CERV VERT-OPN
83913 DISLOC 3RD CERV VERT-OPN
83914 DISLOC 4TH CERV VERT-OPN
83915 DISLOC 5TH CERV VERT-OPN
83916 DISLOC 6TH CERV VERT-OPN
83917 DISLOC 7TH CERV VERT-OPN
83918 DISLOC MLT CERV VERT-OPN
83920 DISLOCAT LUMBAR VERT-CL
83921 DISLOC THORACIC VERT-CL
83930 DISLOCAT LUMBAR VERT-OPN
83931 DISLOC THORACIC VERT-OPN
83971 DISLOCATION STERNUM-OPEN
83979 DISLOCAT SITE NEC-OPEN
8398 DISLOCATION NEC-CLOSED
8399 DISLOCATION NEC-OPEN
8470 SPRAIN OF NECK
8500 CONCUSSION W/O COMA
8501 CONCUSSION-BRIEF COMA
8502 CONCUSSION-MODERATE COMA
8503 CONCUSSION-PROLONG COMA
8504 CONCUSSION-DEEP COMA
8505 CONCUSSION W COMA NOS
8509 CONCUSSION NOS
85100 CEREBRAL CORTX CONTUSION
85101 CORTEX CONTUSION-NO COMA
85102 CORTEX CONTUS-BRIEF COMA
85103 CORTEX CONTUS-MOD COMA
85104 CORTX CONTUS-PROLNG COMA
85105 CORTEX CONTUS-DEEP COMA
85106 CORTEX CONTUS-COMA NOS
85109 CORTEX CONTUS-CONCUS NOS
85110 CORTEX CONTUSION/OPN WND
85111 OPN CORTX CONTUS-NO COMA
85112 OPN CORT CONTUS-BRF COMA
85113 OPN CORT CONTUS-MOD COMA
85114 OPN CORT CONTU-PROL COMA
85115 OPN CORT CONTU-DEEP COMA
85116 OPN CORT CONTUS-COMA NOS
85119 OPN CORTX CONTUS-CONCUSS
85120 CEREBRAL CORTEX LACERAT
85121 CORTEX LACERAT W/O COMA
85122 CORTEX LACERA-BRIEF COMA
85123 CORTEX LACERAT-MOD COMA
85124 CORTEX LACERAT-PROL COMA
85125 CORTEX LACERAT-DEEP COMA
85126 CORTEX LACERAT-COMA NOS
85129 CORTEX LACERAT-CONCUSS
85130 CORTEX LACER W OPN WOUND
85131 OPN CORTEX LACER-NO COMA
85132 OPN CORTX LAC-BRIEF COMA
85133 OPN CORTX LACER-MOD COMA
85134 OPN CORTX LAC-PROLN COMA
85135 OPN CORTEX LAC-DEEP COMA
85136 OPN CORTX LACER-COMA NOS
85139 OPN CORTX LACER-CONCUSS
85140 CEREBEL/BRAIN STM CONTUS
85141 CEREBELL CONTUS W/O COMA
85142 CEREBELL CONTUS-BRF COMA
85143 CEREBELL CONTUS-MOD COMA
85144 CEREBEL CONTUS-PROL COMA
85145 CEREBEL CONTUS-DEEP COMA
85146 CEREBELL CONTUS-COMA NOS
85149 CEREBELL CONTUS-CONCUSS
85150 CEREBEL CONTUS W OPN WND
85151 OPN CEREBE CONT W/O COMA
85152 OPN CEREBE CONT-BRF COMA
85153 OPN CEREBE CONT-MOD COMA
85154 OPN CEREBE CONT-PROL COM
85155 OPN CEREBE CONT-DEEP COM
85156 OPN CEREBE CONT-COMA NOS
85159 OPN CEREBEL CONT-CONCUSS
85160 CEREBEL/BRAIN STEM LACER
85161 CEREBEL LACERAT W/O COMA
85162 CEREBEL LACER-BRIEF COMA
85163 CEREBEL LACERAT-MOD COMA
85164 CEREBEL LACER-PROLN COMA
85165 CEREBELL LACER-DEEP COMA
85166 CEREBEL LACERAT-COMA NOS

MSP ALERT

85169	CEREBEL LACER-CONCUSSION
85170	CEREBEL LACER W OPEN WND
85171	OPN CEREBEL LAC W/O COMA
85172	OPN CEREBEL LAC-BRF COMA
85173	OPN CEREBEL LAC-MOD COMA
85174	OPN CEREBE LAC-PROL COMA
85175	OPN CEREBE LAC-DEEP COMA
85176	OPN CEREBFL LAC-COMA NOS
85179	OPN CEREBELL LAC-CONCUSS
85180	BRAIN LACERATION NEC
85181	BRAIN LACER NEC W/O COMA
85182	BRAIN LAC NEC-BRIEF COMA
85183	BRAIN LACER NEC-MOD COMA
85184	BRAIN LAC NEC-PROLN COMA
85185	BRAIN LAC NEC-DEEP COMA
85186	BRAIN LACER NEC-COMA NOS
85189	BRAIN LACER NEC-CONCUSS
85190	BRAIN LAC NEC W OPEN WND
85191	OPN BRAIN LACER W/O COMA
85192	OPN BRAIN LAC-BRIEF COMA
85193	OPN BRAIN LACER-MOD COMA
85194	OPN BRAIN LAC-PROLN COMA
85195	OPEN BRAIN LAC-DEEP COMA
85196	OPN BRAIN LACER-COMA NOS
85199	OPEN BRAIN LACER-CONCUSS
85200	TRAUM SUBARACHNOID HEM
85201	SUBARACHNOID HEM-NO COMA
85202	SUBARACH HEM-BRIEF COMA
85203	SUBARACH HEM-MOD COMA
85204	SUBARACH HEM-PROLNG COMA
85205	SUBARACH HEM-DEEP COMA
85206	SUBARACH HEM-COMA NOS
85209	SUBARACH HEM-CONCUSSION
85210	SUBARACH HEM W OPN WOUND
85211	OPN SUBARACH HEM-NO COMA
85212	OP SUBARACH HEM-BRF COMA
85213	OP SUBARACH HEM-MOD COMA
85214	OP SUBARACH HEM-PROL COM
85215	OP SUBARACH HEM-DEEP COM
85216	OP SUBARACH HEM-COMA NOS
85219	OPN SUBARACH HEM-CONCUSS
85220	TRAUMATIC SUBDURAL HEM
85221	SUBDURAL HEM W/O COMA
85222	SUBDURAL HEM-BRIEF COMA
85223	SUBDURAL HEMORR-MOD COMA
85224	SUBDURAL HEM-PROLNG COMA
85225	SUBDURAL HEM-DEEP COMA
85226	SUBDURAL HEMORR-COMA NOS
85229	SUBDURAL HEM-CONCUSSION
85230	SUBDURAL HEM W OPN WOUND
85231	OPEN SUBDUR HEM W/O COMA
85232	OPN SUBDUR HEM-BRF COMA
85233	OPN SUBDUR HEM-MOD COMA
85234	OPN SUBDUR HEM-PROL COMA
85235	OPN SUBDUR HEM-DEEP COMA
85236	OPN SUBDUR HEM-COMA NOS
85239	OPN SUBDUR HEM-CONCUSS
85240	TRAUMATIC EXTRADURAL HEM
85241	EXTRADURAL HEM W/O COMA
85242	EXTRADUR HEM-BRIEF COMA
85243	EXTRADURAL HEM-MOD COMA
85244	EXTRADUR HEM-PROLN COMA
85245	EXTRADURAL HEM-DEEP COMA
85246	EXTRADURAL HEM-COMA NOS
85249	EXTADURAL HEM-CONCUSS
85250	EXTRADURAL HEM W OPN WND
85251	EXTRADURAL HEMOR-NO COMA
85252	EXTRADUR HEM-BRIEF COMA
85253	EXTRADURAL HEM-MOD COMA
85254	EXTRADUR HEM-PROLN COMA
85255	EXTRADUR HEM-DEEP COMA
85256	EXTRADURAL HEM-COMA NOS
85259	EXTRADURAL HEM-CONCUSS
85300	TRAUMATIC BRAIN HEM NEC
85301	BRAIN HEM NEC W/O COMA
85302	BRAIN HEM NEC-BRIEF COMA
85303	BRAIN HEM NEC-MOD COMA
85304	BRAIN HEM NEC-PROLN COMA
85305	BRAIN HEM NEC-DEEP COMA
85306	BRAIN HEM NEC-COMA NOS
85309	BRAIN HEM NEC-CONCUSSION
85310	BRAIN HEM NEC W OPN WND
85311	BRAIN HEM OPN W/O COMA
85312	BRAIN HEM OPN-BRF COMA
85313	BRAIN HEM OPEN-MOD COMA
85314	BRAIN HEM OPN-PROLN COMA
85315	BRAIN HEM OPEN-DEEP COMA
85316	BRAIN HEM OPEN-COMA NOS
85319	BRAIN HEM OPN-CONCUSSION
85400	BRAIN INJURY NEC
85401	BRAIN INJURY NEC-NO COMA
85402	BRAIN INJ NEC-BRIEF COMA
85403	BRAIN INJ NEC-MOD COMA
85404	BRAIN INJ NEC-PROLN COMA
85405	BRAIN INJ NEC-DEEP COMA
85406	BRAIN INJ NEC-COMA NOS
85409	BRAIN INJ NEC-CONCUSSION
85410	BRAIN INJURY W OPN WND
85411	OPN BRAIN INJ W/O COMA
85412	OPN BRAIN INJ-BRIEF COMA
85413	OPN BRAIN INJ-MOD COMA
85414	OPN BRAIN INJ-PROLN COMA
85415	OPN BRAIN INJ-DEEP COMA
85416	OPEN BRAIN INJ-COMA NOS
85419	OPN BRAIN INJ-CONCUSSION
8600	TRAUM PNEUMOTHORAX-CLOSE
8601	TRAUM PNEUMOTHORAX-OPEN
8602	TRAUM HEMOTHORAX-CLOSED
8603	TRAUM HEMOTHORAX-OPEN
8604	TRAUM PNEUMOHEMOTHOR-CL
8605	TRAUM PNEUMOHEMOTHOR-OPN
86100	HEART INJURY NOS-CLOSED

MSP ALERT

86101 HEART CONTUSION-CLOSED
86102 HEART LACERATION-CLOSED
86103 HEART CHAMBER LACERAT-CL
86110 HEART INJURY NOS-OPEN
86111 HEART CONTUSION-OPEN
86112 HEART LACERATION-OPEN
86113 HEART CHAMBER LACER-OPN
86120 LUNG INJURY NOS-CLOSED
86121 LUNG CONTUSION-CLOSED
86122 LUNG LACERATION-CLOSED
86130 LUNG INJURY NOS-OPEN
86131 LUNG CONTUSION-OPEN
86132 LUNG LACERATION-OPEN
8628 INTRATHORACIC INJ NOS-CL
8630 STOMACH INJURY-CLOSED
8631 STOMACH INJURY-OPEN
86320 SMALL INTEST INJ NOS-CL
86321 DUODENUM INJURY-CLOSED
86329 SMALL INTEST INJ NEC-CL
86330 SMALL INTEST INJ NOS-OPN
86331 DUODENUM INJURY-OPEN
86339 SMALL INTEST INJ NEC-OPN
86340 COLON INJURY NOS-CLOSED
86341 ASCENDING COLON INJ-CLOS
86342 TRANSVERSE COLON INJ-CL
86343 DESCENDING COLON INJ-CL
86344 SIGMOID COLON INJ-CLOSED
86345 RECTUM INJURY-CLOSED
86346 COLON INJ MULT SITE-CLOS
86349 COLON INJURY NEC-CLOSED
86350 COLON INJURY NOS-OPEN
86351 ASCENDING COLON INJ-OPEN
86352 TRANSVERSE COLON INJ-OPN
86353 DESCENDING COLON INJ-OPN
86354 SIGMOID COLON INJ-OPEN
86355 RECTUM INJURY-OPEN
86356 COLON INJ MULT SITE-OPEN
86359 COLON INJURY NEC-OPEN
86380 GI INJURY NOS-CLOSED
86381 PANCREAS, HEAD INJ-CLOSE
86382 PANCREAS, BODY INJ-CLOSE
86383 PANCREAS, TAIL INJ-CLOSE
86384 PANCREAS INJURY NOS-CLOS
86385 APPENDIX INJURY-CLOSED
86389 GI INJURY NEC-CLOSED
86390 GI INJURY NOS-OPEN
86391 PANCREAS, HEAD INJ-OPEN
86392 PANCREAS, BODY INJ-OPEN
86393 PANCREAS, TAIL INJ-OPEN
86394 PANCREAS INJURY NOS-OPEN
86395 APPENDIX INJURY-OPEN
86399 GI INJURY NEC-OPEN
86400 LIVER INJURY NOS-CLOSED
86401 LIVER HEMATOMA/CONTUSION
86402 LIVER LACERATION, MINOR
86403 LIVER LACERATION, MOD
86404 LIVER LACERATION, MAJOR
86409 LIVER INJURY NEC-CLOSED
86410 LIVER INJURY NOS-OPEN
86411 LIVER HEMATOM/CONTUS-OPN
86412 LIVER LACERAT, MINOR-OPN
86413 LIVER LACERAT, MOD-OPEN
86414 LIVER LACERAT, MAJOR-OPN
86419 LIVER INJURY NEC-OPEN
86500 SPLEEN INJURY NOS-CLOSED
86501 SPLEEN HEMATOMA-CLOSED
86502 SPLEEN CAPSULAR TEAR
86503 SPLEEN PARENCHYMA LACER
86504 SPLEEN DISRUPTION-CLOS
86509 SPLEEN INJURY NEC-CLOSED
86510 SPLEEN INJURY NOS-OPEN
86511 SPLEEN HEMATOMA-OPEN
86512 SPLEEN CAPSULAR TEAR-OPN
86513 SPLEEN PARNCHYM LAC-OPN
86514 SPLEEN DISRUPTION-OPEN
86519 SPLEEN INJURY NEC-OPEN
86600 KIDNEY INJURY NOS-CLOSED
86601 KIDNEY HEMATOMA-CLOSED
86602 KIDNEY LACERATION-CLOSED
86603 KIDNEY DISRUPTION-CLOSED
86610 KIDNEY INJURY NOS-OPEN
86611 KIDNEY HEMATOMA-OPEN
86612 KIDNEY LACERATION-OPEN
86613 KIDNEY DISRUPTION-OPEN
8670 BLADDER/URETHRA INJ-CLOS
8671 BLADDER/URETHRA INJ-OPEN
8672 URETER INJURY-CLOSED
8673 URETER INJURY-OPEN
8674 UTERUS INJURY-CLOSED
8675 UTERUS INJURY-OPEN
8676 PELVIC ORGAN INJ NEC-CL
8676 PELVIC ORGAN INJ NEC-CL
8677 PELVIC ORGAN INJ NEC-OPN
8677 PELVIC ORGAN INJ NEC-OPN
8678 PELVIC ORGAN INJ NOS-CL
8678 PELVIC ORGAN INJ NOS-CL
8679 PELVIC ORGAN INJ NOS-OPN
8679 PELVIC ORGAN INJ NOS-OPN
86800 INTRA-ABDOM INJ NOS-CLOS
86801 ADRENAL GLAND INJURY-CL
86802 BILIARY TRACT INJURY-CL
86803 PERITONEUM INJURY-CLOSED
86804 RETROPERITONEUM INJ-CL
86809 INTRA-ABDOM INJ NEC-CLOS
86810 INTRA-ABDOM INJ NOS-OPEN
86811 ADRENAL GLAND INJURY-OPN
86812 BILIARY TRACT INJURY-OPN
86813 PERITONEUM INJURY-OPEN
86814 RETROPERITONEUM INJ-OPEN
86819 INTRA-ABDOM INJ NEC-OPEN
8690 INTERNAL INJ NOS-CLOSED
8691 INTERNAL INJURY NOS-OPEN

MSP ALERT

8870	AMPUT BELOW ELB, UNILAT
8871	AMP BELOW ELB, UNIL-COMP
8872	AMPUT ABV ELBOW, UNILAT
8873	AMPUT ABV ELB, UNIL-COMP
8874	AMPUTAT ARM, UNILAT NOS
8875	AMPUT ARM, UNIL NOS-COMP
8876	AMPUTATION ARM, BILAT
8877	AMPUTAT ARM, BILAT-COMPL
8960	AMPUTATION FOOT, UNILAT
8961	AMPUT FOOT, UNILAT-COMPL
8962	AMPUTATION FOOT, BILAT
8963	AMPUTAT FOOT, BILAT-COMP
8970	AMPUT BELOW KNEE, UNILAT
8971	AMPUTAT BK, UNILAT-COMPL
8972	AMPUT ABOVE KNEE, UNILAT
8973	AMPUT ABV KN, UNIL-COMPL
8974	AMPUTAT LEG, UNILAT NOS
8975	AMPUT LEG, UNIL NOS-COMP
8976	AMPUTATION LEG, BILAT
8977	AMPUTAT LEG, BILAT-COMPL
90000	INJUR CAROTID ARTERY NOS
90001	INJ COMMON CAROTID ARTER
90002	INJ EXTERNAL CAROTID ART
90003	INJ INTERNAL CAROTID ART
9001	INJ INTERNL JUGULAR VEIN
90081	INJ EXTERN JUGULAR VEIN
90082	INJ MLT HEAD/NECK VESSEL
90089	INJ HEAD/NECK VESSEL NEC
9009	INJ HEAD/NECK VESSEL NOS
925	CRUSH INJ FACE/SCALP/NCK
9268	MULT CRUSHING INJ TRUNK
9290	CRUSH INJ MULT SITE NEC
9299	CRUSHING INJURY NOS
9584	TRAUMATIC SHOCK
9585	TRAUMATIC ANURIA
99600	MALFUNC CARD DEV/GRF NOS
99601	MALFUNC CARDIAC PACEMAKE
99602	MALFUNC PROSTH HRT VALVE
99603	MALFUNC CORON BYPASS GRF
99609	MALFUNC CARD DEV/GRF NEC
9961	MALFUNC VASC DEVICE/GRAF
9962	MALFUN NEURO DEVICE/GRAF
99630	MALFUNC GU DEV/GRAFT NOS
99631	MALFUNC URETHRAL CATH
99632	MALFUNCTION IUD
99639	MALFUNC GU DEV/GRAFT NEC
9964	MALF INT ORTHPED DEV/GRF
9965	MALFUNC DEVICE/GRAFT NEC

BILATERAL PROCEDURE

8151	TOT HIP REPLACE-METHACRY
8159	OTHER TOTAL HIP REPLACE
8161	REPLAC FEM HEAD-METHACRY
8162	REPLACE FEMORAL HEAD NEC
8163	REPLACE ACETAB-METHACRYL
8164	REPLACE ACETABULUM NEC

Addendum F

Page

Out-of-Scope Procedures F-2
Noncovered Procedures F-4
Development Needed F-6
Covered Ambulatory Surgical Procedures F-12

Out-of-Scope Procedures

HCPCS Code*	Description
10040	Acne surgery (e.g., marsuplialization, opening or removal of multiple milia, comedones, cysts, pustules).
16000	Initial treatment, first degree burn, when no more than local treatment is required.
31725	Catheter aspiration (separate procedure); tracheobronchial with fiberscope, bedside.
36000	Introduction of needle or intracatheter, vein; unilateral.
36001	Introduction of needle or intracatheter, vein; bilateral.
36400	Venipuncture, under age 3 years; femoral, jugular, or sagittal sinus.
36405	Venipuncture, under age 3 years; scalp vein.
36406	Venipuncture, under age 3 years; other vein.
36410	Venipuncture, child over age 3 years or adult, necessitating physician's skill (separate procedure), for diagnostic or therapeutic purposes. Not to be used for routine venipuncture.
36415	Routine venipuncture for collection of specimen(s).
36600	Arterial puncture, withdrawal of blood for diagnosis.
46900	Destructional lesion(s), anus (e.g, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; chemical.
51000	Aspiration of bladder by needle.
53670	Catheterization; simple.

*Copyright of the American Medical Association

53675	Catheterization; complicated (may include difficult removal of balloon catheter).
57150	Irrigation and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease.
58102	Office endometrial curettage.
58300	Insertion of intrauterine device (IUD).
58301	Removal of intrauterine device (IUD).
59050	Initiation and/or supervision of internal fetal monitoring during labor by consultant.
59400	Total obstetric care (all-inclusive, "global" care) includes antepartum care, vaginal delivery (with or without episiotomy, and/or forceps or breech delivery) and postpartum care.
59420	Antepartum care only (separate procedure).
59430	Postpartum care only (separte procedure).
69090	Ear piercing.

NOTE: Out-of-scope procedures also includes the following HCPCS codes:

- 00100 - 01999
- 70010 - 99199

Noncovered Procedures

HCPCS Code*	Description
15775	Punch graft for hair transplant 1-15 puch grafts.
15776	Punch graft to hair transplant more than 15 punch grafts.
44131	Enteroenterostomy, anastomosis of intestine; intestinal bypass for morbid obesity.
47135	Liver transplant, with or without recipient hepatectomy.
48160	Pancreatectomy, total; with transplantation.
55250	Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s).
55450	Ligtion (percutaneous) of vas deferens, unilateral or bilateral (separate procedure).
55970	Intersex surgery; male to female.
55980	Intersex surgery; female to male.
57170	Diaphragm fitting with instructions.
58300	Insertion of intrauterine device (IUD).
58301	Removal of intrauterin device (IUD).
58600	Ligation or tsansection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral.
58606	Ligation or transection of fallopian tube(s), abdominal or vagional approach, postpartum, unilateral or bilateral, during same hospitalization (separte procedure).
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean section of intra-abdominal surgery (not a separate procedure).

*Copyright of the American Medical Association

58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, falope ring).
58982	Laparoscopy for visulaization of pelvice viscera; with fulguration of oviducts (with or withut transection).
58983	Laproscopy for visulaization of pelvic viscera; with fulguration of oviducts (with or without transection).
65760	Keratomileusis.
65765	Keratophakia.
65767	Epikeratophakia.
69090	Ear piercing.

Development Needed

HCPCS Code*	Description
11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; 6.0 SQ CM or less.
11921	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin; 6.1 to 20.0 SQ CM.
11922	Tattooing, intradermal introduction of insoluble opaque pigments to correct defects of skin; each additional 20.0 SQ CM.
11950	Subcutaneous injection of "filling" material (e.g., silicone); 1 CC or less.
11951	Subcutaneous injection of "filling" material (e.g., silicone); 1.1 to 5 CC.
11952	Subcutaneous injection of "filling" material (e.g., silicone); 5.1 to 10 CC.
11954	Subcutaneous injection of "filling" material (e.g., silicone); over 10 CC.
15780	Abrasion of skin for removal of scres, tattoos, or keratoses; total face.
15781	Abrasion of skin for removal of scars, tattoos, or keratoses; less than total face (cheeks, perioral ara, chin, nose or forehand).
15782	Abrasion of skin for removal of scars, tattoos, or keratoses; regional, other than face.
15786	Abrasion; single lesion (e.g., keratosis, scar).
15787	Abrasion; each additional fur lesions or less.
15790	Sperficcial checmical peel (chemex foliation); total face.
15791	Superficial checmical peel (chemex foliatio); regional, face, hand, or elsewhere.

*Copyright of the American Medical Association

15810	Salabrasion; 20 SQ CM or less.
15811	Salabrasion; over 20 SQ CM.
15819	Cervicoplasty
15820	Blepharoplasty, lower eyelid.
15821	Blepharoplasty, lower eyelid; with extensive herinated fat pad.
15822	Blepharoplasty, upper eyelid.
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid.
15824	Khytidectomy; forehead.
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, "P-Flap").
15826	Rhytidectomy; glabellar frown lines.
15828	Rhytidectomy; cheek, chin, and neck.
15829	Rhytidectomy; subcutaneous muscoloaponeuotic system (SMAS) flap.
15831	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen (abdominoplasty).
15832	Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh.
15833	Excision, excessive skin and subcutaneous tissue (including lipectomy); leg.
15834	Excision, excessive skin and subcutaneous tissue (including lipectomy); hip.
15835	Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock.
15836	Excision, excessive skin and subcutaneous tissue (including lipectomy); arm.
15837	Excision, excessive skin and subcutaneous tissue (including

	lipectomy); forearm or hand.
15838	Exicision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad.
15839	Excision, excessive skin and subcutaneous tissue (including lipectomy); other area.
17380	Electrolysis epilation, each 1/2/ hour.
19316	Mastopexy.
19318	Reduction mannaplasty.
19324	Mannaplasty, augmentation; without prosthetic implant.
19325	Mammaplasty, augmentation with prosthetic implant.
19328	Removal of intact mannary implant.
19330	Removal of implant material.
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction.
19350	Nipple/areola reconstruction.
19360	Breast reconstruction with muscle or myocutaneous flap.
19364	Breast reconstruction with free flap.
19366	Breast reconstruction with other technique.
19370	Open periprosthetic capsulotomy, breast.
19371	Periprosthetic capsulectomy, breast.
19380	Revision of reconstructed breast.
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip.
30410	Rhinoplasty, primary; complete, external parts including bondy pyramid, lateral and alar cartilages, and/or elevation of.

30420	Rhinoplasty, primary; inncluding major septal repair.
30430	Rhiooplasty, secondary; minor revision (small amount of nasal tip work).
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies).
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies).
33945	Heart transplant, with or without recipient cardiectomy.
41820	Gingivectomy, excision gingiva, each quadrant.
41821	Operculectomy, excision pericoronal tissues.
41822	Excision of fibrous tuperosities.
41823	Excision of osseous tuberosities.
41825	Excision of lesion or tumor (except listed above); without repair.
41826	Excision of lesion or tumor (except listed above); with simple repair.
41827	Excision of lesion or tumor (except listed above); with simple repair.
41828	Excision of hyperplastic alveolar mucosa, each sextant or quadrant (specify).
41830	Alveolectomy, including curettage of osteitis or sequestrectomy.
41850	Destruction of lesion (except excision), dentoalveolar structures.
43844	Gastric bypass for morbid obesity.
43845	Gastric stapling for morbid obesity.
43846	Gastric bypass with roux-en-y gastroenterostomy for morbid obesity.
54660	Insertion of testicular prosthesis (separate procedure); unilateral.

54661	Insertion of testicular prosthesis (separate procedure); bilateral.
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure).
58720	Salpingo-oophorectomy, complete or partial, unilatral or bilateral (separate procedure).
59200	Insertion of hygroscoic cervical dilator (e.g., laminaria) (separate procedure).
59840	Legal (therapeutic) abortion, by dilation and curettage, and/or extraction.
59841	Legal (therapeutic) aboration, by dilation and evacuation.
59850	Legal (therapeutic) abortion, by one or more intra-amniotic injections (amniocentesis-injections) (including hospital admission and visits, delivery of fetus and secundines).
59851	Legal (therapeutic) abortion, by one or more intra-amniotic injections (amniocentesis-injections) (including hospital admission and vists, delivery of fetus and secundines).
59852	Legal (therapeutic) abortion, by one or more intra-amniotic injections (amniocentesis-injections) (including hospital admission and visits, delivery of fetus and secundines).
67901	Repair of blepharoptosis; frontalis muscle technique with suture.
67902	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining facia).
67903	Repair of blepharoptosis; (tarso) levator resection, interal approach.
67904	Repair of blepharoptosis; (tarso) levator resection, external approach.

67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia).
67907	Repair of blepharoptosis; superior rectus tendon transplant.
67908	Repair of blepharoptosis; conjunctivo-tarso-levator esection (fasanella-servat type).
67909	Reduction of overcorrection of ptosis.
67911	Correctiono of lid retraction.
69300	Otoplasty protruding ear, with or without size reduction; unilateral.
69301	Otoplasty protroding ear, with or without size reduction; bilateral.

List of Covered Surgical Procedures*

NOTE: Procedure codes preceded by an asterisk indicate that the procedure has been covered since August 5, 1982.

Procedure codes without an asterisk indicate additions to the list of surgical procedures which are covered effective May 21, 1987. The covered procedures, listed by body system and payment, together with applicable CPT-4 codes, are as follows:

INTEGUMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND AREOLAR TISSUES

INCISION

10141 2 Incision and drainage of hematoma; complicated

EXCISION DEBRIDEMENT

11042 1 Debridement; skin, and subcutaneous tissue
11043 1 Debridement; skin, subcutaneous tissue, and muscle
11044 1 Debridement; skin, subcutaneous tissue, muscle, and bone

EXCISION-BENIGN LESIONS

*	11200	1	Excision, skin tags, multiple fibrocutaneous tags, any area; up to 15
*	11201	1	Each additional ten lesions
*	11401	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, or legs; lesion diameter 0.6 to 1.0 cm
*	11402	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm
*	11403	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 2.1 to 3.0 cm
*	11404	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 3.1 to 4.0 cm
*	11406	1	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter over 4.0 cm
*	11421	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
*	11422	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
*	11423	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm
*	11424	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm
*	11426	1	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
*	11441	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm

*Copyright of the American Medical Association

*	11442	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm
*	11443	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 2.1 to 3.0 cm
*	11444	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 3.1 to 4.0 cm
*	11446	1	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter over 4.0 cm
	11471	2	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with other closure

EXCISION-MALIGNANT LESIONS

*	11600	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less
*	11601	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.6 to 1.0 cm
*	11602	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 1.1 to 2.0 cm
*	11603	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 2.1 to 3.0 cm
*	11604	1	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 3.1 to 4.0 cm
*	11606	2	Excision, malignant lesion, trunk, arms, or legs; lesion diameter over 4.0 cm
*	11620	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less
*	11621	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm
*	11622	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm
*	11623	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 2.1 to 3.0 cm
*	11624	1	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm
*	11626	2	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter over 4.0 cm
*	11640	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm or less
*	11641	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.6 to 1.0 cm
*	11642	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 1.1 to 2.0 cm
*	11643	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 2.1 to 3.0 cm

*	11644	1	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 3.1 to 4.0 cm
*	11646	2	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter over 4.0 cm

NAILS

*	11750	1	Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal

MISCELLANEOUS

*	11770	3	Excision of pilonidal cyst or sinus; simple
*	11771	3	Excision of pilonidal cyst or sinus; extensive
	11772	3	Excision of pilonidal cyst or sinus; complicated

REPAIR-SIMPLE

12006	2	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 20.1 cm to 30.0 cm
12007	2	Simple Repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); over 30.0 cm
12017	2	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12018	2	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm

REPAIR-INTERMEDIATE

12036	2	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 20.1 cm to 30.0 cm
12037	2	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); over 30.0 cm
12046	2	Layer closure of wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm
12047	2	Layer closure of wounds of neck, hands, feet and/or external genitalia; over 30.0 cm
12056	2	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm
12057	2	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm

REPAIR-COMPLEX

13101	1	Repair, complex, trunk; 2.6 cm to 7.5 cm
13121	1	Repair, complex, scalp, arms, and/or legs; 2.6 cm to 7.5 cm
13132	2	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm
13152	3	Repair, complex, eyelids, nose, ears, and/or lips; 2.6 cm to 7.5 cm
13300	3	Repair, unusual, complicated, over 7.5 cm, any area

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

14001	3	Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm
14020	3	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	3	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14041	3	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
14060	3	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14061	3	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm
14300	3	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area
14350	3	Filleted finger or toe flap, including preparation of recipient site

FREE SKIN GRAFTS

* 15000	3	Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as spearate service in addition to skin graft)
* 15050	3	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or minimal open area (except on face), up to defect size 2 cm diameter
* 15100	3	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); 100 sq cm or less, or each one percent of body area of infants and children (except 15050)
* 15101	3	Split graft, trunk, scalp, arms, legs, hands, and/or feet (except multiple digits); each additional 100 sq cm, or each one percent body area of infants and children, or part thereof
15200	3	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less
15201	3	Full thickness graft, free, including direct closure of donor site, trunk; each additional 20 sq cm
15220	3	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less
15221	3	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; each additional 20 sq cm
15240	3	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 20 sq cm or less
15241	3	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 20 sq cm

15260	3	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less
15261	3	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; each additional 20 sq cm
15350	3	Application of allograft (homograft), skin
15410	3	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; 100 sq cm or less
15412	3	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; between 101 and 160 sq cm
15414	3	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; between 161 and 230 sq cm
15416	3	Free transplantation of skin flap by microsurgical technique, including microvascular anastomosis; over 230 sq cm

REPAIR

PEDICLE FLAPS (SKIN AND DEEP TISSUES)

15500	4	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on trunk
15505	4	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on scalp, arms, or legs
15510	4	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on forehead, cheeks, chin, mouth, neck, axillae genitalia, hands, or feet
15515	4	Formation of tube pedicle without transfer, or major "delay" of large flap without transfer; on eyelids, nose, ears, or lips
15540	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to trunk
15545	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to scalp, arms, or legs
15550	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to forehead, cheeks, chin, mouth, neck, axillae, genitalia, or hands, feet
15555	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; to eyelids, nose, ears, or lips
15580	4	Primary attachment of open or tubed pedicle flap to recipient site requiring minimal preparation; cross finger pedicle flap, including free graft to donor site
15600	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at trunk
15610	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at scalp, arms, or legs
15620	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at forehead, cheeks, chin, neck, axillae, genitalia, hands (except 15625), or feet
15625	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; section pedicle of cross finger flap

15630	4	Intermediate "delay" of any flap, primary "delay" of small flap, or sectioning pedicle of tubed or direct flap; at eyelids, nose, ears. or lips
15650	4	Transfer, intermediate, of any pedicle flap (e.g., abdomen to wrist, Walking tube), any location
15700	4	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; trunk
15710	4	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; scalp, arms, or legs
15720	4	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, or feet
15730	4	Excision of lesion and/or excisional preparation of recipient site and attachment of direct or tubed pedicle flap; eyelids, nose, ears, or lips

OTHER GRAFTS

15740	3	Graft; island pedicle flap
15745	4	Graft; myocutaneous flap
15750	4	Graft; neurovascular pedicle flap
15755	4	Graft; free flap (microvascular transfer)
15760	3	Graft; composite (full thickness of external ear or nasal ala), including primary closure, donor area
15770	3	Graft; derma-fat-fascia

MISCELLANEOUS PROCEDURES

15840	4	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)
15841	4	Graft for facial nerve paralysis; free muscle graft (including obtaining graft)
15842	4	Graft for facial nerve paralysis; free muscle graft by microsurgical technique
15845	4	Graft for facial nerve paralysis; regional muscle transfer

PRESSURE ULCERS (DECUBITUS ULCERS)

15920	3	Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
15922	3	Excision, coccygeal pressure ulcer, with coccygectomy; with local or regional skin flap closure
15931	3	Excision, sacral pressure ulcer, with primary suture;
15933	3	Excision, sacral pressure ulcer, with primary suture; with ostectomy
15941	3	Excision, ischial pressure ulcer, with primary suture; with ostectomy (ischiectomy)
15944	3	Excision, ischial pressure ulcer, with local or regional skin flap closure
15945	3	Excision, ischial pressure ulcer, with local or regional skin flap closure; with ostectomy
15946	3	Excision, ischial pressure ulcer, with ostectomy, with muscle flap or myocutaneous flap closure

15950	3	Excision, trochanteric pressure ulcer, with primary suture
15951	3	Excision, trochanteric pressure ulcer, with primary suture; with ostectomy
15952	3	Excision, trochanteric pressure ulcer, with local rotation skin flap closure
15953	3	Excision, trochanteric pressure ulcer, with local rotation skin flap closure; with ostectomy
15954	3	Excision, trochanteric pressure ulcer, with bipedicle flap closure
15955	3	Excision, trochanteric pressure ulcer, with bipedicle flap closure; with ostectomy
15956	3	Excision, trochanteric pressure ulcer, with muscle or myocutaneous flap closure
15958	3	Excision, trochanteric pressure ulcer, with muscle or myocutaneous flap closure; with ostectomy
15960	3	Excision, heel pressure ulcer, with primary suture
15961	3	Excision, heel pressure ulcer, with primary suture; with ostectomy
15964	3	Excision, heel pressure ulcer, with skin flap closure
15965	3	Excision, heel pressure ulcer, with skin flap closure; with ostectomy
15966	3	Excision, heel pressure ulcer, with other flap closure
15967	3	Excision, heel pressure ulcer, with other flap closure; with ostectomy
15970	3	Excision, leg pressure ulcer, with primary suture
15971	3	Excision, leg pressure ulcer, with ostectomy
15972	3	Excision, leg pressure ulcer, with local skin flap(s)
15973	3	Excision, leg pressure ulcer, with local skin flap(s); with ostectomy
15974	3	Excision, leg pressure ulcer, with muscle or myocutaneous flap closure
15975	3	Excision, leg pressure ulcer, with muscle or myocutaneous flap closure; with ostectomy
15980	3	Excision, knee pressure ulcer, with local skin flap closure
15981	3	Excision, knee pressure ulcer, with local skin flap closure; with ostectomy
15982	3	Excision, knee pressure ulcer, with other flap closure
15983	3	Excision, knee pressure ulcer, with other flap closure; with ostectomy

BURNS, LOCAL TREATMENT

16015	1	Dressing and/or debridement, initial or subsequent; under anesthesia, medium or large, or with major debridement

BREAST

INCISION

19020	1	Mastotomy with exploration or drainage of abscess, deep

EXCISION

* 19101	3	Biopsy of breast; incisional
* 19120	3	Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions

* 19140	4	Mastectomy for gynecomastia through circumareolar or other incision
19160	4	Mastectomy, partial
19180	4	Mastectomy, simple, complete
19182	4	Mastectomy, subcutaneous

MUSCULOSKELETAL SYSTEM

GENERAL

INCISION

20005	1	Incision of soft tissue abscess (e.g., secondary to osteomyelitis); deep or complicated

EXCISION

20205	1	Biopsy, muscle; deep
20225	3	Biopsy, bone, trocar or needle; deep (vertebral body, femur)
20240	2	Biopsy, excisional; superficial (e.g., ilium, sternum, spinous process, ribs, trochanter of femur)
20245	3	Biopsy, excisional, deep (e.g., humerus, ischium, femur)
20250	4	Biopsy, vertebral body, open; thoracic
20251	4	Biopsy, vertebral body, open; lumbar or cervical

INTRODUCTION OR REMOVAL

20525	2	Removal of foreign body in muscle; deep or complicated
20650	2	Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)
20660	2	Application of tongs or caliper, including removal (separate procedure)
20661	2	Application of halo; including removal cranial
20662	2	Application of halo; pelvic
20663	2	Application of halo; femoral
20665	2	Removal of tongs or halo applied by another physician
20680	3	Removal of implant; deep (e.g., buried wire, pin, screw, metal band, nail, rod or plate)

GRAFTS (OR IMPLANTS)

20900	3	Bone graft, any donor area; minor or small (e.g., dowel or button)
20902	4	Bone graft, any donor area; major or large
20912	4	Cartilage graft; nasal septum
20920	4	Fascia lata graft; by stripper
20922	4	Fascia lata graft; by incision and area exposure, complex or sheet
20926	4	Tissue grafts, other (e.g., paratenon, fat, dermis, etc.)

MISCELLANEOUS

20955	4	Bone graft with microvascular anastomosis; fibula
20960	4	Bone graft with microvascular anastomosis; rib
20962	4	Bone graft with microvascular anastomosis; other bone graft (specify)
20969	4	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, rib, metatarsal, or great toe

	20970	4	Free osteocutaneous flap with microvascular anastomosis; iliac crest
	20971	4	Free osteocutaneous flap with microvascular anastomosis; rib
	20972	4	Free osteocutaneous flap with microvascular anastomosis; metatarsal
	20973	4	Free osteocutaneous flap with microvascular anastomosis; great toe with web space
	20975	2	Electrical stimulation to aid bone healing; invasive (operative)

HEAD

INCISION

	21010	3	Arthrotomy, temporomandibular joint; unilateral
	21011	3	Arthrotomy, temporomandibular joint; bilateral

GENERAL

EXCISION

	21034	4	Excision of malignant tumor of facial bone other than mandible
*	21040	3	Excision of benign cyst or tumor of mandible; simple
	21044	4	Excision of malignant tumor of mandible
	21050	4	Arthrectomy, temporomandibular joint; unilateral
	21060	4	Meniscectomy, temporomandibular joint; unilateral
	21061	4	Meniscectomy, temporomandibular joint; bilateral

INTRODUCTION OR REMOVAL

	21100	4	Application of halo type appliance for maxillofacial fixation, includes removal (separate procedure)

FRACTURE AND/OR DISLOCATION

*	21310	1	Treatment of closed or open nasal fracture without manipulation
*	21315	1	Manipulative treatment, nasal bone fracture; without stabilization
	21320	1	Manipulative treatment, nasal bone fracture; with stabilization
	21325	3	Open treatment of nasal fracture; uncomplicated
	21330	4	Open treatment of nasal fracture; complicated, with internal and/or external skeletal fixation
	21335	4	Open treatment of nasal fracture; with concomitant open treatment of fractured septum
	21338	4	Open treatment of nasoethmoid fracture; without external fixation
	21340	4	Treatment of closed or open nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus
*	21355	2	Manipulative treatment of closed or open fracture of malar area, including zygomatic arch and malar tripod, towel clip technique
*	21360	2	Open treatment of closed or open depressed malar fracture, including zygomatic arch and malar tripod
	21365	4	Open treatment of closed or open complicated, (e.g, multiple fractures), of malar area, including zygomatic arch and malar tripod, with internal skeletal fixation and multiple surgical approaches
	21450	4	Treatment of closed or open mandibular fracture; without manipulation

21451	4	Treatment of closed or open mandibular fracture; with manipulation, may include external fixation
21452	4	Treatment of open mandibular fracture; without manipulation
21453	4	Treatment of open mandibular fracture; with manipulation
21480	2	Uncomplicated treatment of temporomandibular dislocation, initial or subsequent
21485	3	Complicated manipulative treatment of temporomandibular dislocation, initial or subsequent
21490	4	Open treatment of temporomandibular dislocation
21494	3	Treatment of closed or open hyoid fracture; with manipulation
21495	4	Open treatment of closed or open hyoid fracture

NECK (SOFT TISSUES) AND THORAX

INCISION

21501	1	Incision and drainage, deep abscess or hematoma
21502	3	Incision and drainage, deep abscess or hematoma; with partial rib ostectomy
21510	3	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
21555	1	Excision benign tumor; subcutaneous

EXCISION

21556	2	Excision, benign tumor; deep, subfascial, intramuscular
21600	3	Excision of rib, partial
21610	3	Costotransversectomy (separate procedure)

ABDOMEN

EXCISION

22900	2	Excision, abdominal wall tumor, subfascial (e.g., desmoid)

SHOULDER

INCISION

23000	3	Removal of subdeltoid (or intratendinous) calcareous deposits
23020	3	Capsular contracture release (Sever type procedure) for Erb's palsy
23030	1	Incision and drainage; deep abscess or hematoma
23035	2	Incision, deep, with opening of cortex (e.g., for osteomyelitis or bone abscess)
23040	4	Arthrotomy, glenohumeral joint, for infection, with exploration, drainage or removal of foreign body
23044	4	Arthrotomy with exploration, drainage or removal of foreign body, acromioclavicular, sternoclavicular joint

EXCISION

23066	1	Biopsy, soft tissues; deep
23076	1	Excision, benign tumor; deep, subfascial or intramuscular
23100	4	Arthrotomy for biopsy, glenohumeral joint

	23101	4	Arthrotomy for biopsy or for excision of torn cartilage, acromioclavicular, sternoclavicular joint
	23130	4	Acromionectomy, partial or total
	23140	4	Excision or curettage of bone cyst or benign tumor of clavicle or scapula
	23150	4	Excision or curettage of bone cyst or benign tumor of proximal humerus
*	23170	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), clavicle;
*	23172	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess),scapula;
*	23174	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), humeral head to surgical neck;
	23180	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), clavicle
	23182	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), scapula
	23184	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), proximal humerus
	23190	3	Ostectomy of scapula, partial (e.g., superior medial angle)
	23195	3	Resection humeral head

INTRODUCTION OR REMOVAL

23331	2	Removal of foreign body; deep (e.g., Neer prosthesis removal)

REPAIR, REVISION OR RECONSTRUCTION

23405	3	Tenomyotomy; single
23406	3	Tenomyotomy; multiple through same incision

FRACTURE AND/OR DISLOCATION

23505	2	Treatment of closed clavicular fracture; with manipulation
23515	4	Open treatment of closed or open clavicular fracture, with or without internal or external skeletal fixation
23605	2	Treatment of closed humeral (surgical or anatomical neck) fracture; with manipulation
23610	4	Treatment of open humeral (surgical or anatomical neck) fracture, with uncomplicated soft tissue closure
23625	2	Treatment of closed greater tuberosity fracture; with manipulation
23630	4	Open treatment of closed or open greater tuberosity fracture, with or without internal or external skeletal fixation
23655	1	Treatment of closed shoulder dislocation, with manipulation; requiring anesthesia
23658	4	Treatment of open shoulder dislocation, with uncomplicated soft tissue closure
23660	4	Open treatment of closed or open shoulder dislocation
23665	2	Treatment of closed shoulder dislocation, with fracture of greater tuberosity, with manipulation
23670	4	Open treatment of closed or open shoulder dislocation, with fracture of greater tuberosity
23675	2	Treatment of closed shoulder dislocation, with surgical or anatomical neck fracture, with manipulation

23680	4	Open treatment of closed or open shoulder dislocation, with surgical or anatomical neck fracture

MANIPULATION

23700	2	Manipulation under anesthesia, including application of fixation apparatus (dislocation excluded)

HUMERUS (UPPER ARM) AND ELBOW

INCISION

23930	1	Incision and drainage; deep abscess or hematoma
23935	2	Incision, deep, with opening of (e.g., cortex for osteomyelitis or bone abscess)
24000	2	Arthrotomy, elbow, for infection, with exploration, drainage or removal of foreign body

EXCISION

24075	2	Excision, benign tumor; subcutaneous
24076	2	Excision, benign tumor; deep, subfascial or intramuscular
24100	4	Arthrotomy, elbow; for synovial biopsy only
24101	4	Arthrotomy, elbow; with joint exploration, with or without biopsy, with or without removal of foreign body
* 24105	3	Excision, olecranon bursa
24110	3	Excision, or curettage of bone cyst or benign tumor, humerus
24115	4	Excision or curettage of bone cyst or benign tumor, humerus; with primary autogenous graft (includes obtaining graft)
24116	4	Excision or curettage of bone cyst or benign tumor, humerus; with homogenous or other nonautogenous graft
24120	3	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process
24125	4	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with primary autogenous graft (includes obtaining graft)
24126	4	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process; with homogenous or other nonautogenous graft
24130	3	Excision, radial head
* 24134	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), shaft or distal humerus;
* 24136	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), radial head or neck;
* 24138	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess), olecranon process;

	24140	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), humerus
	24145	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), radial head or neck
	24147	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), olecranon process;
	24155	4	Resection of elbow joint (arthrectomy)

INTRODUCTION OR REMOVAL

	24160	2	Implant removal; elbow joint
	24164	2	Implant removal; radial head
	24201	1	Removal of foreign body; deep

REPAIR REVISION AND RECONSTRUCTION

	24301	3	Muscle or tendon transfer, any type, single (excluding 24320-24331)
	24310	3	Tenotomy, open, elbow to shoulder, single, each
*	24320	4	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)
	24330	4	Flexor-plasty, elbow, (e.g., Steindler type advancement)
	24331	4	Flexor-plasty, elbow, (e.g., Steindler type advancement); with extensor advancement
	24340	4	Tenodesis for rupture of biceps tendon at elbow
	24342	4	Reinsertion of ruptured biceps tendon, distal, with or without tendon graft (includes obtaining graft)
*	24350	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis)
*	24351	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with extensor origin detachment
*	24352	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with annular ligament resection
*	24354	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with stripping
	24356	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with partial ostectomy
	24420	4	Osteoplasty, humerus (e.g., shortening or lengthening)(excluding 64876)
	24470	4	Hemiepiphyseal arrest (e.g., for cubitus varus or valgus, distal humerus)
	24495	3	Decompression fasciotomy, forearm, with brachial artery exploration

FRACTURE AND/OR DISLOCATION

	24505	1	Treatment of closed humeral shaft fracture; with manipulation
	24506	2	Treatment of closed humeral shaft fracture; percutaneous insertion of pin or rod
	24510	3	Treatment of open humeral shaft fracture, with uncomplicated soft tissue closure
	24515	4	Open treatment of closed or open humeral shaft fracture, with or without internal or external skeletal fixation
	24530	1	Treatment of closed supracondylar or transcondylar fracture, without manipulation

24531	2	Treatment of closed supracondylar or transcondylar fracture, without manipulation; with traction (pin or skin)
24535	1	Treatment of closed supracondylar or transcondylar fracture, with manipulation
24536	2	Treatment of closed supracondylar or transcondylar fracture, with manipulation; with traction (pin or skin)
24538	2	Treatment of closed supracondylar or transcondylar fracture, with manipulation; with percutaneous skeletal fixation
24540	4	Treatment of open supracondylar or transcondylar fracture, with uncomplicated soft tissue closure
24542	4	Treatment of open supracondylar or transcondylar fracture, with uncomplicated soft tissue closure; with traction (pin or skin)
24545	4	Open treatment of closed or open supracondylar or transcondylar fracture, with or without internal or external skeletal fixation
24565	1	Treatment of closed epicondylar fracture, medial or lateral; with manipulation
24570	3	Treatment of open epicondylar fracture, medial or lateral, with uncomplicated soft tissue closure
24575	4	Open treatment of closed or open epicondylar fracture, medial or lateral, with or without internal or external skeletal fixation
24577	1	Treatment of closed condylar fracture, medial or lateral; with manipulation
24578	3	Treatment of open condylar fracture, medial or lateral, with uncomplicated soft tissue closure
24579	4	Open treatment of closed or open condylar fracture, medial or lateral, with or without internal or external skeletal fixation
24580	1	Treatment of closed comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), treatment with traction, (pin or skin); without manipulation
24581	1	Treatment of closed comminuted elbow fracture (fracture distal and/or proximal ulna and/or proximal radius), treatment with traction, (pin or skin); with manipulation
24140	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), humerus
24145	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), radial head or neck
24147	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis), olecranon process;
24155	4	Resection of elbow joint (arthrectomy)

INTRODUCTION OR REMOVAL

24160	2	Implant removal; elbow joint
24164	2	Implant removal; radial head
24201	1	Removal of foreign body; deep

REPAIR REVISION AND RECONSTRUCTION

	24301	3	Muscle or tendon transfer, any type, single (excluding 24320-24331)
	24310	3	Tenotomy, open, elbow to shoulder, single, each
*	24320	4	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)
	24330	4	Flexor-plasty, elbow, (e.g., Steindler type advancement)
	24331	4	Flexor-plasty, elbow, (e.g., Steindler type advancement); with extensor advancement
	24340	4	Tenodesis for rupture of biceps tendon at elbow
	24342	4	Reinsertion of ruptured biceps tendon, distal, with or without tendon graft (includes obtaining graft)
*	24350	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis)
*	24351	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with extensor origin detachment
*	24352	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with annular ligament resection
*	24354	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with stripping
	24356	4	Fasciotomy, lateral or medial (e.g., "tennis elbow" or epicondylitis); with partial ostectomy
	24420	4	Osteoplasty, humerus (e.g., shortening or lengthening)(excluding 64876)
	24470	4	Hemiepiphyseal arrest (e.g., for cubitus varus or valgus, distal humerus)
	24495	3	Decompression fasciotomy, forearm, with brachial artery exploration

FRACTURE AND/OR DISLOCATION

24505	1	Treatment of closed humeral shaft fracture; with manipulation
24506	2	Treatment of closed humeral shaft fracture; percutaneous insertion of pin or rod
24510	3	Treatment of open humeral shaft fracture, with uncomplicated soft tissue closure
24515	4	Open treatment of closed or open humeral shaft fracture, with or without internal or external skeletal fixation
24530	1	Treatment of closed supracondylar or transcondylar fracture, without manipulation
24531	2	Treatment of closed supracondylar or transcondylar fracture, without with traction (pin or skin)
24535	1	Treatment of closed supracondylar or transcondylar fracture, with manipulation
24536	2	Treatment of closed supracondylar or transcondylar fracture, with manipulation; with traction (pin or skin)
24538	2	Treatment of closed supracondylar or transcondylar fracture, with manipulation; with percutaneous skeletal fixation
24540	4	Treatment of open supracondylar or transcondylar fracture, with uncomplicated soft tissue closure

24542	4	Treatment of open supracondylar or transcondylar fracture, with uncomplicated soft tissue closure; with traction (pin or skin)
24545	4	Open treatment of closed or open supracondylar or transcondylar fracture, with or without internal or external skeletal fixation
24565	1	Treatment of closed epicondylar fracture, medial or lateral; with manipulation
24570	3	Treatment of open epicondylar fracture, medial or lateral, with uncomplicated soft tissue closure
24575	4	Open treatment of closed or open epicondylar fracture, medial or lateral, with or without internal or external skeletal fixation
24577	1	Treatment of closed condylar fracture, medial or lateral; with manipulation
24578	3	Treatment of open condylar fracture, medial or lateral, with uncomplicated soft tissue closure
24579	4	Open treatment of closed or open condylar fracture, medial or lateral, with or without internal or external skeletal fixation
24580	1	Treatment of closed comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), treatment with traction, (pin or skin); without manipulation
24581	1	Treatment of closed comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), treatment with traction, (pin or skin); with manipulation
24583	4	Treatment of open comminuted elbow fracture (fracture distal humerus and/or proximal ulna and/or proximal radius), with uncomplicated soft tissue closure
24585	4	Open treatment of closed or open comminuted elbow fracture (fracture distal humerus and/or proximal ulna/radius), with or without internal or external skeletal fixation
24586	4	Open treatment of closed or open comminuted elbow fracture (fracture distal humerus and/or proximal ulna/radius), with or without internal or external skeletal fixation; with elbow resection
24605	1	Treatment of closed elbow dislocation; requiring anesthesia
24610	3	Treatment of open elbow dislocation, with uncomplicated soft tissue closure
24615	3	Open treatment of closed or open elbow dislocation
24620	2	Treatment of closed Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head)
24625	4	Treatment of open Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with uncomplicated soft tissue closure
24635	4	Open treatment of closed or open Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with or without internal or external skeletal fixation
24655	1	Treatment of closed radial head or neck fracture; with manipulation with complicated soft tissue closure

24665	4	Open treatment of closed or open radial head or neck fracture, with or without internal fixation or radial head excision
24666	4	Open treatment of closed or open radial head or neck fracture, with or without internal fixation or radial head excision; with implant
24675	1	Treatment of closed ulnar fracture, proximal end (olecranon process); with manipulation
24680	3	Treatment of open ulnar fracture, proximal end (olecranon process), with uncomplicated soft tissue closure
24685	4	Open treatment of closed or open ulnar fracture proximal end (olecranon process), with or without internal or external skeletal fixation

FOREARM AND WRIST

INCISION

* 25000	2	Tendon sheath incision; at radial styloid for deQuervain's disease
25005	2	Tendon sheath incision; at wrist for other stenosing tenosynovitis
* 25020	4	Decompression fasciotomy, flexor and/or extensor compartment
* 25023	4	Decompression fasciotomy, flexor and/or extensor compartment; with debridement of nonviable muscle and/or nerve
25028	1	Incision and drainage, deep abscess or hematoma
25035	2	Incision, deep, with opening of cortex (e.g., for osteomyelitis or bone abscess)
25040	2	Arthrotomy, radiocarpal or mediocarpal joint, for infection, with exploration, drainage, or removal of loose or foreign body

EXCISION

25066	1	Biopsy, soft tissues; deep
25076	1	Excision, benign tumor, deep, subfascial or intramuscular
25085	3	Capsulotomy, wrist (e.g., for contracture)
25100	2	Arthrotomy, wrist joint; for biopsy
25101	3	Arthrotomy, wrist joint; with joint exploration, with or without biopsy, with or without removal of foreign body
25107	3	Arthrotomy distal radioulnar joint for repair of triangular cartilage complex
25110	3	Excision, lesion of tendon sheath
* 25111	3	Excision of ganglion, wrist (dorsal or volar); primary
* 25112	3	Excision of ganglion, wrist (dorsal or volar); recurrent
25120	3	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process)
25125	4	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with primary autogenous graft (includes obtaining graft)
25126	4	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process); with homogenous or other nonautogenous graft

25130	3	Excision or curettage of bone cyst or benign tumor of carpal bones
25135	3	Excision or curettage of bone cyst or benign tumor of carpal bones; with primary autogenous graft (includes obtaining graft)
25136	4	Excision or curettage of bone cyst or benign tumor of carpal bones; with homogenous or other nonautogenous graft
25145	2	Sequestrectomy (e.g. for osteomyelitis or bone abscess);
25150	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis); ulna
25151	2	Partial excision (craterization, saucerization or diaphysectomy) of bone (e.g., for osteomyelitis); radius
25210	3	Carpectomy; one bone
25215	3	Carpectomy; all bones of proximal row
25230	3	Radial styloidectomy (separate procedure)
25240	3	Excision distal ulna (Darrach type procedure)
25248	2	Exploration for removal of deep foreign body

REPAIR, REVISION OR RECONSTRUCTION

*	25260	3	Repair, tendon or muscle, flexor; primary, single, each tendon or muscle
*	25263	3	Repair, tendon or muscle, flexor; secondary, single, each tendon or muscle
*	25265	4	Repair tendon or muscle, flexor; secondary, with free graft (includes obtaining graft), each tendon or muscle
*	25270	3	Repair, tendon or muscle, extensor; primary, single, each tendon or muscle
*	25272	3	Repair, tendon or muscle, extensor; secondary, single, each tendon or muscle
	25274	4	Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), each tendon
	25280	3	Lengthening or shortening of flexor or extensor tendon, single, each tendon
	25290	3	Tenotomy, open, single, flexor or extensor tendon, each tendon
	25295	3	Tenolysis, single flexor or extensor tendon, each tendon
	25300	3	Tenodesis at wrist; flexors of fingers
	25301	3	Tenodesis at wrist; extensors of fingers
*	25310	4	Tendon transplantation or transfer, flexor or extensor, single; each tendon
*	25312	4	Tendon transplantation or transfer, flexor or extensor, single; with tendon graft(s) (includes obtaining graft), each tendon
	25315	3	Flexor origin slide for cerebral palsy
	25316	3	Flexor origin slide for cerebral palsy; with tendon(s) transfer
	25317	3	Flexor origin slide for Volkmann contracture
	25318	3	Flexor origin slide for Volkmann contracture; with tendon(s) transfer

25320	4	Capsulorrhaphy or reconstruction, capsulectomy, wrist (includes synovectomy, resection of capsule, tendon insertions)
25390	4	Osteoplasty radius OR ulna; shortening
25391	4	Osteoplasty, radius OR ulna; lengthening with autogenous bone graft
25392	4	Osteoplasty, radius AND ulna; shortening (excluding 64876)
25393	4	Osteoplasty, radius AND ulna; lengthening with autogenous bone graft
25450	4	Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna
25455	4	Epiphyseal arrest by epiphysiodesis or stapling; distal radius AND ulna

FRACTURE AND/OR DISLOCATION

25505	1	Treatment of closed radial shaft fracture; with manipulation
25510	3	Treatment of open radial shaft fracture, with uncomplicated soft tissue closure
25515	4	Open treatment of closed or open radial shaft fracture, with or without internal or external skeletal fixation
25535	1	Treatment of closed ulnar shaft fracture; with manipulation
25540	3	Treatment of open ulnar shaft fracture, with uncomplicated soft tissue closure
25545	4	Open treatment of closed or open ulnar shaft fracture, with or without internal or external skeletal fixation
25565	1	Treatment of closed radial and ulnar shaft fractures; with manipulation
25570	3	Treatment of open radial and ulnar shaft fractures, with uncomplicated soft tissue closure
25575	4	Open treatment of closed or open radial and ulnar shaft fractures, with or without internal or external skeletal fixation
25605	1	Treatment of closed distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation
25610	2	Treatment of closed, complex, distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; without external skeletal fixation or percutaneous pinning
25611	2	Treatment of closed, complex, distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation; percutaneous pinning or pins and plaster technique
25615	3	Treatment of open distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with uncomplicated soft tissue closure
25620	4	Open treatment of closed or open distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external skeletal fixation
25626	3	Treatment of open carpal scaphoid (navicular) fracture, with uncomplicated soft tissue closure
25628	4	Open treatment of closed or open carpal scaphoid (navicular) fracture, with or without skeletal fixation

25635	1	Treatment of closed carpal bone fracture (excluding carpal scaphoid (navicular)); with manipulation, each bone
25640	4	Treatment of open carpal bone fracture (excluding carpal scaphoid (navicular)), with uncomplicated soft tissue closure, each bone
25645	4	Open treatment of closed or open carpal bone fracture (excluding carpal scaphoid (navicular)), each bone
25660	1	Treatment of closed radiocarpal or intercarpal dislocation, one or more bones, with manipulation
25665	3	Treatment of open radiocarpal or intercarpal dislocation, one or more bones, with uncomplicated soft tissue closure
25670	4	Open treatment of closed or open radiocarpal or intercarpal dislocation, one or more bones
25675	1	Treatment of closed distal radioulnar dislocation with manipulation
25676	3	Open treatment of closed or open distal radioulnar dislocation, acute or chronic
25680	1	Treatment of closed trans-scaphoperilunar type of fracture dislocation, with manipulation
25685	3	Open treatment of closed or open trans-scaphoperilunar type of fracture dislocation
25690	1	Treatment of lunate dislocation, with manipulation
25695	3	Open treatment of lunate dislocation

HANDS AND FINGERS

INCISION

	26011	1	Drainage of finger abscess; complicated (e.g., felon, etc)
	26020	1	Drainage of tendon sheath, one digit and/or palm
	26025	1	Drainage of palmar bursa; single, ulnar or radial
	26030	1	Drainage of palmar bursa; multiple or complicated
	26034	2	Incision, deep, with opening of cortex (e.g., for osteomyelitis or bone abscess)
	26035	2	Decompression fingers and/or hand, injection injury (e.g., grease gun, etc.)
*	26040	4	Fasciotomy, palmar, for Dupuytren's contracture; closed (subcutaneous)
*	26045	4	Faciotomy, palmar, for Dupuytren's contracture; open, partial
*	26055	1	Tendon sheath incision for trigger finger
*	26060	1	Tenotomy, subcutaneous, single, each digit
	26070	2	Arthrotomy, for infection, with exploration, drainage or removal of loose or foreign body; carpometacarpal joint
	26075	2	Arthrotomy with exploration, drainage or removal of loose or foreign body; metacarpophalangeal joint
	26080	2	Arthrotomy with exploration, drainage or removal of loose or foreign body; interphalangeal joint, each

EXCISION

26100	3	Arthrotomy for synovial biopsy; carpometacarpal joint
26105	3	Arthrotomy for synovial biopsy; metacarpophalangeal joint

	26110	3	Arthrotomy for synovial biopsy; interphalangeal joint, each
	26115	3	Excision of benign tumor; subcutaneous
	26116	3	Excision of benign tumor; deep, subfascial, intramuscular
*	26120	4	Fasciectomy, palmar, simple, for Dupuytren's contracture; partial excision
*	26122	4	Fasciectomy, palmar, simple, for Dupuytren's contracture; up to one-half palmar fascia, with single digit involvement, with or without Z-plasty or other local tissue rearrangement
	26124	4	Fasciectomy, palmar, complicated, requiring skin grafting (includes obtaining graft); with single digit involvement
	26126	4	Fasciectomy, palmar, complicated, requiring skin grafting (includes obtaining graft); each additional digit
*	26128	4	Fasciectomy, palmar, complicated, requiring skin grafting (includes obtaining graft); each finger joint release
	26135	4	Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit
*	26140	4	Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint
*	26145	4	Synovectomy tendon sheath, radical (tenosynovectomy), flexor, palm or finger, single, each digit
	26160	3	Excision of lesion of tendon sheath or capsule (e.g., cyst or ganglion)
	26170	3	Excision of tendon, palm, flexor, single (separate procedure), each
	26180	3	Excision of tendon, finger, flexor (separate procedure)
	26200	3	Excision or curettage of bone cyst or benign tumor of metacarpal
	26205	3	Excision or curettage of bone cyst or benign tumor of metacarpal; with autogenous graft (includes obtaining graft)
	26210	3	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx
	26215	3	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx; with autogenous graft (includes obtaining graft)
	26230	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); metacarpal
	26235	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); proximal or middle phalanx
	26250	4	Radical resection (ostectomy) for tumor, metacarpal
	26255	4	Radical resection (ostectomy) for tumor, metacarpal; with autogenous graft (includes obtaining graft)
	26261	4	Radical resection (ostectomy) for tumor, proximal or middle phalanx; with autogenous graft (includes obtaining graft)

REPAIR, REVISION OR RECONSTRUCTION

*	26350	3	Flexor tendon repair or advancement, single, not in "no man's land"; primary or secondary without free graft, each tendon
*	26352	4	Flexor tendon repair or advancement, single, not in "no man's land"; secondary with free graft (includes obtaining graft), each tendon
*	26356	3	Flexor tendon repair or advancement, single, in "no man's land"; primary, each tendon

*	26358	4	Flexor tendon repair or advancement, single, in "no man's land"; secondary with free graft (includes obtaining graft), each tendon
*	26370	3	Profundus tendon repair or advancement, with intact sublimis; primary
*	26372	4	Profundus tendon repair or advancement, with intact sublimis; secondary with free graft (includes obtaining graft)
*	26373	3	Profundus tendon repair or advancement, with intact sublimis; secondary without free graft
*	26390	3	Flexor tendon excision, implantation of plastic tube or rod for delayed tendon graft
*	26392	4	Removal of tube or rod and insertion of tendon graft (includes obtaining graft)
*	26410	3	Extensor tendon repair, dorsum of hand, single, primary or secondary; without free graft, each tendon
*	26412	4	Extensor tendon repair, dorsum of hand, single, primary or secondary; with free graft (includes obtaining graft), each tendon
*	26418	3	Extensor tendon repair, dorsum of finger, single, primary or secondary; without free graft, each tendon
*	26420	4	Extensor tendon repair, dorsum of finger, single, primary or secondary; with free graft (includes obtaining graft), each tendon
*	26426	4	Extensor tendon repair, central slip repair, secondary (boutonniere deformity); using local tissues
*	26428	4	Extensor tendon repair, central slip repair, secondary (boutonniere deformity); with free graft (includes obtaining graft)
*	26432	4	Extensor tendon repair, distal insertion ("mallet finger"), closed, splinting with or without percutaneous pinning
*	26433	3	Extensor tendon repair, open, primary or secondary repair; without graft
*	26434	4	Extensor tendon repair, open, primary or secondary repair; with free graft (includes obtaining graft)
	26440	3	Tenolysis, simple, flexor tendon; palm OR finger, single, each tendon
	26442	3	Tenolysis, simple, flexor tendon; palm AND finger, each tendon
	26445	3	Tenolysis, extensor tendon, dorsum of hand or finger; each tendon
	26449	4	Tenolysis, complex, extensor tendon, dorsum of hand or finger, including hand and forearm
*	26450	1	Tenotomy, flexor, single, palm, open, each
*	26455	1	Tenotomy, flexor, single finger, open, each
*	26460	1	Tenotomy, extensor, hand or finger, single, open, each
	26471	2	Tenodesis; for proximal interphalangeal joint stabilization
	26474	2	Tenodesis; for distal joint stabilization
	26476	3	Tendon lengthening, extensor, single, each
	26477	3	Tendon shortening, extensor, single, each
*	26480	4	Tendon transfer or transplant, carpometacarpal area
*	26483	4	Tendon transfer or transplant, carpometacarpal area
*	26485	4	Tendon transfer or transplant, palmar, single, each tendon; without free tendon graft

*	26489	4	Tendon transfer or transplant, palmar, single, each tendon; with free tendon graft (includes obtaining graft), each tendon
	26490	4	Opponens plasty; sublimis tendon transfer type
	26492	4	Opponens plasty; tendon transfer with graft (includes obtaining graft)
	26494	4	Opponens plasty; hypothenar muscle transfer
	26496	4	Opponens plasty; other methods
	26497	4	Tendon transfer to restore intrinsic function; ring and small finger
	26498	4	Tendon transfer to restore intrinsic function; all four fingers
	26499	4	Correction claw finger; other methods
	26500	4	Tendon pulley reconstruction; with local tissues (separate procedure)
	26502	4	Tendon pulley reconstruction; with tendon or fascial graft (includes obtaining graft) (separate procedure)
	26508	4	Thenar muscle release for thumb contracture
	26510	4	Cross intrinsic transfer
	26516	2	Capsulodesis for M-P joint stabilization; single digit
	26517	2	Capsulodesis for M-P joint stabilization; two digits
	26518	3	Capsulodesis for M-P joint stabilization; three or four digits
*	26520	3	Capsulectomy for contracture; metacarpophalangeal joint, single, each
*	26525	3	Capsulectomy for contracture; interphalangeal joint, single, each
*	26530	4	Arthroplasty, metacarpophalangeal joint; single, each
*	26531	4	Arthroplasty, metacarpophalangeal joint; with prosthetic implant, single, each
*	26535	4	Arthroplasty interphalangeal joint; single, each
*	26536	4	Arthroplasty interphalangeal joint; with prosthetic implant, single, each
*	26540	4	Primary repair of collateral ligament, metacarpophalangeal joint
*	26541	4	Reconstruction, collateral ligament, metacarpophalangeal joint; with tendon or fascial graft (includes obtaining graft)
	26542	4	Primary repair of collateral ligament, metacarpophalangeal joint; with local tissue
*	26545	4	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint
	26552	4	Reconstruction thumb with toe
	26555	4	Positional change of other finger
	26557	4	Toe to finger transfer; first stage
	26558	4	Toe to finger transfer; each delay
	26559	4	Toe to finger transfer; second stage
*	26567	4	Osteotomy for correction of deformity; phalanx
	26568	4	Osteoplasty for lengthening of metacarpal or phalanx
	26570	4	Bone graft, (includes obtaining graft); metacarpal
	26574	4	Bone graft, (includes obtaining graft); phalanx

FRACTURES AND/OR DISLOCATIONS

26605	1	Treatment of closed metacarpal fracture, single; with manipulation, each bone
26607	2	Treatment of closed metacarpal fracture, single, with manipulation, with skeletal fixation, each bone

26610	2	Treatment of open metacarpal fracture, single, with uncomplicated soft tissue closure, each bone
26645	1	Treatment of closed carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation
26650	2	Treatment of closed carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation; with skeletal fixation
26655	3	Treatment of open carpometacarpal fracture dislocation, thumb (Bennett fracture), with uncomplicated soft tissue closure
26660	3	Treatment of open carpometacarpal fracture dislocation, thumb (Bennett fracture), with uncomplicated soft tissue closure; with skeletal fixation
26665	3	Open treatment of closed or open carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external skeletal fixation
26675	1	Treatment of closed carpometacarpal dislocation, other than Bennett fracture, single, with manipulation; requiring anesthesia
26676	2	Treatment of closed carpometacarpal dislocation, other than Bennett fracture, single, with manipulation; with percutaneous pinning
26680	2	Treatment of open carpometacarpal dislocation, other than Bennett fracture,single, with uncomplicated soft closure
26685	3	Open treatment of closed or open carpometacarpal dislocation, other than Bennett fracture; single, with or without internal or external skeletal fixation
26686	3	Open treatment of closed or open carpometacarpal dislocation, other than Bennett fracture; complex, multiple or delayed reduction
26705	1	Treatment of closed metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia
26706	2	Treatment of closed metacarpalphalangeal dislocation, single, with manipulation; with percutaneous pinning
26710	2	Treatment of open metacarpophalangeal dislocation, single, with uncomplicated soft tissue closure
26715	3	Open treatment of closed or open metacarpophalangeal dislocation, single, with or without internal or external skeletal fixation
26727	2	Treatment of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, requiring traction or fixation, each
26730	2	Treatment of open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with uncomplicated soft tissue closure, each
26735	3	Open treatment of closed or open phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external skeletal fixation, each
26744	2	Treatment of open articular fracture, involving metacarpophalangeal or proximal interphalangeal joint; with uncomplicated soft tissue closure, each
26746	3	Open treatment of closed or open articular fracture, involving metacarpophalangeal or proximal interphalangeal joint, each

26765	3	Open treatment of closed or open distal phalangeal fracture, finger or thumb, each
26780	2	Treatment of open interphalangeal joint dislocation, single, with uncomplicated soft tissue closure
26785	3	Open treatment of closed or open interphalangeal joint dislocation, single

ARTHRODESIS

* 26820	4	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)
* 26841	4	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation
* 26842	4	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation; with autogenous graft (includes obtaining graft)
* 26843	4	Arthrodesis, carpometacarpal joint, digits, other than thumb
* 26844	4	Arthrodesis, carpometacarpal joint, digits, other than thumb; with autogenous graft (includes obtaining graft)
* 26860	4	Arthrodesis, interphalangeal joint, with or without internal fixation
* 26861	4	Arthrodesis, interphalangeal joint, with or without internal fixation; each additional interphalangeal joint
* 26862	4	Arthrodesis, interphalangeal joint, with or without internal fixation; with autogenous graft (includes obtaining graft)
* 26863	4	Arthrodesis, interphalangeal joint, with or without internal fixation; with autogenous graft (includes obtaining graft), each additional joint

AMPUTATION

* 26910	2	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseus transfer
* 26951	2	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure
* 26952	4	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps (V-Y, hood)

PELVIS AND HIP JOINT

INCISION

26990	2	Incision and drainage; deep abscess or hematoma
26991	2	Incision and drainage; infected bursa
26992	2	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
27000	3	Tenotomy, adductor, subcutaneous, closed (separate procedure)
27001	4	Tenotomy, adductor, subcutaneous, open; unilateral
27002	4	Tenotomy, adductor, subcutaneous, open; bilateral
27003	4	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy; unilateral
27004	4	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy; bilateral

27030	4	Arthrotomy, hip, for infection, with drainage
27033	4	Arthrotomy, hip, for exploration or removal of loose or foreign body
27035	4	Hip joint denervation, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or obturator nerves

EXCISION

27040	4	Biopsy, soft tissues; superficial
27041	4	Biopsy, soft tissues; deep
27047	4	Excision, benign tumor; subcutaneous
27048	4	Excision, benign tumor; deep, subfascial, intramuscular
27052	4	Arthrotomy for biopsy; hip joint
27065	4	Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanter of femur) with or without autogenous bone graft
27066	4	Excision of bone cyst or benign tumor; deep, with or without bone graft
27080	4	Coccygectomy, primary

INTRODUCTION AND/OR REMOVAL

27087	2	Removal of foreign body; deep
27095	1	Injection procedure for hip arthrography; with anesthesia

FRACTURES AND/OR DISLOCATIONS

27201	4	Treatment of open coccygeal fracture
27202	4	Open treatment of closed or open coccygeal fracture

MANIPULATION

27275	2	Manipulation, hip joint, requiring general anesthesia

FEMUR (THIGH REGION) AND KNEE JOINT

INCISION

	27301	2	Incision and drainage of deep abscess, infected bursa, or hematoma
	27303	2	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
*	27305	4	Fasciotomy, iliotibial (tenotomy), open
*	27306	1	Tenotomy, subcutaneous, closed, adductor or hamstring, (separate procedure); single
*	27307	1	Tenotomy, subcutaneous, closed, adductor or hamstring, (separate procedure); multiple
	27310	4	Arthrotomy, knee, for infection, with exploration, drainage or removal of foreign body
*	27315	4	Neurectomy, hamstring muscle
*	27320	4	Neurectomy, popliteal (gastrocnemius)

EXCISION

27324	2	Biopsy, soft tissues; deep
27327	1	Excision, benign tumor; subcutaneous

27328	2	Excision, benign tumor; deep, subfascial, or intramuscular
27330	4	Arthrotomy, knee; for synovial biopsy only
27345	4	Excision of synovial cyst of popliteal space (Baker's cyst)
27350	4	Patellectomy or hemipatellectomy
27355	4	Excision or curettage of bone cyst or benign tumor of femur
27360	4	Partial excision (craterization, saucerization or diaphysectomy) of bone, (e.g., for osteomyelitis), femur, proximal tibia and/or fibula

INTRODUCTION AND/OR REMOVAL

27372	3	Removal foreign body, deep

REPAIR, REVISION OR RECONSTRUCTION

27390	4	Tenotomy, open, hamstring, knee to hip; single
27391	4	Tenotomy, open, hamstring, knee to hip; multiple, one leg
27392	4	Tenotomy, open, hamstring, knee to hip; multiple, bilateral
27393	4	Lengthening of hamstring, tendon; single
27394	4	Lengthening of hamstring, tendon; multiple, one leg
27395	4	Lengthening of hamstring, tendon; multiple, bilateral
27396	4	Transplant, hamstring tendon to patella; single
27397	4	Transplant, hamstring tendon to patella; multiple
27400	4	Tendon or muscle transfer, hamstrings to femur (Eggers type procedure)
27420	4	Reconstruction for recurrent dislocating patella; (Hauser type procedure)
27422	4	Reconstruction for recurrent dislocating patella; with extensor realignment and/or muscle advancement or release (Campbell, Goldwaite, etc., type procedure)
27424	4	Reconstruction for recurrent dislocating patella; with patellectomy
27425	4	Lateral retinacular release (any method)
27430	4	Quadriceps plasty (Bennett or Thompson type)
27435	4	Capsulotomy, knee, posterior capsular release

FRACTURES AND/OR DISLOCATIONS

27522	3	Treatment of open pateller fracture, with uncomplicated soft tissue closure
27524	4	Open treatment of closed or open patellar fracture, with repair and/or excision

EXCISION

27532	1	Treatment of closed tibial fracture, proximal (plateau); with manipulation

FRACTURES AND/OR DISLOCATIONS

27534	3	Treatment of open tibial fracture, proximal (plateau), with uncomplicated soft tissue closure

EXCISION

27552	1	Treatment of closed knee dislocation; requiring anesthesia
27562	1	Treatment of closed patellar dislocation; requiring anesthesia

FRACTURES AND/OR DISLOCATIONS

	27564	4	Treatment of open patellar dislocation, with uncomplicated soft tissue closure
	27566	4	Open treatment of closed or open patellar dislocation, with or without partial or total patellectomy

MANIPULATION

	27570	2	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)

LEG (TIBIA AND FIBULA) AND ANKLE JOINT

INCISION

	27603	2	Incision and drainage; deep abscess or hematoma
*	27605	1	Tenotomy, Achilles tendon, subcutaneous (separate procedure); local anesthesia
*	27606	1	Tenotomy, Achilles tendon, subcutaneous (separate procedure); general anesthesia
	27607	2	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
	27610	2	Arthrotomy, ankle, with exploration, drainage or removal of loose or foreign body
	27612	4	Arthrotomy, ankle, posterior capsular release, with or without Achilles tendon lengthening

EXCISION

	27620	3	Arthrotomy, ankle, for biopsy
	27630	3	Excision of lesion of tendon sheath or capsule (e.g., cyst or ganglion)
	27635	3	Excision or curettage of bone cyst or benign tumor, tibia or fibula
	27637	4	Excision or curettage of bone cyst, or benign tumor, tibia or fibula; with primary autogenous graft (includes obtaining graft)
	27638	4	Excision or curettage of bone cyst, or benign tumor, tibia or fibula; with primary homogenous graft
	27640	4	Partial excision (craterization, saucerization, or diaphysectomy) of bone, (e.g., for osteomyelitis); tibia
	27641	4	Partial excision (craterization, saucerization, or diaphysectomy) of bone, (e.g., for osteomyelitis); fibula

REPAIR, REVISION OR RECONSTRUCTION

*	27650	3	Repair, primary, open or percutaneous, ruptured Achilles tendon
*	27652	4	Repair, primary, open or percutaneous, ruptured Achilles tendon; with graft (includes obtaining graft)
*	27654	4	Suture, secondary, ruptured Achilles tendon, with or without graft
*	27656	3	Repair, fascial defect of leg
*	27658	3	Repair or suture of flexor tendon of leg; primary, without free graft, single, each

*	27659	4	Repair or suture of flexor tendon of leg; secondary with or without free graft, single tendon, each
*	27664	3	Repair or suture of extensor tendon of leg; primary, without free graft, single, each
*	27665	4	Repair or suture of extensor tendon of leg; secondary with or without free graft, single tendon, each
*	27675	3	Repair for dislocating peroneal tendons; without fibular osteotomy
*	27676	4	Repair for dislocated peroneal tendons; with fibular osteotomy
	27680	3	Tenolysis, including tibia, fibula and ankle flexor; single
	27681	4	Tenolysis, including tibia, fibula and ankle flexor; multiple (through same incision), each
	27685	3	Lengthening or shortening of tendon; single (separate procedure)
	27686	4	Lengthening or shortening of tendon; multiple (through same incision), each
	27690	4	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (e.g., anterior tibial extensors into midfoot)
	27691	4	Transfer or transplant of single tendon (with muscle redirection or rerouting); anterior tibial or posterior tibial through interosseous space
	27692	4	Transfer or transplant of single tendon (with muscle redirection or rerouting); each additional tendon

FRACTURES AND/OR DISLOCATIONS

27756	4	Open treatment of closed or open tibial shaft fracture, with internal skeletal fixation; simple
27758	4	Open treatment of closed or open tibial shaft fracture, with internal or external skeletal fixation; complicated
27764	3	Treatment of open distal tibial fracture (medial malleolus), with uncomplicated soft tissue closure
27766	3	Open treatment of closed or open distal tibial fracture (medial malleolus), with fixation
27781	1	Treatment of closed proximal fibula or shaft fracture; with manipulation
27782	3	Treatment of open proximal fibula or shaft fracture, with uncomplicated soft tissue closure
27784	4	Open treatment of closed or open proximal fibula or shaft fracture, with or without internal or external skeletal fixation
27790	3	Treatment of open distal fibular fracture (lateral malleolus), with uncomplicated soft tissue closure
27792	4	Open treatment of closed or open distal fibular fracture (lateral malleolus), with fixation
27802	1	Treatment of closed tibia and fibula fractures, shafts; with manipulation
27804	3	Treatment of open tibia and fibula fractures, shafts, with uncomplicated soft tissue closure (e.g., "pins above and below")

	27842	1	Treatment of ankle dislocation; requiring anesthesia
	27844	3	Treatment of open ankle dislocation, with uncomplicated soft tissue closure
	27846	4	Open treatment of closed or open ankle dislocation
	27848	4	Open treatment of closed or open ankle dislocation; with fixation

MANIPULATION

	27860	1	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)

FOOT

INCISION

	28002	2	Deep infection, below fascia, requiring deep dissection, with or without tendon sheath involvement; single bursal space, specify
	28003	2	Deep infection, below fascia, requiring deep dissection, with or without tendon sheath involvement; multiple areas
	28005	2	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess)
*	28008	4	Fasciotomy, plantar and/or toe, subcutaneous
*	28010	1	Tenotomy, subcutaneous, toe; single
*	28011	1	Tenotomy, subcutaneous, toe; multiple
*	28030	4	Neurectomy of intrinsic musculature of foot
	28035	4	Tarsal tunnel release (posterior tibial nerve decompression)

EXCISION

	28045	2	Excision, benign tumor; deep, subfascial, intramuscular
	28050	3	Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint
	28062	4	Fasciectomy, excision of plantar fascia; radical (separate procedure)
*	28072	4	Synovectomy; metatarsophalangeal joint, each
*	28080	3	Excision of Morton neuroma, single, each
*	28086	4	Synovectomy, tendon sheath; flexor
*	28088	4	Synovectomy, tendon sheath; extensor
*	28090	4	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) cyst or ganglion); foot
*	28092	4	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); toes
	28102	4	Excision or curettage of bone cyst or benign tumor, talus or calcaneus; with iliac or other autogenous bone graft (includes obtaining graft)
	28103	4	Excision or curettage of bone cyst or benign tumor, talus or calcaneus, with homogenous bone graft
	28107	3	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except talus or calcaneus; with homogenous bone graft
*	28110	3	Ostectomy, partial excision, fifth metatarsal head (bunionette) (separate procedure)
*	28111	3	Ostectomy; complete excision; first metatarsal head
*	28112	3	Ostectomy; complete excision other metatarsal head (second, third, or fourth)

*	28113	3	Ostectomy; complete excision fifth metatarsal head
*	28114	3	Ostectomy; complete excision all metatarsal heads, with proximal phalangectomy, excluding first metatarsal (Clayton type procedure)
	28118	3	Ostectomy, calcaneus; partial
	28120	3	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (e.g., for osteomyelitis), talus or calcaneus
	28122	3	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis), tarsal or metatarsal bone, except talus or calcaneus
	28140	3	Metatarsectomy
	28171	3	Radical resection for tumor; tarsal (except talus or calcaneus)
	28173	3	Radical resection for tumor; metatarsal
	28175	3	Radical resection for tumor; phalanx

INTRODUCTION AND/OR REMOVAL

	28193	2	Remove foreign body; complicated

REPAIR, REVISION OR RECONSTRUCTION

*	28200	3	Repair or suture of tendon, foot, flexor, single; primary or secondary, without free graft, each tendon
*	28202	4	Repair or suture of tendon, foot, flexor, single; secondary with free graft, each tendon (includes obtaining graft)
*	28208	3	Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon
*	28210	4	Repair or suture of tendon, foot, extensor, single; secondary with free graft, each tendon (includes obtaining graft)
*	28222	3	Tenolysis, flexor; multiple (through same incision)
*	28225	3	Tenolysis, extensor; single
*	28226	3	Tenolysis, extensor; multiple (through same incision),
*	28230	1	Tenotomy, open, flexor; foot, single or multiple (separate procedure)
*	28232	1	Tenotomy, open, flexor; toe, single (separate procedure)
*	28234	1	Tenotomy, open, extensor, foot or toe
*	28240	1	Tenotomy or release, abductor hallucis muscle
	28250	2	Division of plantar fascia and muscle ("Steindler stripping") (separate procedure)
	28260	3	Capsulotomy, midfoot; medial release only (separate procedure)
	28261	3	Capsulotomy, midfoot; with tendon lengthening
*	28264	3	Capsulotomy, midtarsal (Heyman type procedure)
*	28270	3	Capsulotomy for contracture; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure)
*	28272	3	Capsulotomy for contracture; interphalangeal joint, single, each joint (separate procedure)
*	28285	4	Hammertoe operation; one toe (e.g., interphalangeal fusion, filleting, phalangectomy) (separate procedure)

*	28286	4	Hammertoe operation; for cock-up fifth toe with plastic skin closure, (Ruiz-Mora type procedure)
*	28290	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)
*	28292	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; Keller, McBride or Mayo type procedure
*	28293	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; resection of joint with implant
*	28294	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; with tendon transplants (Joplin type procedure)
	28296	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; with metatarsal osteotomy (e.g., Mitchell, Chevron, or concentric type procedures)
	28297	4	Hallux valgus (bunion) correction, with or without sesamoidectomy; Lapidus type procedure
*	28298	4	Hallux valgus (bunion) correction with or without sesamoidectomy; by phalanx osteotomy
*	28299	4	Hallux valgus (bunion) correction with or without sesamoidectomy; by other methods (e.g., double osteotomy)
*	28306	4	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; first metatarsal
*	28308	4	Osteotomy, metatarsal, base or shaft, single, for shortening or angular correction; other than first metatarsal
*	28310	4	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
*	28312	4	Osteotomy for shortening, angular or rotational correction; other phalanges, any toe
	28315	3	Sesamoidectomy, first toe (separate procedure)
	28320	4	Repair of nonunion or malunion; tarsal bones (calcaneus, talus, etc)
	28322	4	Repair of nonunion or malunion; metatarsal, with or without bone graft (includes obtaining graft)

FRACTURE AND/OR DISLOCATION

28405	1	Treatment of closed calcaneal fracture; with manipulation including Cotton or Bohler type reductions
28406	2	Treatment of closed calcaneal fracture; with manipulation and skeletal fixation
28420	4	Open treatment of closed or open calcaneal fracture, with or without internal or external skeletal fixation; with primary iliac or other autogenous bone graft (includes obtaining graft)
28435	1	Treatment of closed talus fracture; with manipulation
28436	2	Treatment of closed talus fracture; with manipulation and percutaneous pinning
28465	4	Open treatment of closed or open tarsal bone fracture (except talus and calcaneus), with or without internal or external skeletal fixation, each

28485	4	Open treatment of closed or open metatarsal fracture, with or without internal or external skeletal fixation, each
28500	3	Treatment of open fracture great toe, phalanx or phalanges, with uncomplicated soft tissue closure
28505	3	Open treatment of closed or open fracture great toe, phalanx or phalanges, with or without internal or external skeletal fixation
28520	2	Treatment of open fracture, phalanx or phalanges, other than great toe, with uncomplicated soft tissue closure, each
28525	3	Open treatment of closed or open fracture, phalanx or phalanges, other than great toe, with or without internal or external skeletal fixation, each
28545	1	Treatment of closed tarsal bone dislocation; requiring anesthesia
28546	2	Treatment of closed tarsal bone dislocation, with percutaneous skeletal fixation
28555	4	Open treatment of closed or open tarsal bone dislocation, with or without internal or external skeletal fixation
28575	1	Treatment of closed talotarsal joint dislocation; requiring anesthesia
28585	4	Open treatment of closed or open talotarsal joint dislocation, with or without internal or external skeletal fixation
28605	1	Treatment of closed tarsometatarsal joint dislocation; requiring anesthesia
28606	2	Treatment of closed tarsometatarsal joint dislocation, with percutaneous skeletal fixation
28615	4	Open treatment of closed or open tarsometatarsal joint dislocation, with or without internal or external skeletal fixation
28645	4	Open treatment of closed or open metatarsophalangeal joint dislocation
28670	3	Treatment of open interphalangeal joint dislocation, with uncomplicated soft tissue closure
28675	4	Open treatment of closed or open interphalangeal joint dislocation

ARTHRODESIS

* 28750	4	Arthrodesis, great toe; metatarsophalangeal joint
* 28755	4	Arthrodesis, great toe; interphalangeal joint
* 28760	4	Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)

AMPUTATION

* 28810	2	Amputation, metatarsal, with toe, single
* 28820	2	Amputation, toe; metatar sophalangeal joint
* 28825	2	Amputation, toe; interphalanged joint

ARTHROSCOPY

29870	4	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29874	4	Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)
29875	4	Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection)

	29876	4	Synovectomy, major, two or more compartments (e.g., medial or lateral)
	29877	4	Debridement/shaving of articular cartilage (chondroplasty)
	29881	4	Arthroscopy, knee, surgical; with meniscectomy (medial or lateral including any meniscal shaving)
	29887	4	Drilling for intact osteochondritis dissecans lesion with internal fixation

RESPIRATORY SYSTEM

NOSE

EXCISION

*	30115	2	Excision, nasal polyp(s), extensive; unilateral
	30116	2	Excision, nasal polyp(s), extensive; bilateral
	30117	2	Excision, intranasal lesion; internal approach
	30118	2	Excision, intransal lesion; external approach (lateral rhinotomy)
	30125	3	Excision dermoid cyst, nose; complex, under bone or cartilage
*	30130	1	Excision turbinate, partial or complete
*	30140	4	Submucous resection turbinate, partial or complete
	30150	4	Rhinectomy; partial
	30160	4	Rhinectomy; total

REMOVAL FOREIGN BODY

	30310	1	Removal of foreign body, intranasal; requiring general anesthesia,
	30320	2	Removal foreign body; by lateral rhinotomy

REPAIR

	30400	4	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
	30410	4	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
	30420	4	Rhinoplasty, primary; including major septal repair
	30430	4	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
	30435	4	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
	30450	4	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
	30520	4	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
	30580	4	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)
	30600	4	Repair fistula; oronasal
*	30620	4	Reconstruction, functional, internal nose (septal or other intranasal dermatoplasty) (does not include obtaining graft)
*	30630	4	Repair nasal septal perforations

OTHER PROCEDURES

	30915	4	Ligation arteries; ethmoidal
	30920	4	Ligation arteries; internal maxillary artery, transantral

ACCESSORY SINUSES

INCISION

*	31020	2	Sinusotomy, maxillary (antrotomy); intranasal, unilateral
*	31021	2	Sinusotomy, maxillary (antrotomy); intranasal, bilateral
*	31030	2	Sinusotomy, maxillary (antrotomy); radical, unilateral (Caldwell-Luc) without removal of antrochoanal polyps
*	31031	2	Sinusotomy, maxillary (antrotomy); radical, bilateral (Caldwell-Luc) without removal of antrochoanal polyps
	31032	4	Sinusotomy, maxillary (antrotomy); radical unilateral (Caldwell-Luc) with removal antrochoanal polyps
	31033	4	Sinusotomy, maxillary (antrotomy); radical, bilateral (Caldwell-Luc) with removal antrochoanal polyps
	31070	2	Sinusotomy frontal; external, simple (trephine operation)

EXCISION

*	31200	3	Ethmoidectomy; intranasal, anterior
*	31201	3	Ethmoidectomy; intranasal, total
*	31205	3	Ethmoidectomy; extranasal, total

LARYNX

ENDOSCOPY

*	31505	1	Laryngoscopy, indirect (separate procedure); diagnostic
*	31510	1	Laryngoscopy, indirect (separate procedure); with biopsy
*	31511	1	Laryngoscopy, indirect (separate procedure); with removal of foreign body
*	31512	1	Laryngoscopy, indirect (separate procedure); with removal of lesion
	31513	2	Laryngoscopy, indirect (separate procedure); with vocal cord injection
*	31515	1	Laryngoscopy direct; for aspiration
*	31525	1	Laryngoscopy, direct; diagnostic, except newborn
*	31526	1	Laryngoscopy, indirect; diagnostic, with operating microscope
	31527	2	Laryngoscopy, direct; with insertion of obturator
*	31530	1	Laryngoscopy, direct, operative, with foreign body removal
*	31531	1	Laryngoscopy, direct, operative, with foreign body removal; with operating microscope
*	31535	1	Laryngoscopy, direct, operative, with biopsy
*	31536	1	Laryngoscopy, direct, operative, with biopsy; with operating microscope
*	31540	1	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis
*	31541	1	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis; with operating microscope
*	31560	1	Laryngoscopy, direct, operative, with arytenoidectomy
*	31561	1	Laryngoscopy, direct, operative, with arytenoidectomy; with operating microscope
*	31570	1	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic

*	31571	1	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope
	31576	1	Laryngoscopy, flexible fiberscopic; with biopsy
	31577	1	Laryngoscopy, flexible fiberscopic; with removal of foreign body
	31578	1	Laryngoscopy, flexible fiberscopic; with removal of lesion

TRACHEA AND BRONCHI

INCISION

	31600	2	Tracheostomy, planned (separate procedure)
	31612	1	Tracheal puncture, percutaneous for aspiration of mucus (transtracheal aspiration)
	31613	2	Tracheostoma revision; simple, without flap rotation
	31614	2	Tracheostoma revision; complex, with flap rotation

ENDOSCOPY

	31615	1	Tracheobronchoscopy through established tracheostomy incision
	31622	1	Bronchoscopy; diagnostic, (flexible original), with or without cell washing or brushing
*	31625	1	Bronchoscopy; with biopsy
	31628	1	Bronchoscopy; with transbronchial lung biopsy, with or without fluoroscopic guidance
*	31630	1	Bronchoscopy; with tracheal or bronchial dilation or closed reduction of fracture
	31631	1	Bronchoscopy; with tracheal dilation and placement of tracheal stent
*	31635	1	Bronchoscopy; with removal of foreign body
*	31640	1	Bronchoscopy; with excision of tumor
	31641	1	Bronchoscopy; with destruction of tumor or relief of stenosis by any method other than excision (e.g., laser)
*	31645	1	Bronchoscopy; with therapeutic aspiration of tracheobronchial tree, initial (e.g., drainage of lung abscess)
	31646	1	Bronchoscopy; with therapeutic aspiration of tracheobronchial tree, subsequent
	31656	1	Bronchoscopy; with injection of contrast material for segmental bronchography (fiberscope only)
	31659	1	Bronchoscopy; with other bronchoscopic procedures

INTRODUCTION

	31700	1	Catheterization, transglottic (separate procedure)
	31708	1	Instillation of contrast material for laryngography or bronchography, without catheterization
	31710	1	Catheterization for bronchography, with or without instillation of contrast material
	31715	1	Transtracheal injection for bronchography
	31717	1	Catheterization with bronchial brush biopsy
	31719	1	Transtracheal (percutaneous) introduction of indwelling tube for therapy (tickle tube)

	31720	1	Catheter aspiration (separate procedure); nasotracheobronchial

CARDIOVASCULAR SYSTEM

REPAIR, LIGATION AND OTHER PROCEDURES

	37609	1	Ligation or biopsy, temporal artery
*	37700	4	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions, unilateral
*	37701	4	Ligation and division of long saphenous vein at saphenofemoral juncton, or distal interruptions, unilateral; bilateral
*	37720	4	Ligation and division and complete stripping of long or short saphenous veins; unilateral
*	37721	4	Ligation and division and complete stripping of long or short saphenous veins; bilateral
*	37730	4	Ligation and division and complete stripping of long and short saphenous veins; unilateral
*	37731	4	Ligation and division and complete stripping of long and short saphenous veins: bilateral
	37735	4	Ligation and division and complete stripping of long or short saphenous veins with radical excison of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia; unilateral
	37737	4	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep facia; bilateral
	37760	4	Ligation and perforators, subfascial, radical (Linton Type), with or without skin graft
*	37780	4	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure); unilateral
*	37781	4	bilateral. Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
	37785	3	Ligation, division and/or excision of secondary varicose veins (clusters) of leg; unilateral
	37787	3	Ligation, division and/or excision of secondary varicose veins (clusters) of leg; bilateral

HEMIC AND LYMPHATIC SYSTEM

LYMPH NODES AND LYMPHATIC CHANNELS

INCISION

	38305	1	Drainage of lymph node abscess or lymphadenitis; extensive
	38308	1	Lymphangiotomy or other operations on lymphatic channels

EXCISION

*	38500	2	Biopsy or excision of lymph node(s); superficial (separate procedure)
*	38510	2	Biopsy or excision of lymph node(s); deep, cervical node(s)

*	38520	2	Biopsy or excision of lymph node(s); deep cervical node(s) with excision scalene fat pad
	38530	3	Biopsy or excision of lymph node(s); internal mammary node(s) (separate procedure)
	38542	3	Dissection; deep jugular node(s)
	38550	3	Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection; simple
	38555	4	Excision of cystic hygroma, axillary or cervical, without deep neurovascular dissection; complex

RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)

38700	4	Suprahyoid lymphadenectomy; unilateral
38701	4	Suprahyoid lymphadenectomy; bilateral
38740	3	Axillary lymphadenectomy; superficial
38745	3	Axillary lymphadenectomy; complete
38760	3	Inguinofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure); unilateral
38761	3	Inguinofemoral lymphadenectomy, superficial, including Cloquet's node (separate procedure); bilateral

INTRODUCTION

38790	1	Injection procedure for lymphangiography; unilateral
38791	1	Injection procedure for lymphangiography; bilateral

DIGESTIVE SYSTEM

LIPS

EXCISION

*	40500	2	Vermilionectomy (lip shave), with mucosal advancement
*	40510	3	Excision of lip; transverse wedge excision with primary closure
*	40520	3	Excision lip; V-excision with primary direct linear closure
	40525	3	Excision lip; full thickness, reconstruction with local flap (Estlander or fan)
	40527	3	Excision lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
	40530	3	Resection of lip, more than one-fourth, without reconstruction

REPAIR (CHEILOPLASTY)

40650	3	Repair lip, full thickness; vermilion only
40654	4	Repair lip, full thickness; over one half vertical height, or complex

VESTIBULE OF MOUTH

INCISION

40801	1	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated
40805	1	Removal of embedded foreign body; complicated

EXCISION, DESTRUCTION

40814	2	Excision of lesion of mucosa and submucosa; with complex repair
40816	2	Excision of lesion of mucosa and submucosa; complex with excision of underlying muscle
40818	2	Excision of mucosa as donor graft

REPAIR

40831	2	Closure of laceration; over 2.6 cm or complex
40840	2	Vestibuloplasty; anterior
40842	2	Vestibuloplasty; posterior, unilateral
40843	2	Vestibuloplasty; posterior, bilateral
40844	3	Vestibuloplasty; entire arch
40845	4	Vestibuloplasty; complex

TONGUE, FLOOR OF MOUTH

INCISION

* 41000	1	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual
* 41005	1	Intraoral incision and drainage of abcess, cyst, or hematoma of tongue or floor of mouth; sublingual, superficial

EXCISION

* 41100	1	Biopsy of tongue; anterior two-thirds
* 41105	1	Biopsy of tongue; posterior one-third
41114	2	Excision of lesion of tongue with closure; with local tongue flap
41115	1	Excision of lingual frenum (frenectomy)
41116	1	Excision lesion of floor of mouth
41120	3	Glossectomy; less than one-half tongue

REPAIR

41251	3	Repair laceration up to 2 cm; posterior one-third of tongue

DENTOALVEOLAR STRUCTURES

INCISION

41806	2	Removal embedded foreign body; from bone

EXCISION, DESTRUCTION

41826	2	Excision of lesion or tumor (except listed above); with simple repair
41827	3	Excision of lesion or tumor (except listed above); with complex repair

PALATE, UVULA

INCISION

* 42000	1	Drainage of abscess of palate, uvula

EXCISION, DESTRUCTION

42104	1	Excision, lesion of palate, uvula; without closure
42106	1	Excision, lesion of palate, uvula; with simple primary closure
42107	1	Excision, lesion of palate, uvula; with local flap closure
42120	2	Resection of palate or extensive resection of lesion
42140	2	Uvulectomy, excision of uvula

REPAIR

42182	1	Repair laceration of palate; over 2 cm or complex

SALIVARY GLAND AND DUCTS

INCISION

42305	1	Drainage of abscess; parotid, complicated
42320	1	Drainage of abscess; submaxillary external
42325	2	Fistulization of sublingual salivary cyst (ranula)
42335	2	Sialolithotomy; submandibular (submaxillary), complicated, intraoral
42340	2	Sialolithotomy; parotid, extraoral or complicated intraoral

EXCISION

42408	2	Excision of sublingual salivary cyst (ranula)
42410	4	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection
42440	4	Excision of submandibular (submaxillary) gland
42450	4	Excision of sublingual gland

REPAIR

42500	3	Plastic repair of salivary duct, sialodochoplasty; primary or simple
42505	4	Plastic repair salivary duct, sialodochoplasty; secondary or complicated
42507	4	Parotid duct diversion, bilateral (Wilke type procedure)
42508	4	Parotid duct diversion, bilateral (Wilke type procedure); with excision of one submandibular gland
42509	4	Parotid duct diversion, bilateral (Wilke type procedure); with excision of both submandibular glands

OTHER PROCEDURES

42600	1	Closure salivary fistula
42665	1	Ligation salivary duct, intraoral

PHARYNX, ADENOIDS, AND TONSILS

INCISION

	42720	1	Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach
	42725	1	Incision and drainage abscess; retropharyngeal or parapharyngeal, external approach

EXCISION

	42806	2	Biopsy; nasopharynx, survey for unknown primary lesion
	42808	1	Excision of lesion of pharynx
*	42810	2	Excision branchial cleft cyst or vestige; confined to skin and subcutaneous tissues
*	42815	2	Excision branchial cleft cyst or vestige; extending beneath subcutaneous tissues
	42860	2	Excision of tonsil tags
	42870	2	Excision lingual tonsil (separate procedure)
	42880	2	Excision nasopharyngeal lesion (e.g., fibroma)

REPAIR

	42900	2	Suture pharynx for wound or injury
	42950	4	Pharyngoplasty (plastic or reconstructive operation on pharnyx)

OTHER PROCEDURES

	42955	2	Pharyngostomy (fistulization of pharynx, external for feeding)

ESOPHAGUS

ENDOSCOPY

*	43200	1	Esophagoscopy, rigid or flexible fiberoptic (specify); diagnostic procedure
*	43202	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for biopsy and/or collection of specimen by brushing or washing
	43204	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for injection sclerosis of esophageal varices
*	43215	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of foreign body
*	43217	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for removal of polypoid lesion(s)
	43219	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for insertion of plastic tube or stent
*	43220	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for dilation, direct
	43226	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for insertion of wire to guide dilation

43227	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
43228	1	Esophagoscopy, rigid or flexible fiberoptic (specify); for ablation of tumor or mucosal lesion
43235	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; complex diagnostic
43239	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for biopsy and/or collection of specimen by brushing or washing
43247	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for removal of foreign body
43251	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for removal of polypoid lesion(s)
43255	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
43258	1	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; for ablation of tumor or mucosal lesion (e.g., electrocoagulation, with laser photocoagulation)
43260	2	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection
43262	2	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection; for sphincterotomy/papillotomy
43263	2	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection; for pressure measurement of sphincter of Oddi
43264	2	Endoscopic retrograde cholangiopancreatography (ERCP), with or without specimen collection; for removal of stone(s) from biliary and/or pancreatic ducts

MANIPULATION

43450	1	Dilation of esophagus, by unguided sound or bougie single or multiple passes; initial session
43451	1	Dilation of esophagus, by unguided sound or bougie single or multiple passes; subsequent session
43453	1	Dilation of esophagus, over guide wire or string
43455	1	Dilation of esophagus, by balloon or Stark dilator
43456	1	Dilation of esophagus by balloon or Stark dilator; retrograde

INTESTINES (EXCEPT RECTUM)

ENTEROSTOMY-EXTERNAL FISTULIZATION OF INTESTINES (SEPARATE PROCEDURE)

* 44340	3	Revision of colostomy; simple (release of superficial scar)
44345	4	Revision of colostomy; complicated reconstruction in depth
44346	4	Revision of colostomy; with repair of paracolostomy Lernia

ENDOSCOPY, SMALL BOWEL AND STOMAL

44360	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; diagnostic
44361	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for biopsy and/or collection of specimen by brushing or washing
44363	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for removal of foreign body
44364	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for removal of polypoid lesion(s)
44366	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
44369	1	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum; for ablation of tumor or mucosal lesion (e.g., laser)
44380	1	Fiberoptic ileoscopy through stoma
44382	1	Fiberoptic ileoscopy through stoma; with biopsy and/or collection of specimen by brushing or washing
44388	1	Fiberoptic colonoscopy through colostomy
44389	1	Fiberoptic colonoscopy through colostomy; for biopsy and/or collection of specimen by brushing or washing
44390	1	Fiberoptic colonoscopy through colostomy; for removal of foreign body
44391	1	Fiberoptic colonoscopy through colostomy; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
44392	1	Fiberoptic colonoscopy through colostomy; for removal of polypoid lesion(s)

RECTUM

INCISION

45000	3	Transrectal drainage of pelvic abscess
45005	1	Incision and drainage of submucosal abscess, rectum
45020	2	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess

EXCISION

45170	3	Excision of rectal tumor, simple, transanal approach

45180	3	Excision and/or electrodesiccation of malignant tumor of rectum, transanal approach; palliative
45181	3	Excision and/or electrodesiccation of malignant tumor of rectum, transanal approach; therapeutic

ENDOSCOPY

45355	1	Colonoscopy, with standard sigmoidoscope, transabdominal via colotomy, single or multiple
45360	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; diagnostic procedure
45365	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; for biopsy and/or collection of specimen by brushing or washing
45367	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; for removal of foreign body
45368	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
45370	1	Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; for removal of polypoid lesion(s)
45378	1	Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure
45379	1	Colonoscopy, fiberoptic, beyond splenic flexure; for removal of foreign body
45380	1	Colonoscopy, fiberoptic, beyond splenic flexure; for biopsy and/or collection of specimen by brushing or washing
45382	1	Colonoscopy, fiberoptic, beyond splenic flexure; for control of hemorrhage (e.g., electrocoagulation, laser photocoagulation)
45385	1	Colonoscopy, fiberoptic, beyond splenic flexure; for removal of polypoid lesion(s)

REPAIR

45500	4	Proctoplasty; for stenosis
45505	4	Proctoplasty; for prolapse of mucous membrane
45521	1	Perirectal injection of sclerosing solution for prolapse; hospital
45560	4	Repair of rectocele (separate procedure)

MANIPULATION

45900	1	Reduction of procidentia (separate procedure) under anesthesia
* 45910	1	Dilation of rectal structure (separate procedure) under anesthesia other than local
45915	1	Removal of fecal impaction or foreign body (separate procedure) under anesthesia

ANUS

INCISION

46000	2	Fistulotomy, subcutaneous
46040	2	Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)
46045	2	Incision and drainage of intramural, intramuscular or submucosal abscess, transanal, under anesthesia

*	46060	2	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy, submuscular
	46080	2	Sphincterotomy, anal, division of sphincter (separate procedure)

EXCISION

	46200	2	Fissurectomy, with or without sphincterotomy
	46211	2	Cryptectomy; multiple (separate procedure)
*	46250	3	Hemorrhoidectomy, external, complete
*	46255	3	Hemorrhoidectomy internal and external, simple
*	46257	3	Hemorrhoidectomy internal and external, simple; with fissurectomy
*	46258	3	Hemorrhoidectomy internal and external, simple; with fistulectomy, with or without fissurectomy
	46260	2	Hemorrhoidectomy, internal and external, complex or extensive
	46261	2	Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy
*	46262	2	Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy
*	46270	2	Fistulectomy; subcutaneous
*	46275	2	Fistulectomy; submuscular
*	46280	2	Fistulectomy; complex or multiple
	46285	2	Fistulectomy; second stage

ANUS

INTRODUCTION

	46750	4	Sphincteroplasty, anal, for incontinence or prolapse; adult
	46753	4	Graft (Thiersch operation) for rectal incontinence and/or prolapse
	46754	4	Removal of Thiersch wire or suture
	46760	4	Sphincteroplasty, anal, for incontinence, adult, muscle transplant

DESTRUCTION

	46924	1	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method
	46937	2	Cryosurgery of rectal tumor; benign
	46938	2	Cryosurgery of rectal tumor; malignant

LIVER

INCISION

*	47000	2	Biopsy of liver, percutaneous needle

ABDOMEN, PERITONEUM, AND OMENTUM

INCISION

	49000	4	Exploratory laparotomy, exploratory celiotomy (separate procedure)

ENDOSCOPY

*	49300	4	Peritoneoscopy; without biopsy
*	49301	4	Peritoneoscopy; with biopsy
	49302	4	Peritoneoscopy with guided transhepatic cholangiography; without biopsy
	49303	4	Peritoneoscopy with guided transhepatic cholangiography; with biopsy

INTRODUCTION

	49400	1	Pneumoperitoneum; initial
	49401	1	Pneumoperitoneum; subsequent
	49420	1	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary
	49421	1	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; permanent
	49425	1	Peritoneal-venous shunt (e.g., Le Veen shunt)
	49426	1	Revision of peritoneal-venous shunt

REPAIR

HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY

*	49505	4	Repair inguinal hernia, age 5 or over
	49510	4	Repair inguinal hernia, age 5 or over; with orchiectomy, with or without implantation of prosthesis
*	49515	4	Repair inguinal hernia, age 5 or over; with excision of hydrocele or spermatocele
*	49520	4	Repair inguinal hernia, any age; recurrent
*	49525	4	Repair inguinal hernia, any age; sliding
	49540	4	Repair lumbar hernia
*	49550	4	Repair femoral hernia, groin incision
	49552	4	Repair femoral hernia, Henry approach
*	49555	4	Repair femoral hernia, recurrent, any approach
*	49560	4	Repair ventral (incisional) hernia (separate procedure)
*	49565	4	Repair ventral (incisional) hernia (separate procedure); recurrent
	49570	4	Repair epigastric hernia, properitoneal fat (separate procedure); simple
	49575	4	Repair epigastric hernia, properitoneal fat (separate procedure); complex
	49581	4	Repair umbilical hernia; age 5 or over
	49590	4	Repair spigelian hernia

URINARY SYSTEM

KIDNEY

INCISION

	50020	3	Drainage of perirenal or renal abscess (separate procedure)
	50040	4	Nephrostomy, nephrotomy with drainage

EXCISION

50200	1	Renal biopsy, percutaneous by trocar or needle
50205	4	Renal biopsy, percutaneous; by surgical exposure of kidney

INTRODUCTION

50390	1	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous
50392	1	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous
50393	1	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous
50394	1	Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter (separate procedure)
50396	1	Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter
50398	1	Change of nephrostomy or pyelostomy tube

ENDOSCOPY

50553	1	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50559	1	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance with or without biopsy and/or fulguration
50561	1	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50570	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50572	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50576	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration, with or without biopsy
50578	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration
50580	1	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus

URETER

INTRODUCTION

50684	1	Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter (separate procedure)
50690	1	Injection procedure for visualization of ilial conduit and/or ureteropyelography, exclusive of radiologic service (separate procedure)

ENDOSCOPY

50953	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50955	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50957	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration, with or without biopsy
50959	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance with or without biopsy and/or fulguration (not including provision of material)
50961	1	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus
50970	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
50972	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with ureteral catheterization
50974	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with biopsy
50976	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with fulguration, with or without biopsy
50978	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of materal)
50980	1	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service; with removal of foreign body or calculus

BLADDER

INCISION

51005	1	Aspiration of bladder; by trocar or intracatheter
51010	1	Aspiration of bladder; with insertion of suprapubic catheter

INTRODUCTION

51600	1	Injection procedure for cystography or voiding urethrocystography
51605	1	Injection procedure and placement of chain for contrast and/or chain urethrocystography
51610	1	Injection procedure for retrograde urethrocystography
51710	1	Change of cystostomy tube; complicated

BLADDER

REPAIR

51865	4	Cystorrhaphy, suture of bladder wound, injury or rupture; complicated
51900	4	Closure of vesicovaginal fistula, abdominal approach

URETER

ENDOCOPY-CYSTOSCOPY, URETHROSCOPY CYSTOURETHROSCOPY NOTES

* 52000	1	Cystourethroscopy; (separate procedure)
52005	1	Cystourethroscopy; with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service
52007	1	Cystourethroscopy; with ureteral catheterization and brush biopsy of ureter and/or renal pelvis
52010	1	Cystourethroscopy: with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service

BLADDER

TRANSURETHRAL SURGERY (URETHRA, AND BLADDER)

52204	3	Cystourethroscopy, with biopsy
52214	3	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands
52224	3	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s), with or without biopsy
52234	3	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)
52235	3	Cystourethroscopy, with fulguration (including cryosurgery) and/or resection of; MEDIUM bladder tumor(s) (2.0 to 5.0 cm)
52240	3	Cystourethroscopy, with fulguration (including cryosurgery) and/or resection of; LARGE bladder tumor(s)
52250	3	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration
52260	3	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia
52270	3	Cystourethroscopy, with internal urethrotomy; female
52275	3	Cystourethroscopy, with internal urethrotomy; male

52276	3	Cystourethroscopy with direct vision internal urethrotomy
52277	3	Cystourethroscopy, with resection of external sphincter (sphincterotomy)
52281	3	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female
52283	3	Cystourethroscopy, with steroid injection into stricture
52285	3	Cystourethroscopy for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone
52290	3	Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral
52300	3	Cystourethroscopy; with resection or fulguration of ureterocele(s), unilateral or bilateral
52305	3	Cystourethroscopy; with incision or resection of orifice of bladder diverticulum, single or multiple
52310	4	Cystourethroscopy, with removal of foreign body calculus or ureteral stent from urethra or bladder; simple
52315	4	Cystourethroscopy, with removal of foreign body calculus or ureteral stent from urethra or bladder; complicated
52317	4	Litholapaxy: crushing of fragmentation or calculus by any means in bladder and removal of fragments, simple; small (less than 2.5 c.m.)
52318	4	Litholapaxy: crushing of fragmentation or calculus by any means in bladder and removal of fragments, simple; complicated or large (over 2.5 c.m.)
52320	4	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus
52330	4	Cystourethroscopy (including ureteral catheterization); with manipulation, without removal of ureteral calculus
52332	4	Cystourethroscopy, with insertion of indwelling ureteral stent (e.g., Gibbons or double-J type)
52335	3	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter by any method)

TRANSURETHERAL SURGERY (VESICAL NECK AND PROSTATE)

52340	3	Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic mucosal folds)
52500	3	Transurethral resection of bladder neck (separate procedure)

TRANSURETHRAL SURGERY(URETHA AND BLADDER)

52601	4	Transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

52606	4	Transurethral fulguration for postoperative bleeding occurring after the usual follow-up time
52612	4	Transurethral resection of prostate; first stage of two-stage resection (partial resection)
52614	4	Transurethral resection of prostate; second stage of two-stage resection (resection completed)
52620	4	Transurethral resection; of residual obstructive tissue after 90 days postoperative
52630	4	Transurethral resection; of regrowth of obstructive tissue longer than one year postoperative
52640	4	Transurethral resection; of postoperative bladder neck contracture
52650	4	Transurethral cryosurgical removal of prostate (postoperative irrigations and aspiration of sloughing tissue included)
52700	4	Transurethral drainage of prostatic abscess

URETHRA

INCISION

53000	2	Urethrotomy or urethrostomy, external (separate procedure); pendulous urethra
53010	2	Urethrotomy or urethrostomy, external (separate procedure); perineal urethra, external
53020	2	Meatotomy, cutting of meatus (separate procedure); except infant
53040	2	Drainage of deep periurethral abscess

EXCISION

53220	3	Excision or fulguration of carcinoma of urethra
53230	3	Excision of urethral diverticulum (separate procedure); female
53235	3	Excision of urethral diverticulum (separate procedure); male
53240	3	Marsupialization of urethral diverticulum, male or female
53265	3	Excision or fulguration; urethral caruncle
53275	3	Excision or fulguration; urethral prolapse

REPAIR

53400	4	Urethroplasty; first stage, for fistula, diverticulum, or stricture, e.g., Johannsen type
53405	4	Urethroplasty; second stage (formation of urethra), including urinary diversion
53410	4	Urethroplasty, one-stage reconstruction of male anterior urethra
53420	4	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	4	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	4	Urethroplasty, reconstruction of female urethra
53440	4	Operation for correction of male urinary incontinence, with or without introduction of prosthesis

53447	4	Removal, repair or replacement of inflatable sphincter including pump and/or reservoir and/or cuff
53449	4	Surgical correction of hydraulic abnormality of inflatable sphincter device
53450	4	Urethromeatoplasty, with mucosal advancement
53460	4	Urethromeatoplasty, with partial excision of distal urethral segment (Richardson type procedure)

SUTURE

53502	4	Urethrorrhaphy, suture of urethral wound or injury, female
53510	4	Urethrorrhaphy, suture of urethral wound or injury; perineal
53515	4	Urethrorrhaphy, suture of urethral wound or injury; prostatomembranous
53520	4	Closure of urethrostomy or urethrocutaneous fistula, male (separate procedure)

MANIPULATION

• 53600	1	Dilation of urethral stricture by passage of sound or urethral dilator male; initial
• 53601	1	Dilation of urethral stricture by passage of sound or urethral dilator, male; subsequent
• 53605	1	Dilation of urethral stricture of vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia
• 53620	1	Dilation of urethral stricture by passage of filiform and follower, male; initial
• 53621	1	Dilation of urethral stricture by passage of filiform and follower, male; subsequent
• 53660	1	Dilation of female urethra including suppository and/or instillation; initial
• 53661	1	Dilation of female urethra including suppository and/or instillation; subsequent
• 53665	1	Dilation of female urethra, general or conduction (spinal) anesthesia

MALE GENITAL SYSTEM

PENIS

INCISION

54001	1	Slitting of prepuce, dorsal or lateral, (separate procedure); except newborn

EXCISION

54105	1	Biopsy of penis; deep structures
54110	3	Excision of penile plaque (Peyronie disease)
54115	3	Removal foreign body from deep penile tissue (e.g., plastic implant)
54120	3	Amputation of penis; partial
54125	4	Amputation of penis; complete
54152	2	Circumcision, clamp procedure; except newborn
54161	2	Circumcision, surgical excision other than clamp or dorsal slit; except newborn

INTRODUCTION

	54205	1	Injection procedure for Peyronie disease; with surgical exposure of plaque
	54220	1	Irrigation of corpora cavernosa for priapism
	54230	1	Injection procedure for corpora cavernosography

REPAIR

	54440	4	Plastic operation of penis for injury

TESTIS

EXCISION

	54505	1	Biopsy of testis, incisional (separate procedure; unilateral
	54506	1	bilateral
	54510	1	Excision of local lesion of testis
*	54520	2	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; unilateral
*	54521	2	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach; bilateral
	54530	3	Orchiectomy, radical, for tumor; inguinal approach

REPAIR

	54670	2	Suture or repair of testicular injury
	54680	4	Transplantation of testis(es) to thigh (because of scrotal destruction)

EPIDIDYMIS

EXCISION

	54700	2	Incision and drainage of epididymis, testis and/or scrotal space (e.g., abscess or hematoma)
	54820	1	Exploration of epididymis, with or without biopsy
	54830	2	Excision of local lesion of epididymis
*	54840	3	Excision of spermatocele, with or without epididymectomy
	54860	3	Epididymectomy; unilateral
	54861	3	Epididymectomy; bilateral

REPAIR

	54900	3	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral
	54901	3	Epididymovasostomy, anastomosis of epididymis to vas deferens; bilateral

TUNICA VAGINALIS

EXCISION

*	55040	3	Excision of hydrocele; unilateral
*	55041	3	Excision of hydrocele; bilateral

REPAIR

	55060	3	Repair of hydrocele (Bottle type)

INCISION

55120	1	Removal of foreign body in scrotum

SCROTUM

EXCISION

55150	3	Resection of scrotum

REPAIR

55175	3	Scrotoplasty; simple
55180	3	Scrotoplasty; complicated

VAS DEFERENS

REPAIR

55400	3	Vasovasostomy, vasovasorrhaphy; unilateral
55401	3	Vasovasostomy, vasovasorrhaphy; bilateral

SPERMATIC CORD

EXCISION

55500	3	Excision of hydrocele of spermatic cord, unilateral (separate procedure)
55520	3	Excision of lesion of spermatic cord (separate procedure)
* 55530	4	Excision of varicocele or ligation of spermatic veins for varicocele; (separate procedure)
55535	4	Excision of varicocele or ligation of spermatic veins for varicocele; abdominal approach
55540	4	Excision of varicocele or ligation of spermatic veins for varicocele; with hernia repair

SEMINAL VESICLES

INCISION

55605	1	Vesiculotomy; complicated

EXCISION

55650	4	Vesiculectomy, any approach; unilateral
55651	4	Vesiculectomy, any approach; bilateral
55680	4	Excision of Mullerian duct cyst

PROSTATE

INCISION

* 55700	1	Biopsy, prostate; needle or punch, single or multiple, any approach
* 55705	1	Biopsy, prostate; incisional any approach
55720	1	Prostatotomy, external drainage of prostatic abscess, any approach; simple

FEMALE GENITAL SYSTEM

VAGINA

PERINEUM

56000	2	Incision and drainage of perineal abscess (nonobstetrical)

VULVA AND INTROITUS

INCISION

56440	3	Marsupialization of Bartholin's gland cyst

DESTRUCTION

56515	3	Destruction of lesion(s), vulva; extensive, any method

EXCISION

56740	3	Excision of Bartholin's gland or cyst

VAGINA

INCISION

57020	1	Colpocentesis (separate procedure)

EXCISION

57105	3	Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)
57130	3	Excision of vaginal septum

REPAIR

57268	4	Repair of enterocele, vaginal approach (separate procedure)

MANIPULATION

* 57400	1	Dilation of vagina under anesthesia
* 57410	1	Pelvic examination under anesthesia

ENDOSCOPY

* 57450	1	Culdoscopy, diagnostic

CERVIX UTERI

EXCISION

57520	2	Biopsy of cervix, circumferential (cone), with or without dilation and curettage, with or without Sturmdorff type repair

REPAIR

57720	3	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach

MANIPULATION

57820	2	Dilation and curettage of cervical stump

CORPUS UTERI

EXCISION

*	58120	3	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)

OVARY

EXCISION

	58900	4	Biopsy of ovary, unilateral or bilateral (separate procedure)

ENDOSCOPY-LAPAROSCOPY

*	58980	4	Laparoscopy for visualization of pelvic viscera
*	58984	4	Laparoscopy for visualization of pelvic viscera; with fulguration of ovarian or peritoneal lesions
*	58985	4	Laparoscopy for visualization of pelvic viscera; with lysis of adhesions
*	58986	4	Laparoscopy for visualization of pelvic viscera; with biopsy (single or multiple)
*	58987	4	Laparoscopy for visualization of pelvic viscera; with aspiration (single or multiple)

ENDOCRINE SYSTEM

THYROID GLAND

EXCISION

	60200	3	Excision of cyst or adenoma of thyroid, or transection of isthmus
	60220	4	Total thyroid lobectomy, unilateral
	60225	4	Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmus
*	60280	3	Excision of thyroglossal duct cyst or sinus

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

PUNCTURE FOR INJECTION, DRAINAGE OR ASPIRATION

	61020	1	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection
	61026	1	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular chatheter/reservoir; with injection of drug or other substance for diagnosis or treatment
	61050	1	Cisternal or lateral cervical puncture; without injection (separate procedure)
	61070	1	Puncture of shunt tubing or reservoir for aspiration or injection procedure

SPINE AND SPINAL CORD

PUNCTURE FOR INJECTION, DRAINAGE, OR ASPIRATION

62270	1	Spinal puncture, lumbar, diagnostic
62273	1	Injection, lumbar epidural, of blood or clot patch
62274	1	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural, simple
62276	1	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural, differential
62277	1	Injection of anesthetic substance, diagnostic or therapeutic; subarachnoid or subdural, continuous
62278	1	Injection of anesthetic substance, diagnostic or therapeutic; epidural or caudal, single
62279	1	Injection of anesthetic substance, diagnostic or therapeutic; epidural or caudal, continuous
62288	1	Injection of substance other than anesthetic, contrast, or neurolytic solutions; subarachnoid (separate procedure)
62289	1	Injection of substance other than anesthetic, contrast, or neurolytic solutions; epidural or caudal

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC

SOMATIC NERVES

64408	1	Injection, anesthetic agent; vagus nerve
64410	1	Injection, anesthetic agent; phrenic nerve
64415	1	Injection, anesthetic agent; brachial plexus
64417	1	Injection, anesthetic agent; axillary nerve
64420	1	Injection, anesthetic agent; intercostal nerve, single
64421	1	Injection, anesthetic agent; intercostal nerves, multiple, regional block
64430	1	Injection, anesthetic agent; pudendal nerve
64442	1	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, single level
64443	1	Injection, anesthetic agent; paravertebral facet joint nerve, lumbar, each additional level

SYMPATHETIC NERVES

64510	2	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64520	2	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	2	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring

DESTRUCTION BY NEUROLYTIC AGENT (E.G., CHEMICAL, THERMAL, ELECTRICAL, RADIOFREQUENCY)

SOMATIC NERVES

	64600	2	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
	64605	2	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
	64610	2	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
	64622	2	Destruction by neurolytic agent; paravertebral facet joint nerve, lumbar, single level
	64630	2	Destruction by neurolytic agent; pudendal nerve

EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION (NEUROPLASTY)

*	64702	3	Neurolysis; digital, one or both, same digit
*	64704	3	Neurolysis; nerve of hand or foot
*	64708	3	Neurolysis, major peripheral nerve, arm or leg; other than specified
	64712	3	Neurolysis, major peripheral nerve, arm or leg; sciatic nerve
	64713	3	Neurolysis, major peripheral nerve, arm or leg; brachial plexus
	64714	3	Neurolysis, major peripheral nerve, arm or leg; lumbar plexus
*	64716	4	Neurolysis and/or transposition; cranial nerve (specify)
*	64718	4	Neurolysis and/or transposition; ulnar nerve at elbow
*	64719	4	Neurolysis and/or transposition; ulnar nerve at wrist
*	64721	3	Neurolysis and/or transposition; median nerve at carpal tunnel
	64722	3	Decompression; unspecified nerve(s) (specify)
	64726	3	Decompression; plantar digital nerve
	64727	4	Internal neurolysis by dissection, with or without microdissection (list separately in addition to code for primary neuroplasty)

TRANSECTION OR AVULSION OF NERVE

	64732	3	Transection or avulsion of; supraorbital nerve
	64734	3	Transection or avulsion of; infraorbital nerve
	64736	3	Transection or avulsion of; mental nerve
	64738	3	Transection or avulsion of; inferior alveolar nerve by osteotomy
	64740	3	Transection or avulsion of; lingual nerve
	64742	3	Transection or avulsion of; facial nerve, differential or complete
	64744	3	Transection or avulsion of; greater occipital nerve
	64772	3	Transection or avulsion of other spinal nerve, extradural

EXCISION-SOMATIC NERVES

	64774	3	Excision of neuroma; cutaneous nerve, surgically identifiable
	64776	3	Excision of neuroma; digital nerve, one or both, same digit
	64778	3	Excision of neuroma; digital nerve, each additional digit (list separately by this number)

*	64782	3	Excision of neuroma; hand or foot, except digital nerve
	64784	3	Excision of neuroma; major peripheral nerve, except sciatic
	64786	3	Excision of neuroma; sciatic nerve
	64787	3	Insertion of plastic cap on nerve end
	64788	3	Excision of neurofibroma or neurolemmoma; cutaneous nerve
	64790	3	Excision of neurofibroma or neurolemmoma; major peripheral nerve
	64795	3	Biopsy of nerve

EXCISION-SYMPATHETIC NERVES

64802	4	Sympathectomy, cervical; unilateral
64803	4	Sympathectomy, cervical; bilateral

NERVE REPAIR BY SUTURE (NEURORRHAPHY)

64830	4	Microdissection and/or microrepair of nerve (list separately in addition to code for nerve repair)
64831	4	Suture of digital nerve, hand or foot; one nerve
64832	4	Suture of digital nerve, hand or foot; each additional digital nerve
64834	4	Suture of one nerve, hand or foot; common sensory nerve
64835	4	Suture of one nerve, hand or foot; median motor thenar
64836	4	Suture of one nerve, hand or foot; ulnar motor
64837	4	Suture of each additional nerve, hand or foot
64840	4	Suture of posterior tibial nerve
64856	4	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition
64857	4	Suture of major peripheral nerve, arm or leg, except sciatic; without transposition
64872	4	Suture of nerve; requiring secondary or delayed suture (list separately in addition to code for primary neurorrhaphy)
64874	4	Suture of nerve; requiring extensive proximal mobilization, or transposition of nerve (list separately in addition to code for nerve suture)
64876	4	Suture of nerve; requiring shortening of bone of extremity (list separately in addition to code for nerve suture)

NEURORRHAPHY WITH NERVE GRAFT

64890	4	Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length
64891	4	Nerve graft (includes obtaining graft), single strand, hand or foot; more than 4 cm length
64892	4	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length
64893	4	Nerve graft (includes obtaining graft), single strand, arm or leg; more than 4 cm length
64895	4	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length

	64896	4	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; more than 4 cm length
	64897	4	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length
	64898	4	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; more than 4 cm length
	64901	4	Nerve graft, each additional nerve; single strand
	64902	4	Nerve graft, each additional nerve; multiple strands (cable)
	64905	4	Nerve pedicle transfer; first stage
	64907	4	Nerve pedicle transfer; second stage

EYE/OCULAR ADNEXA

EYEBALL

REMOVAL OF EYE

*	65091	4	Evisceration of ocular contents; without implant
*	65093	4	Evisceration of ocular contents; with implant
*	65101	4	Enucleation of eye; without implant
*	65103	4	Enucleation of eye; with implant, muscles not attached to implant
*	65105	4	Enucleation of eye; with implant, muscles attached to implant
	65110	4	Exenteration of orbit (does not include skin graft), removal of orbital contents; only

SECONDARY IMPLANT PROCEDURES

	65130	3	Insertion of ocular implant secondary; after evisceration, in scleral shell
	65135	3	Insertion of ocular implant secondary; after enucleation, muscles not attached to implant
	65140	3	Insertion of ocular implant secondary; after enucleation, muscles attached to implant
	65150	3	Reinsertion of ocular implant; with or without conjunctival graft
	65155	3	Reinsertion of ocular impant; with use of foreign material for reinforcement and/or attachment of muscles to implant
	65175	3	Removal of ocular implant

REMOVAL OF OCULAR FOREIGN BODY

*	65230	1	Removal of foreign body, intraocular; from anterior chamber, magnetic extraction
*	65235	1	Removal of foreign body, intraocular; from anterior chamber, nonmagnetic extraction
	65245	4	Removal of foreign body, intraocular; from lens (without extraction lens), nonmagnetic extraction
	65260	4	Removal of foreign body, intraocular; from posterior segment, magnetic extraction, anterior or posterior route
	65265	4	Removal of foreign body, intraocular; from posterior segment, nonmagnetic extraction

REPAIR OF LACERATION OF EYEBALL

65272	2	Repair of laceration; conjunctiva, by mobilization and rearrangement, without hospitalization
65280	4	Repair of laceration; cornea and/or sclera, perforating, not involving uveal tissue
65285	4	Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue
65290	3	Repair of wound, extraocular muscle, tendon and/or Tenon's capsule

ANTERIOR SEGMENT - CORNEA

EXCISION

65400	1	Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium
65410	1	Biopsy of cornea
* 65420	1	Excision or transposition of pterygium; without graft
65426	1	Excision or transposition of pterygium; with graft

KERATOPLASTY

65710	4	Keratoplasty (corneal transplant), lamellar; autograft
65720	4	Keratoplasty (corneal transplant), lamellar; homograft, fresh
65725	4	Keratoplasty (corneal transplant), lamellar; homograft, preserved
65730	4	Keratoplasty (corneal transplant), penetrating (except in aphakia); autograft
65740	4	Keratoplasty (corneal transplant), penetrating (except in aphakia); homograft, fresh
65745	4	Keratoplasty (corneal transplant), penetrating (except in aphakia); homograft, preserved
65750	4	Keratoplasty (corneal transplant), penetrating, in aphakia

ANTERIOR SEGMENT-ANTERIOR CHAMBER

INCISION

65800	1	Paracentesis of anterior chamber of eye (separate procedure); with diagnostic aspiration of aqueous
65805	1	Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous
65810	4	Paracentesis of anterior chamber of eye (separate procedure); with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection
65815	1	Paracentesis of anterior chamber of eye (separate procedure); with removal of blood, with or without irrigation and/or air injection

OTHER PROCEDURES

65865	1	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure; goniosynechiae
65870	1	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); anterior synechiae, except goniosynechiae

65875	1	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); posterior synechiae
65880	1	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) (separate procedure); corneovitreal adhesions
65900	4	Removal of epithelial downgrowth, anterior chamber eye
65920	4	Removal of implanted material, anterior segment eye
65930	4	Removal of blood clot, anterior segment eye
66020	1	Injection, anterior chamber (separate procedure); air or liquid
66030	1	Injection, anterior chamber (separate procedure); medication

ANTERIOR SEGMENT-ANTERIOR SCLERA

EXCISION

66130	4	Excision of lesion, sclera
66150	4	Fistulization of sclera for glaucoma; trephination with iridectomy
66155	4	Fistulization of sclera for glaucoma; thermocauterization with iridectomy
66160	4	Fistulization of sclera for glaucoma; sclerectomy with punch or scissors, with iridectomy
66165	4	Fistulization of sclera for glaucoma; iridencleisis or iridotasis
66170	4	Fistulization of sclera for glaucoma; trabeculectomy ab externo

REPAIR

66220	4	Repair of scleral staphyloma; without graft
66225	4	Repair of scleral staphyloma; with graft

REVISION OPERATION WOUND

66250	4	Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure

ANTERIOR SEGMENT-IRIS, CILIARY BODY

IRIDOTOMY, IRIDECTOMY

	66500	1	Iridotomy by stab incision (separate procedure); except transfixion
	66505	1	Iridotomy by stab incision (separate procedure); with transfixion as for iris bombe
*	66600	4	Iridectomy, with corneoscleral or corneal section; for removal of lesion
	66605	3	Iridectomy with corneoscleral or corneal section; with cyclectomy
*	66625	4	Iridectomy, with corneoscleral or corneal section; peripheral for glaucoma (separate procedure)
*	66630	4	Iridectomy, with corneoscleral or corneal section; sector for glaucoma (separate procedure)
*	66635	4	Iridectomy, with corneoscleral or corneal section; "optical" (separate procedure)

REPAIR

	66680	4	Repair of iris, ciliary body (as for iridodialysis)
	66682	4	Suture of iris, ciliary body (separate procedure) with retrieval of suture through small incision (e.g., McCannel suture)

DESTRUCTION

	66700	1	Cyclodiathermy; initial
	66701	1	Cyclodiathermy; subsequent
	66720	1	Cyclocryotherapy; initial
	66721	3	Cyclocryotherapy; subsequent
	66741	3	Cyclodialysis; subsequent
	66762	3	Coreoplasty by photocoagulation (one or more sessions) (e.g., for improvement of vision)

ANTERIOR SEGMENT-LENS

INCISION

*	66800	1	Discission of lens capsule; incisional technique (needling of lens); initial
*	66801	1	Discission of lens capsule; incisional technique (needling of lens); subsequent
	66821	1	Discission of secondary membraneous cataract ("after cataract") and/or anterior hyaloid; laser surgery (one or more stages)

REMOVAL CATARACT

*	66830	4	Removal of secondary membranous cataract ("after cataract"), with corneoscleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy)
*	66840	4	Removal of lens material; aspiration technique, one or more stages
*	66850	4	Removal of lens material; phacofragmentation technique (mechanical or ultrasonic, e.g., phacoemulsification), with aspiration
	66915	4	Expression of lens, linear, one or more stages
*	66920	4	Extraction of lens with or without iridectomy; intracapsular, with or without enzymes
*	66930	4	Extraction of lens with or without iridectomy; intracapsular, for dislocated lens
*	66940	4	Extraction of lens with or without iridectomy; extracapsular (other than 66840, 66850, 66915)
	66945	4	Extraction of lens with or without iridectomy; in presence of fistulization bleb and/or by temporal, inferior or inferotemporal route, intracapsular or extracapsular
*	66983	4	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
	66984	4	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or phacoemulsification technique
*	66985	4	Insertion of intraocular lens subsequent to cataract removal (separate procedure)

POSTERIOR SEGMENT-VITREOUS

67005	4	Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal
67010	4	Removal of vitreous, anterior approach (open sky technique or limbal incision); subtotal removal with mechanical vitrectomy (such as VISC or Rotoextractor)
67015	2	Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)
67025	2	Injection of vitreous substitute, pars plana approach (separate procedure) excludes air or balanced salt solutions
67030	2	Discission of vitreous strands (without removal), pars plana approach
67036	4	Virectomy, mechanical, pars plana approach

POSTERIOR SEGMENT-RETINAL DETACHMENT

REPAIR

67101	4	Repair of retinal detachment, one or more sessions, same hospitalization, cryotherapy or diathermy, with or without drainage or subretinal fluid
67107	4	Repair of retinal detachment (one or more stages, same hospitalization); scleral buckling (such as lamella excision, imbrication or encircling procedure), with or without implant, may include procedures 67101-67105
67108	4	Repair of retinal detachment (one or more stages, same hospitalization); with vitrectomy, any method, with or without air tamponade, may include procedures 67101-67107 and/or removal of lens by same technique
67109	4	Repair of retinal detachment (one or more stages, same hospitalization); by technique other than 67101-67108
67120	4	Removal of implanted material, posterior segment, extraocular

POSTERIOR SEGMENT-OTHER PROCEDURES

DESTRUCTION-RETINA, CHOROID

67208	1	Destruction of localized lesion of retina (e.g., maculopathy, choroidopathy, small tumors), one or more sessions; cryotherapy, diathermy
67218	4	Destruction of localized lesion, retina or choroid (e.g., choroidopathy), one or more stages; radiation by implantation of source (includes removal of source)
67227	1	Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy

SCLERAL REPAIR

	67250	4	Scleral reinforcement (separate procedure); without graft
	67255	4	Scleral reinforcement (separate procedure); with graft
•	67311	4	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); one muscle
•	67312	4	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); two muscles, one or both eyes
•	67313	4	Strabismus surgery on patient not previously operated on, any procedure, any muscle (may include minor displacement, e.g., for A or V pattern); three or more muscles, and/or adjustable suture, one or both eyes

OCULAR ADNEXA-EXTRAOCULAR MUSCLES

67320	3	Transposition of extraocular muscle (e.g., for paretic muscle), one or more stages, one or more muscles, with displacement of plane of action more than 5mm
67331	3	Strabismus surgery on patient previously operated on; not involving reoperation of muscles
67332	3	Strabismus surgery on patient previously operated on; involving reoperation of muscles

OTHER PROCEDURES

67350	3	Biopsy of extraocular muscle

OCULAR ADNEXA-ORBIT

EXPLORATION, EXCISION

67400	4	Orbitotomy without bone flap (frontal approach); for exploration, with or without biopsy
67405	4	Orbitotomy without bone flap (frontal approach); with drainage only
67412	4	Orbitotomy without bone flap (frontal approach); with removal of lesion
		674134Orbitotomy without bone flap (frontal approach); with removal of foreign body
67415	1	Transconjunctival or aspirational biopsy

OTHER PROCEDURES

67550	4	Orbital implant (implant outside muscle cone); insertion
67560	4	Orbital implant (implant outside muscle cone); removal or revision

OCULAR ADNEXA-EYELIDS

INCISION

67715	1	Canthotomy (separate procedure)

EXCISION OR REMOVAL OF LESION INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)

*	67801	1	Excision of chalazion; multiple, same lid
*	67808	1	Excision of chalazion; under general anesthesia and/or requiring hospitalization, single or multiple
	67830	3	Correction of trichiasis; incision of lid margin
	67835	2	Correction of trichiasis; incision of lid margin, with free mucous membrane graft

TARSORRHAPHY

	67880	1	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;
	67882	3	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy; with transposition of tarsal plate

REPAIR BLEPHAROPTOSIS, LID RETRACTION

	67901	1	Repair of blepharoptosis; frontalis muscle technique with suture
	67902	3	Repair of blepharoptosis; frontalis muscle technique with fascial sling (includes obtaining fascia)
	67903	3	Repair of blepharoptosis; (tarso)levator resection, internal approach
	67904	3	Repair of blepharoptosis; (tarso)levator resection, external approach
	67906	3	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
	67907	3	Repair of blepharoptosis; superior rectus tendon transplant
	67908	1	Repair of blepharoptosis; conjunctivo-tarso-levator resection (Fasanella-Servat type)
	67909	1	Reduction of overcorrection of ptosis

REPAIR ECTROPION, ENTROPION

*	67914	3	Repair of ectropion; suture
*	67916	3	Repair of ectropion; blepharoplasty, excision tarsal wedge
*	67917	3	Repair of ectropion; blepharoplasty, extensive (e.g., Kuhnt-Szymanowski operation)
*	67921	3	Repair of entropion; suture
*	67923	3	Repair of entropion; blepharoplasty, excision tarsal wedge
*	67924	3	Repair of entropion; blepharoplasty, extensive (e.g., Wheeler operation)

RECONSTRUCTIVE SURGERY, BLEPHAROPLASTY INVOLVING MORE THAN SKIN (I.E., INVOLVING LID MARGIN, TARSUS, AND/OR PALPEBRAL CONJUNCTIVA)

	67935	2	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva) direct closure; full thickness
*	67950	2	Canthoplasty (reconstruction of canthus)
	67961	3	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin

67966	3	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; over one-fourth of lid margin
67971	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage
67973	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, lower, one stage or first stage
67974	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; total eyelid, upper, one stage or first stage
67975	3	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; second stage

OCULAR ADNEXA-CONJUNCTIVA

EXCISION, DESTRUCTION

68130	1	Excision of lesion, conjunctiva; with adjacent sclera

CONJUNCTIVOPLASTY

68320	2	Conjunctivoplasty; with conjunctival graft or extensive rearrangement
68325	2	Conjunctivoplasty; with buccal mucous membrane graft (includes obtaining graft)
68326	2	Conjunctivoplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement
68328	3	Conjunctivoplasty, reconstruction cul-de-sac; with buccal mucous membrane graft (includes obtaining graft)

OTHER PROCEDURES

68360	2	Conjunctival flap; bridge or partial (separate procedure)
68362	2	Conjunctival flap; total (such as Gunderson thin flap or purse string flap)

OCULAR ADNEXA-LACRIMAL SYSTEM

EXCISION

68500	3	Excision of lacrimal gland (dacryoadenectomy), except for tumor; total
68505	3	Excision of lacrimal gland (dacryoadenectomy), except for tumor; partial
68510	3	Biopsy of lacrimal gland
68520	3	Excision of lacrimal sac (dacryocystectomy)

EXCISION

68540	4	Excision of lacrimal gland tumor; frontal approach involving osteotomy.
68550	4	Excision of lacrimal gland tumor; frontal approach

REPAIR

*	68700	1	Plastic repair of canaliculi
	68720	3	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)
	68745	3	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube
	68750	3	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); with insertion of tube or stent

PROBING AND RELATED PROCEDURES

*	68830	1	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral; with insertion of tube or stent (without general anesthesia)

AUDITORY SYSTEM

EXTERNAL EAR

EXCISION

69105	1	Biopsy external auditory canal
69110	2	Excision external ear; partial, simple repair
69120	3	Excision external ear; complete amputation
69140	2	Excision exostosis(es), external auditory canal
69145	2	Excision soft tissue lesion, external auditory canal
69150	4	Radical excision external auditory canal lesion; without neck dissection

MIDDLE EAR

INCISION

*	69420	1	Myringotomy including aspiration and/or eustachian tube inflation
	69440	3	Middle ear exploration through postauricular or ear canal incision
	69450	3	Tympanolysis, transcanal

EXCISION

*	69501	4	Transmastoid antrotomy ("simple" mastoidectomy)

REPAIR

*	69620	4	Myringoplasty (surgery confined to drumhead and donor area)
*	69631	4	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction
	69632	4	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction, e.g., postfenestration
	69633	4	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; with ossicular chain reconstruction and synthetic prosthesis (e.g., total ossicular replacement prosthesis, TORP)

	69635	4	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction
	69636	4	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction
	69637	4	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); with ossicular chain reconstruction and synthetic prosthesis (e.g., total ossicular replacement prosthesis, TORP)
	69641	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction
	69642	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with ossicular chain reconstruction
	69643	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed wall, without ossicular chain reconstruction
	69644	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); with intact or reconstructed canal wall, with ossicular chain reconstruction
	69645	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, without ossicular chain reconstruction
	69646	4	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); radical or complete, with ossicular chain reconstruction
*	69650	4	Stapes mobilization
*	69660	4	Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material;
	69661	4	Stapedectomy with reestablishment of ossicular continuity, with or without use of foreign material; with footplate drill out
	69666	4	Repair oval window fistula
	69667	4	Repair round window fistula
	69670	4	Mastoid obliteration (separate procedure)
	69676	4	Tympanic neurectomy; unilateral
	69677	4	Tympanic neurectomy; bilateral

EXTERNAL EAR

OTHER PROCEDURES

69700	2	Closure postauricular fistula, mastoid (separate procedure)

MIDDLE EAR

OTHER PROCEDURES

69720	4	Decompression facial nerve, intratemporal; lateral to geniculate ganglion
69725	4	Decompression facial nerve, intratemporal; including medial to geniculate ganglion
69740	4	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion
69745	4	Suture facial nerve, intratemporal, with or without graft or decompression; inlcuding medial to geniculate ganglion

PROCEDURES ALLOWED FOR FEMALES ONLY

00842	ANESTH, AMINOCENTESIS
00846	ANESTH, HYSTERECTOMY
00850	ANESTH, CESAREAN SECTION
00855	ANESTH, HYSTERECTOMY
00906	ANESTH, REMOVAL OF VULVA
00940	ANESTH, VAGINAL PROCEDURES
00942	ANESTH, SURGERY ON VAGINA
00944	ANESTH, VAGINAL HYSTERECTOMY
00946	ANESTH, VAGINAL DELIVERY
00948	ANESTH, REPAIR OF CERVIX
00950	ANESTH, VAGINAL ENDOSCOPY
00952	ANESTH, UTERINE ENDOSCOPY
46715	REPAIR OF ANOVAGINAL FISTULA
46716	REPAIR ON ANOVAGINAL FISTULA
50722	RELEASE OF URETER
51840	ATTACH BLADDER/URETHRA
51841	ATTACH BLADDER/URETHRA
51845	REPAIR BLADDER NECK
51900	REPAIR BLADDER/VAGINA LESION
51920	CLOSE BLADDER-UTERUS FISTULA
51925	HYSTERECTOMY/BLADDER REPAIR
52270	CYSTOSCOPY & REVISE URETHRA
53210	REMOVAL OF URETHRA
53230	REMOVAL OF URETHRA LESION
53430	RECONSTRUCTION OF URETHRA
53502	REPAIR OF URETHRA INJURY
53660	DILATION OF URETHRA
53661	DILATION OF URETHRA
53665	DILATION OF URETHRA
56000	DRAINAGE OF PERINEAL ABSCESS
56100	BIOPSY OF PERINEUM
56200	REPAIR OF PERINEUM
56400	DRAINAGE OF VULVA ABSCESS
56420	DRAINAGE OF VULVA ABSCESS
56440	SURGERY FOR VULVA LESION
56501	DESTRUCTION, VULVA LESION(S)
56515	DESTRUCTION, VULVA LESION(S)
56600	BIOPSY OF VULVA
56620	PARTIAL REMOVAL OF VULVA
56625	REMOVAL OF VULVA
56630	EXTENSIVE VULVA SURGERY
56635	EXTENSIVE VULVA SURGERY
56636	EXTENSIVE VULVA SURGERY
56640	EXTENSIVE VULVA SURGERY
56641	EXTENSIVE VULVA SURGERY
56680	REMOVAL OF CLITORIS
56685	EXTENSIVE CLITORIS SURGERY
56700	PARTIAL REMOVAL OF HYMEN
56710	REVISION OF HYMEN
56720	INCISION OF HYMEN
56740	REMOVE VAGINA GLAND LESION
56800	REPAIR OF VAGINA
57000	EXPLORATION OF VAGINA
57010	DRAINAGE OF PELVIC ABSCESS
57020	DRAINAGE OF PELVIC FLUID
57061	DESTRUCTION VAGINA LESION(S)
57065	DESTRUCTION VAGINA LESION(S)
57100	BIOPSY OF VAGINA
57105	BIOPSY OF VAGINA
57108	PARTIAL REMOVAL OF VAGINA
57110	REMOVAL OF VAGINA
57120	CLOSURE OF VAGINA
57130	REMOVE VAGINA LESION
57135	REMOVE VAGINA LESION
57150	TREAT VAGINA INFECTION
57160	INSERTION OF PESSARY
57170	FITTING OF DIAPHRAGM
57180	TREAT VAGINAL BLEEDING
57200	REPAIR OF VAGINA
57210	REPAIR VAGINA/PERINEUM
57220	REVISION OF URETHRA
57230	REPAIR OF URETHRAL LESION
57240	REPAIR BLADDER & VAGINA
57250	REPAIR RECTUM & VAGINA
57260	REPAIR OF VAGINA
57265	EXTENSIVE REPAIR OF VAGINA
57268	REPAIR OF BOWEL BULGE
57270	REPAIR OF BOWEL POUCH
57280	SUSPENSION OF VAGINA
57282	REPAIR OF VAGINAL PROLAPSE
57288	REPAIR BLADDER DEFECT
57289	REPAIR BLADDER & VAGINA
57291	CONSTRUCTION OF VAGINA
57292	CONSTRUCT VAGINA WITH GRAFT
57300	REPAIR RECTUM-VAGINA FISTULA
57305	REPAIR RECTUM-VAGINA FISTULA
57307	FISTULA REPAIR & COLOSTOMY
57310	REPAIR URETHROVAGINAL LESION
57311	REPAIR URETHROVAGINAL LESION
57320	REPAIR BLADDER VAGINAL LESION

PROCEDURES ALLOWED FOR FEMALES ONLY

57330	REPAIR BLADDER-VAGINA LESION
57400	DILATION OF VAGINA
57410	PELVIC EXAMINATION
57450	PELVIS ENDOSCOPY VIA VAGINA
57451	PELVIS ENDOSCOPY & BIOPSY
57452	EXAMINATION OF VAGINA
57454	VAGINA EXAMINATION & BIOPSY
57500	BIOPSY OF CERVIX
57505	ENDOCERVICAL CURETTAGE
57510	CAUTERIZATION OF CERVIX
57511	CRYOCAUTERY OF CERVIX
57513	LASER SURGERY OF CERVIX
57520	BIOPSY OF CERVIX
57530	REMOVAL OF CERVIX
57540	REMOVAL OF RESIDUAL CERVIX
57545	REMOVE CERVIX, REPAIR PELVIS
57550	REMOVAL OF RESIDUAL CERVIX
57555	REMOVE CERVIX, REPAIR VAGINA
57556	REMOVE CERVIX, REPAIR BOWE
57700	REVISION OF CERVIX
57720	REVISION OF CERVIX
57800	DILATION OF CERVICAL CANAL
57820	D&C OF RESIDUAL CERVIX
58100	BIOPSY OF UTERUS LINING
58101	WASH SAMPLE OF UTERUS LINING
58102	CURETTAGE OF UTERUS LINING
58103	MENSTRUAL EXTRACTION
58120	DILATION AND CURETTAGE
58140	REMOVAL OF UTERUS LESION
58145	REMOVAL OF UTERUS LESION
58150	TOTAL HYSTERECTOMY
58152	TOTAL HYSTERECTOMY
58180	PARTIAL HYSTERECTOMY
58200	EXTENSIVE HYSTERECTOMY
58205	EXTENSIVE HYSTERECTOMY
58210	EXTENSIVE HYSTERECTOMY
58240	REMOVAL OF PELVIS CONTENTS
58260	VAGINAL HYSTERECTOMY
58265	HYSTERECTOMY & VAGINA REPAIR
58267	HYSTERECTOMY & VAGINA REPAIR
58270	HYSTERECTOMY & VAGINA REPAIR
58275	HYSTERECTOMY, REVISE VAGINA
58280	HYSTERECTOMY, REVISE VAGINA
58285	EXTENSIVE HYSTERECTOMY
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
58310	ARTIFICIAL INSEMINATION
58311	AFTIFICIAL INSEMINATION
58320	AIR STUDY OF UTERUS & TUBES
58340	INJECT FOR UTERUS/TUBE X-RAY
58350	REOPEN FALLOPIAN TUBE
58400	SUSPENSION OF UTERUS
58410	SUSPENSION OF UTERUS
58520	REPAIR OF RUPTURED UTERUS
58540	REVISION OF UTERUS
58600	DIVISION OF FALLOPIAN TUBE
58605	DIVISION OF FALLOPIAN TUBE
58611	LIGATE OVIDUCT(S)
58615	OCCLUDE FALLOPIAN TUBE(S)
58700	REMOVAL OF FALLOPIAN TUBE
58720	REMOVAL OF OVARY/TUBE(S)
58740	REVISE FALLOPIAN TUBES(S)
58750	REPAIR OVIDUCT(S)
58752	REVISE OVARIAN TUBE(S)
58760	REMOVE TUBAL OBSTRUCTION
58770	CREATE NEW TUBAL OPENING
58800	DRAINAGE OF OVARIAN CYST(S)
58805	DRAINAGE OF OVARIAN CYST(S)
58820	DRAINAGE OF OVARIAN ABSCESS
58822	DRAINAGE OF OVARIAN ABSCESS
58900	BIOPSY OF OVARY(S)
58920	PARTIAL REMOVAL OF OVARY(S)
58925	REMOVAL OF OVARIAN CYST(S)
58940	REMOVAL OF OVARY(S)
58945	REMOVE OVARY(S) & OMENTUM
58980	LAPAROSCOPY OF PELVIS
58982	LAPAROSCOPY; TUBAL CAUTERY
58983	LAPAROSCOPY; TUBAL BLOCK
58984	LAPAROSCOPY OF PELVIS
58985	LAPAROSCOPY OF PELVIS
58986	PELVIS LAPAROSCOPY & BIOPSY
58987	LAPAROSCOPY OF PELVIS
58990	DIAGNOSTIC HYSTEROSCOPY
58995	TREATMENT HYSTEROSCOPY
58999	GENITAL SURGERY PROCEDURE
59000	AMNIOCENTESIS
59010	AMNIOSCOPY
59011	AMNIOSCOPY
59015	CHORION BIOPSY
59020	FETAL OXYTOCIN STRESS TEST
59025	FETAL NON-STRESS TEST
59030	FETAL SCALP BLOOD SAMPLE
59031	FETAL SCALP BLOOD RESAMPLE
59050	MONITOR FETUS DURING LABOR
59100	REMOVE UTERUS LESION
59101	REMOVE LESION, TUBAL LIGATION
59105	ABORTION

PROCEDURES ALLOWED FOR FEMALES ONLY

59106	ABORTION AND TUBAL LIGATION
59120	TREAT ECTOPIC PREGNANCY
59121	TREAT ECTOPIC PREGNANCY
59125	TREAT ECTOPIC PREGNANCY
59126	TREAT ECTOPIC PREGNANCY
59130	TREAT ECTOPIC PREGNANCY
59135	TREAT ECTOPIC PREGNANCY
59140	TREAT ECTOPIC PREGNANCY
59160	D&C AFTER DELIVERY
59200	INSERT CERVICAL DILATOR
59300	EPISIOTOMY OR VAGINAL REPAIR
59305	EPISIOTOMY OR VAGINAL REPAIR
59350	REPAIR OF UTERUS
59351	REPAIR OF UTERUS
59400	OBSTETRICAL CARE
59410	OBSTETRICAL CARE
59420	CARE BEFORE DELIVERY
59430	CARE AFTER DELIVERY
59500	CESAREAN SECTION
59501	CESAREAN SECTION
59520	CESAREAN SECTION
59521	CESAREAN SECTION
59540	CESAREAN SECTION
59541	CESAREAN SECTION
59560	CESAREAN HYSTERECTOMY
56561	CESAREAN HYSTERECTOMY
59580	CESAREAN HYSTERECTOMY
59581	CESAREAN HYSTERECTOMY
59800	CARE OF MISCARRIAGE
59801	CARE OF MISCARRIAGE
59810	CARE OF MISCARRIAGE
59811	CARE OF MISCARRIAGE
59820	CARE OF MISCARRIAGE
59830	TREAT UTERUS INFECTION
59840	ABORTION
59841	ABORTION
59850	ABORTION
59851	ABORTION
59852	ABORTION
59899	MATERNITY CARE PROCEDURE
64435	INJECTION FOR NERVE BLOCK
74710	X-RAY MEASUREMENT OF PELVIS
74720	X-RAY EXAM PREGNANT UTERUS
74725	X-RAY EXAM PREGNANT UTERUS
74740	X-RAY FEMAL GENITAL TRACT
74741	X-RAY FEMALE GENITAL TRACT
74775	X-RAY EXAM OF PERINEUM
76805	ECHO EXAM OF PREGNANT UTERUS
76815	ECHO EXAM FOR FETAL GROWTH
76816	ECHO EXAM FOLLOWUP OR REPEAT
76818	FETAL BIOPHYSICAL PROFILE
76825	ECHO EXAM OF FETAL HEART
76946	ECHO GUIDE FOR AMNIOCENTESIS
76947	ECHO GUIDE FOR AMNIOCENTESIS
80055	OBSTETRIC PROFILE
80056	AMENORRHEA PANEL
82670	RIA ASSAY OF ESTRADIOL
82671	ESTROGENS ASSAY
82672	ESTROGEN ASSAY
82673	ESTRIOL ASSAY
82674	ESTRIOL ASSAY
82676	ASSAY ESTRIOL
82677	RIA ASSAY OF ESTRIOL
82678	ASSAY ESTRONE
82679	RIA ASSAY OF ESTRONE
84135	RIA ASSAY PREGNANEDIOL
84136	ASSAY PREGNANEDIOL
84138	RIA ASSAY PREGNANETRIOL
84139	ASSAY PREGNANTRIOL
84146	RIA ASSAY FOR PROLACTIN
84234	ASSAY PROGESTERONE
84236	ASSAY FEMALE HORMONES
88150	CYTOPATHOLOGY, PAP SMEAR
88151	CYTOPATHOLOGY, INTERPRETATION
88155	CYTOPATHOLOGY, PAP SMEAR
88267	CHROMOSOME COUNT: AMNIOTIC

PROCEDURES ALLOWED FOR MALES ONLY

00908	ANESTH, REMOVAL OF PROSTATE
00914	ANESTH, REMOVAL OF PROSTATE
00920	ANESTH, GENITALIA SURGERY
00922	ANESTH, SPERM DUCT SURGERY
00924	ANESTH, TESTIS EXPLORATION
00928	ANESTH, REMOVAL OF TESTIS
00926	ANESTH, REMOVAL OF TESTIS
00930	ANESTH, TESTIS SUSPENSION
00932	ANESTH, AMPUTATION OF PENIS
00934	ANESTH, PENIS, NODES REMOVAL
00936	ANESTH, PENIS, NODES REMOVAL
00938	ANESTH, INSERT PENIS DEVICE
19140	REMOVAL OF BREAST TISSUE
52275	CYSTOSCOPY & REVISE URETHRA
52601	PROSTATECTOMY (TUR)
52612	PROSTATECTOMY, FIRST STAGE
52614	PROSTATECTOMY, SECOND STAGE
52650	PROSTATECTOMY
52700	DRAINAGE OF PROSTATE ABSCESS
53215	REMOVAL OF URETHRA
53235	REMOVAL OF URETHRA LESION
53410	RECONSTRUCTION OF URETHRA
53415	RECONSTRUCTION OF URETHRA
53420	RECONSTRUCT URETHRA, STAGE 1
53425	RECONSTRUCT URETHRA, STAGE 2
53440	CORRECT BLADDER FUNCTION
53505	REPAIR OF URETHRA INJURY
53510	REPAIR OF URETHRA INJURY
53515	REPAIR OF URETHRA INJURY
53520	REPAIR OF URETHRA DEFECT
53600	DILATE URETHRA STRICTURE
53601	DILATE URETHRA STRICTURE
53605	DILATE URETHRA STRICTURE
53620	DILATE URETHRA STRICTURE
53621	DILATE URETHRA STRICTURE
53640	RELIEVE BLADDER RETENTION
54000	SLITTING OF PREPUCE
54001	SLITTING OF PREPUCE
54015	DRAIN PENIS LESION
54050	DESTRUCTION, PENIS LESION(S)
54055	DESTRUCTION, PENIS LESION(S)
54056	CRYOSURGERY, PENIS LESION(S)
54057	LASER SURG, PENIS LESION(S)
54060	EXCISION OF PENIS LESION(S)
54065	DESTRUCTION, PENIS LESION(S)
54100	BIOPSY OF PENIS
54105	BIOPSY OF PENIS
54110	TREATMENT OF PENIS LESION
54111	TREAT PENIS LESION, GRAFT
54112	TREAT PENIS LESION, GRAFT
54115	TREATMENT OF PENIS LESION
54120	PARTIAL REMOVAL OF PENIS
54125	REMOVAL OF PENIS
54130	REMOVE PENIS & NODES
54135	REMOVE PENIS & NODES
54150	CIRCUMCISION
54152	CIRCUMCISION
54160	CIRCUMCISION
54161	CIRCUMCISION
54200	TREATMENT OF PENIS LESION
54205	TREATMENT OF PENIS LESION
54220	TREATMENT OF PENIS LESION
54230	PREPARE PENIS STUDY
54240	PENIS PRESSURE STUDY
54250	TEST PENILE ERECTION
54300	REVISION OF PENIS
54304	REVISION OF PENIS
54308	RECONSTRUCTION OF URETHRA
54312	RECONSTRUCTION OF URETHRA
54316	RECONSTRUCTION OF URETHRA
54318	RECONSTRUCTION OF URETHRA
54322	RECONSTRUCTION OF URETHRA
54324	RECONSTRUCTION OF URETHRA
54326	RECONSTRUCTION OF URETHRA
54328	REVISE PENIS, URETHRA
54332	REVISE PENIS, URETHRA
54336	REVISE PENIS, URETHRA
54340	SECONDARY URETHRAL SURGERY
54344	SECONDARY URETHRAL SURGERY
54348	SECONDARY URETHRAL SURGERY
54352	RECONSTRUCT URETHRA, PENIS
54360	PENIS PLASTIC SURGERY
54380	REPAIR PENIS
54385	REPARI PENIS
54390	REPAIR PENIS AND BLADDER
54400	REVISION OF PENIS
54402	REMOVE PENIS PROSTHESIS
54405	PENIS PLASTIC SURGERY

PROCEDURES ALLOWED FOR MALES ONLY

54407	REMOVE PENIS PROSTHESIS
54409	REVISE PENIS PROSTHESIS
54420	REVISION OF PENIS
54430	REVISION OF PENIS
54435	REVISION OF PENIS
54440	REPAIR OF PENIS
54450	PREPUTIAL STRETCHING
54500	BIOPSY OF TESTIS
54505	BIOPSY OF TESTIS
54506	BIOPSY OF TESTES
54510	REMOVAL OF TESTIS LESION
54520	REMOVAL OF TESTIS
54521	REMOVAL OF TESTES
54530	REMOVAL OF TESTIS
54535	EXTENSIVE TESTIS SURGERY
54550	EXPLORATION FOR TESTIS
54555	EXPLORATION FOR TESTES
54560	EXPLORATION FOR TESTIS
54565	EXPLORATION FOR TESTES
54600	REDUCE TESTIS TORSION
54620	SUSPENSION OF TESTIS
54640	SUSPENSION OF TESTIS
54641	SUSPENSION OF TESTES
54645	SUSPENSION OF TESTIS, STAGE 2
54660	REVISION OF TESTIS
54661	REVISION OF TESTES
54670	REPAIR TESTIS INJURY
54680	RELOCATION OF TESTIS(ES)
54700	DRAINAGE OF SCROTUM
54800	BIOPSY OF EPIDIDYMIS
54820	EXPLORATION OF EPIDIDYMIS
54830	REMOVE EPIDIDYMIS LESION
54840	REMOVE EPIDIDYMIS LESION
54860	REMOVAL OF EPIDIDYMIS
54861	REMOVAL OF EPIDIDYMES
54900	FUSION OF SPERMATIC DUCTS
54901	FUSION OF SPERMATIC DUCTS
55000	DRAINAGE OF HYDORCELE
55040	REMOVAL OF HYDROCELE
55041	REMOVAL OF HYDROCELES
55060	REPAIR OF HYDROCELE
55100	DRAINAGE OF SCROTUM ABSCESS
55110	EXPLORE SCROTUM
55120	REMOVAL OF SCROTUM LESION
55150	REMOVAL OF SCROTUM
55175	REVISION OF SCROTUM
55180	REVISION OF SCROTUM
55200	INCISION OF SPERM DUCT
55250	REMOVAL OF SPERM DUCT(S)
55300	PREPARATION, SPERM DUCT X-RAY
55400	REPAIR OF SPERM DUCT
55401	REPAIR OF SPERM DUCTS
55450	LIGATION OF SPERM DUCT
55500	REMOVAL OF HYDROCELE
55520	REMOVAL OF SPERM CORD LESION
55530	REVISE SPERMATIC CORD VEINS
55535	REVISE SPERMATIC CORD VEINS
55540	REVISE HERNIA & SPERM VEINS
55600	INCISE SPERM DUCT POUCH
55601	INCISE SPERM DUCT POUCHES
55605	INCISE SPERM DUCT POUCH
55650	REMOVE SPERM DUCT POUCH
55651	REMOVE SPERM DUCT POUCHES
55680	REMOVE SPERM POUCH LESION
55700	BIOPSY OF PROSTATE
55705	BIOPSY OF PROSTATE
55720	DRAINAGE OF PROSTATE ABSCESS
55725	DRAINAGE OF PROSTATE ABSCESS
55740	REMOVAL OF PROSTATE STONE
55801	REMOVAL OF PROSTATE
55810	EXTENSIVE PROSTATE SURGERY
55812	EXTENSIVE PROSTATE SURGERY
55815	EXTENSIVE PROSTATE SURGERY
55821	REMOVAL OF PROSTATE
55831	REMOVAL OF PROSTATE
55840	EXTENSIVE PROSTATE SURGERY
55842	EXTENSIVE PROSTATE SURGERY
55845	EXTENSIVE PROSTATE SURGERY
55860	SURGICAL EXPOSURE, PROSTATE
55862	EXTENSIVE PROSTATE SURGERY
55865	EXTENSIVE PROSTATE SURGERY
55899	GENITAL SURGERY PROCEDURE
74440	XRAY EXAM MALE GENITAL TRACT
74441	XRAY EXAM MALE GENITAL TRACT

PROCEDURES ALLOWED FOR MALES ONLY

74445	X-RAY EXAM OF PENIS
74446	X-RAY EXAM OF PENIS
76870	ECHO EXAM OF SCROTUM
78760	NUCLEAR SCAN OF TESTES
78761	SCAN OF TESTES/BLOOD FLOW
80057	MALE ENDOCRINE PANEL
84403	RIA ASSAY BLOOD TESTOSTERONE
84405	RIA ASSAY URINE TESTOSTERONE
84406	ASSAY PROTEIN-TESTOSTERONE
89300	SEMEN ANALYSIS
89310	SEMEN ANALYSIS
89320	SEMEN ANALYSIS
89325	SPERM ANTIBODY TEST
89329	SPERM EVALUATION TEST

ASC MSA Wage Index and Constituent Counties

Code	MSA and Constituent Counties or County Equivalents			Wage Index
0040	Abilene, TX			.8485
	Callahan	Taylor		
0080	Akron, OH			1.0417
	Portage	Summit		
0120	Albany, GA			.8566
	Dougherty	Lee		
0160	Albany-Schenectady-Troy, NY			.9624
	Albany	Montgomery	Rensselaer	
	Saratoga	Schenectady		
0200	Albuquerque, NM			1.0009
	Bernalillo	Sandoval		
0220	Alexandria, LA			.9218
	Grant	Rapides		
0240	Allentown-Bethlehem-Easton, PA-NJ			1.0569
	Warren, NJ	Carbon, PA		
	Lehigh, PA	Northampton, PA		
0280	Altoona, PA			1.0219
	Blair			
0320	Amarillo, TX			.9233
	Potter	Randall		
0360	Anaheim-Santa Ana-Garden Grove, CA			1.2115
	Orange			
0380	Anchorage, AK			1.6461
	Anchorage			

Code	MSA and Constituent Counties or County Equivalents	Wage Index
0400	Anderson, IN	.9812
	Madison	
0405	Anderson, SC	.8814
	Anderson	
0440	Ann Arbor, MI	1.2446
	Washtenaw	
0450	Anniston, AL	.8400
	Calhoun	
0460	Appleton-Oshkosh, WI	1.0124
	Calumet Outagamie Winnebaga	
0470	Arecibo, PR	.6481
	Arecibo Camuy Hatillo	
0480	Asheville, NC	.9678
	Buncombe Madison	
0500	Athens, GA	.8812
	Clarke Jackson Madison Oconee	
0520	Atlanta, GA	.9162
	Butts Cherokee Clayton Cobb DeKalb Douglas Fayette Forsyth Fulton Gwinnett Henry Newton Paulding Rockdale Walton	
0560	Atlantic City, NJ	1.0174
	Atlantic	
0600	Augusta, GA-SC	.9237
	Columbia, GA Richmond, GA Aiken, SC	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
0640	Austin TX	.9859
	Hays Travis Williamson	
0680	Bakersfield, CA	1.1223
	Kern	
0720	Baltimore, MD	1.1698
	Anne Arundel Baltimore Carroll Harford Howard Baltimore City	
0733	Bangor, ME	.9239
	Penobscot	
0760	Baton Rouge, LA	.8813
	Ascension East Baton Rouge Livingston West Baton Rouge	
0780	Battle Creek, MI	1.0229
	Barry Calhoun	
0800	Bay City, MI	1.1238
	Bay	
0840	Beaumont-Port Arthur-Orange, TX	.8530
	Hardin Jefferson Orange	
0860	Bellingham, WA	1.0124
	Whatcom	
0870	Benton Harbor, MI	.8569
	Berrien	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
0880	Billings, MT	.9506
	Yellowstone	
0920	Biloxi-Gulfport, MS	.8143
	Hancock Harrison Stone	
0960	Binghamton, NY-PA	.9769
	Broome, NY Tioga, NY Susquehanna, PA	
1000	Birmingham, AL	.9658
	Jefferson St. Clair Shelby Walker	
1010	Bismarck, ND	.9118
	Burleigh Morton	
1020	Bloomington, IN	.9481
	Monroe	
1040	Bloomington-Normal, IL	.8913
	McLean	
1080	Boise City, ID	.9834
	Ada	
1123	Boston-Lowell-Brockton-Lawrence-Haverhill, MA	1.1277
	Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA	
1140	Bradenton, FL	.8631
	Manatee	
1150	Bremerton, WA	.8899
	Kitsap	

Code	MSA and Constituent Counties or County Equivalents			Wage Index
1163	Bridgeport-Stamford-Norwalk-Danbury, CT			1.1647
	Fairfield			
1240	Brownsville-Harlingen-San Benito, TX			.9312
	Cameron			
1260	Bryan-College Station, TX			.8377
	Brazos			
1280	Buffalo, NY			.9926
	Erie	Niagara		
1300	Burlington, NC			.8899
	Alamance			
1303	Burlington, VT			.9441
	Chittenden			
1310	Caguas, PR			.6007
	Caguas	Gurabo	SanLorenzo	
1320	Canton, OH			.9447
	Carroll	Stark		
1350	Caspar, WY			1.0506
	Natrona			
1360	Cedar Rapids, IA			.9193
	Linn			
1400	Champaign-Urbana-Rantoul, IL			1.1197
	Champaign			

Code	MSA and Constituent Counties or County Equivalents	Wage Index
1440	Charleston-North Charleston, SC	.9751
	Berkeley Charleston Dorchester	
1480	Charleston, WV	1.0628
	Kanawha Putnam	
1520	Charlotte-Gastonia, NC	.9456
	Gaston Mecklenburg Union	
1540	Charlottesville, VA	.9943
	Albemarle Fluvanna Greene Charlottesville City	
1560	Chattanooga, TN-GA	1.0226
	Catoosa, GA Dale, GA Walker, GA Hamilton, TN Marion, TX Sequatchie, TN	
1600	Chicago, IL	1.2061
	Cook DuPage Kane Lake McHenry Will	
1620	Chico, CA	1.0327
	Butte	
1640	Cincinnati, OH-KY-IN	1.0819
	Deaborn, IN Boone, KY Campbell, KY Kenton, KY Clearmont, OH Hamilton, OH Warren, OH	
1660	Clarksville-Hopkinsville, TN-KY	.8397
	Christian, KY Montgomery, TN	

Code	MSA and Constituent Counties or County Equivalents				Wage Index
1680	Cleveland, OH				1.1957
	Cuyahoga	Geauga			
	Lake	Medina			
1720	Colorado Springs, CO				.9743
	El Paso	Teller			
1740	Columbia, MO				1.1712
	Boone				
1760	Columbia, SC				.9743
	Lexington	Richland			
1800	Columbus, GA-AL				.9021
	Russell, AL	Chattahoochee, GA			
	Columbus City, GA				
1840	Columbus, OH				1.1184
	Delaware	Fairfield	Franklin		
	Madison	Pickway			
1880	Corpus Christi, TX				.9337
	Nueces	San Patricio			
1900	Cumberland, MD-WV				.8594
	Allegany, MD	Mineral, WV			
1920	Dallas-Fort Worth, TX				.9403
	Collin	Dallas	Denton	Ellis	
	Hood	Johnson	Kaufman		
	Parker	Rockwell	Tarrant	Wise	
1950	Danville, VA				.8807
	Pittsylvania	Danville City			
1960	Davenport-Rock Island-Moline IA-IL				.9695
	Henry, IL	Rock Island, IL			
	Scott, IA				

Code	MSA and Constituent Counties or County Equivalents	Wage Index
2000	Dayton, OH	1.1064
	Greene Miami Montgomery Preble	
2020	Daytona Beach, FL	.9423
	Volusia	
2040	Decatur, IL	.9506
	Macon	
2080	Denver-Boulder, CO	1.0960
	Adams Arapahoe Boulder Denver Douglas Gilpin Jefferson	
2120	Des Moines, IA	1.0156
	Polk Warren	
2160	Detroit, MI	1.2280
	Lapeer Livingston Macomb Oakland St. Clair Wayne	
2200	Dubuque, IA	.9426
	Dubuque	
2240	Duluth-Superior, MN-WI	.9193
	St. Louis, MN Douglas, WI	
2290	Eau Claire, WI	.9806
	Chippewa Eau Claire	
2320	El Paso, TX	.8714
	El Paso	
2330	Elkhart, IN	.8372
	Elkhart	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
2335	Elmira, NY	.9642
	Chemung	
2340	Enid, OK	.8785
	Garfield	
2360	Erie, PA	.9652
	Erie	
2400	Eugene-Springfield, OR	.9639
	Lane	
2440	Evansville, IN-KY	1.0742
	Gibson, IN Vanderburgh, IN Henderson, KY Posey, IN Warrick, IN	
2520	Fargo-Moorhead, ND-MN	.9478
	Clay, MN Cass, ND	
2560	Fayetteville, NC	.8353
	Cumberland	
2580	Fayetteville-Springdale, AR	.7997
	Benton Washington	
2640	Flint, MI	1.1919
	Genesee Shiawassee	
2650	Florence, AL	.8056
	Colbert Lauderdale	
2655	Florence, SC	.8328
	Florence	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
2670	Fort Collins, CO Larimer	.8353
2680	Fort Lauderdale-Hollywood, FL Broward	1.0506
2700	Fort Myers, FL Lee	.9391
2720	Fort Smith, AR-OK Crawford AR Sebastian, AR LeFlore, OK Sequoyah, OK	.8899
2750	Fort Walton Beach, FL Okaloosa	.7997
2760	Fort Wayne, IN Adams Allen DeKalb Wells	.8985
2840	Fresno, CA Fresno	1.1265
2880	Gadsden, AL Etowah	.9264
2900	Gainsville, FL Alachua	.9019
2920	Galveston-Texas City, TX Galveston	1.0607
2960	Gary-Hammond-East Chicago, IN Lake Porter	1.1664

Code	MSA and Constituent Counties or County Equivalents	Wage Index
2975	Glen Falls, NY	.9023
	Warren Washington	
2985	Grand Forks, ND-MN	.8779
	Polk, MN Grand Forks, ND	
3000	Grand Rapids, MI	.9463
	Kent Ottawa	
3040	Great Falls, MT	.9162
	Cascade	
3060	Greeley, CO	.9312
	Weld	
3080	Green Bay, WI	.9740
	Brown	
3120	Greensboro-Winston-Salem-High Point, NC	.9232
	Davidson Forsyth Guilford Randolph Stokes Yadkin	
3160	Greenville-Spartanburg, SC	.9371
	Greenville Pickens Spartanburg	
3180	Hagerstown, MD	1.0742
	Washington	
3200	Hamilton-Middleton, OH	1.0620
	Butler	
3240	Harrisburg, PA	1.0534
	Cumberland Dauphin Perry	
3283	Hartford-New Britain-Bristol, CT	1.1601
	Hartford Middlesex Tolland	

Code	MSA and Constituent Counties or County Equivalents			Wage Index
3290	Hickory, NC			.8454
	Alexander	Catawba		
3320	Honolulu, HI			1.1645
	Honolulu			
3360	Houston, TX			1.0630
	Brazoria	Fort Bend	Harris	
	Liberty	Montgomery	Waller	
3400	Huntington-Ashland, WU-KY-OH			.9270
	Boyd, KY	Greeup, KY		
	Lawrence, OH	Cabell, WV		
	Wayne, WV			
3440	Huntsville, AL			.8593
	Limestone	Madison		
	Marshall			
3480	Indianapolis, IN			1.0519
	Boone	Hamilton	Hancock	
	Hendricks	Johnson	Marion	
	Morgan	Shelby		
3500	Iowa City, IA			1.1780
	Johnson			
3520	Jackson, MI			1.0173
	Jackson			
3560	Jackson, MS			.8699
	Hinds	Rankin		
3600	Jacksonville, FL			.9331
	Baker	Clay	Duval	
	Nassau	St. James		

Code	MSA and Constituent Counties or County Equivalents	Wage Index
3605	Jacksonville, NC	.8936
	Onslow	
3620	Janesville, Beloit, WI	.8579
	Rock	
3640	Jersey City, NJ	1.1180
	Hudson	
3660	Johnson City-Kingsport-Bristol, TN-VA	.8786
	Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA	
3680	Johnstown, PA	1.0445
	Cambria Somerset	
3710	Joplin, MO	.8500
	Jasper Newton	
3720	Kalamazoo-Portage, MI	1.1695
	Kalamazoo Van Buren	
3740	Kankakee, IL	1.0073
	Kankakee	
3760	Kansas City, MO-KS	.9427
	Johnson, KS Wyandotte, KS Cass, MO Clay, MO Jackson, MO Platte, MO Ray, MO	
3800	Kenosha, WI	1.0789
	Kenosha	

Code	MSA and Constituent Counties or County Equivalents		Wage Index
3810	Killeen-Temple, TX		.8868
	Bell	Coryell	
3840	Knoxville, TN		.9100
	Anderson Knox	Blunt Union	
3850	Kokomo, IN		.9846
	Howard	Tipton	
3870	La Crosse, WI		.9016
	LaCrosse		
3880	Layfayette, LA		.8622
	Lafayette		
3920	Lafayette-West Lafayette, IN		.9141
	Tippecanoe		
3960	Lake Charles, LA		.8706
	Calcasieu		
3980	Lakeland-Winter Haven, FL		.9749
	Polk		
4000	Lancaster, PA		1.0674
	Lancaster		
4040	Lansing-East Lansing, MI		1.0811
	Clinton Ingham	Eaton Ionia	
4080	Laredo, TX		.8593
	Webb		

Code	MSA and Constituent Counties or County Equivalents	Wage Index
4100	Las Cruces, NM	.8129
	Dona Ana	
4120	Las Vegas, NV	1.1884
	Clark	
4150	Lawrence, KS	.9193
	Douglas	
4200	Lawton, OK	.8377
	Comanche	
4243	Lewiston-Auborn, ME	.8899
	Androsoggin	
4280	Lexington-Fayette, KY	.9016
	Bourbon Clark Fayette Jessamine Scott Woodford	
4320	Lima, OH	.9932
	Allen Auglaize Putnam Van Wert	
4360	Lincoln, NE	.9259
	Lancaster	
4400	Little Rock-North Little Rock, AR	1.0205
	Pulaski Saline	
4410	Long Branch-Asbury Park, NJ	1.0648
	Monmouth	
4420	Long View, TX	.8129
	Gregg Harrison	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
4440	Lorain-Elyria, OH	1.0207
	Lorain	
4480	Los Angeles-Long Beach, CA	1.2899
	Los Angeles	
4520	Louisvile, KY-IN	.9920
	Clark, ID Floyd, ID Bullitt, Ky Jefferson, KY Oldham, KY	
4600	Lubbock, TX	.9042
	Lubbock	
4640	Lynchburg, VA	.8876
	Amherst Appomattox Campbell Lynchburg City	
4680	Macon, GA	.9637
	Bibb Houston Jones Twiggs	
4720	Madison, WI	1.0257
	Dane	
4763	Manchester-Nashua, NH	.9441
	Hillsborough	
4800	Mansfield, OH	.9196
	Richland	
4840	Mayaguez, PR	.5902
	Anasco Hormigueros Mayaguez	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
4880	McAllen-Pharr-Edinburg, TX	.8165
	Hidalgo	
4890	Medford, OR	.9668
	Jackson	
4900	Melbourne-Titusville-Cocoa, FL	.9374
	Brevard	
4920	Memphis, TN-AR-MS	1.0371
	Crittenden, AR DeSoto, MS Shelby, TN Tipton, TN	
5000	Miami, FL	1.1050
	Dade	
5040	Midland, TX	.9141
	Midland	
5080	Milwaukee, WI	1.0080
	Milwaukee Ozaukee Washington Waukesha	
5120	Minneapolis-St. Paul, MN-WI	.9802
	Anoka, MN Carver, MN Chisago, MN Dakota, MN Hennepin, MN Ramsey, MN Scott, MN Washington, MN Wright, WI St. Croix, WI	
5160	Mobile, AL	.9416
	Baldwin Mobile	
5170	Modesto, CA	1.0508
	Stanislaus	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
5200	Monroe, LA	.9451
	Ouachita	
5240	Montgomery, AL	.9626
	Autauga Elmore Montgomery	
5280	Muncie, IN	.9852
	Delaware	
5320	Muskegon-Norton Shores-Muskegon Heights, MI	.9658
	Muskegon Oceana	
5360	Nashville-Davidson, TN	1.0187
	Cheatham Davidson Dickson Robertson Rutherford Sumner Williamson Wilson	
5380	Nassau-Suffolk, NY	1.2758
	Nassau Suffolk	
5403	New Bedford-Fall River, MA	.9687
	Bristol	
5460	New Brunswick-Perth Amboy-Sayreville, NJ	1.0409
	Middlesex	
5483	New Haven-Waterbury-Meriden, CT	1.0990
	New Haven	
5523	New London-Norwich, CT	1.0903
	New London	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
5560	New Orleans, LA Jefferson Orleans St. Bernard St. Tammany	.9644
5600	New York, NY-NJ Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY Bergen, NJ	1.3956
5640	Newark, NJ Essex Morris Somerset Union	1.2099
5645	Newark, OH Licking	.9592
5660	Newburgh-Middletown, NY Orange	1.0789
5680	Newport News-Hampton, VA Hampton City Williamsburg City Newport News City Gloucester York James City Poquoson	.8974
5720	Norfolk-Virginia Beach-Portsmouth, VA-NC Chesapeake City, VA Norfolk City, VA Portsmouth City, VA Virginia Beach City, VA Currituck, NC	.9887
5745	Northeast Pennsylvania Lackawanna Luzerne Monroe	1.0598
5790	Ocala, FL Marion	.9306
5800	Odessa, TX Ector	.9506

Code	MSA and Constituent Counties or County Equivalents	Wage Index
5880	Oklahoma City, OK	.9252
	Canadian Cleveland McClain Oklahoma Pottawatomie	
5910	Olympia, WA	1.0142
	Thurston	
5920	Omaha, NE-IA	.9425
	Pottawattamie, IA Douglas, NE Sarpy, NE	
5960	Orlando, FL	.9087
	Orange Osceola Seminole	
5990	Owensboro, KY	.8377
	Daviess	
6000	Oxnard-Simi Valley-Ventura, CA	1.3788
	Ventura	
6015	Panama City, FL	.8777
	Bay	
6020	Parkersburg-Marietta, WV-OH	1.0461
	Washington Wirt Wood	
6025	Pascagoula-Moss Point, MS	1.1547
	Jackson	
6040	Paterson-Clifton-Passaic, NJ	1.0959
	Passaic	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
6080	Pensacola, FL	.8841
	Escambia Santa Rosa	
6120	Peoria, IL	1.1130
	Peoria Tazewell Woodford	
6140	Petersburg-Colonial Heights-Hopewell, VA	.9484
	Dinwiddie Prince George Colonial Heights City Hopewell City Petersburg City	
6160	Philadelphia, PA-NJ	1.1810
	Burlington, NJ Camden, NJ Gloucester, NJ Bucks, PA Chester, PA Delware, PA Montgomery, PA Philadephia, PA	
6200	Phoenix, AZ	1.1100
	Maricopa	
6240	Pine Bluff, AR	.7997
	Jefferson	
6280	Pittsburgh, PA	1.1275
	Allegheny Beaver Washington Westmoreland	
6323	Pittsfield, MA	1.0276
	Berkshire	
6360	Ponce, PR	.7832
	Juana Diaz Ponce Villalba	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
6403	Portland, ME	1.0032
	Cumberland Sagadahoc	
6440	Portland, OR-WA	1.1034
	Clackamas, OR Multnomah, OR Washington, OR Clark, WA	
6450	Portsmouth-Dover-Rochester, NH-ME	.8115
	Rockingham, NH Strafford, NH York, ME	
6460	Poughkeepsie, NY	1.1151
	Dutchess	
6480	Providence-Warwick-Pawtucket, RI	1.0349
	Bristol Kent Providence Washington	
6520	Provo-Orem, UT	.9454
	Utah	
6560	Pueblo, Co	1.0981
	Pueblo	
6600	Racine, WI	.9240
	Racine	
6640	Raleigh-Durham, NC	1.0173
	Durham Orange Wake	
6680	Reading, PA	1.0101
	Berks	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
6690	Redding, CA	1.0271
	Shasta	
6720	Reno, NV	1.2428
	Washoe	
6740	Richland-Kennewick, WA	.9935
	Benton Franklin	
6760	Richmond, VA	.9252
	Charles City Chesterfield Goochland Hanover Henrico New Kent Powhatan Richmond City	
6780	Riverside-San Bernadino-Ontario, CA	1.1729
	Riverside San Bernardino	
6800	Roanoke, VA	.9614
	Botetourt Craig Roanoke Roanoke City Salem City	
6820	Rochester, MN	.9852
	Olmsted	
6840	Rochester, NY	1.0653
	Livingston Monroe Ontario Orleans Wayne	
6880	Rockford, IL	1.0222
	Boone Winnebago	
6885	Rock Hill, SC	.9136
	York	

Code	MSA and Constituent Counties or County Equivalents			Wage Index
6920	Sacramento, CA			1.2231
	Placer	Sacramento	Yolo	
6960	Saginaw, MI			1.1279
	Saginaw			
6980	St. Cloud, MN			.8680
	Benton Stearns	Sherburne		
7000	St. Joseph, MO			.9749
	Andres	Buchanan		
7040	St. Louis, MO-IL			.9977
	Clinton, IL St. Clair, IL St. Charles, MO	Madison, IL Franklin, MO St. Louis, MO	Monroe, IL Jefferson, MO St. Louis City, MO	
7080	Salem, OR			1.1083
	Mario	Polk		
7120	Salinas-Seaside-Monteray, CA			1.2428
	Monterey			
7140	Salisbury-Concord, NC			1.0368
	Cabarrus	Rowan		
7160	Salt Lake City-Ogden, UT			.8550
	Davis Tooele	Salt Lake Weber		
7200	San Angelo, TX			.8364
	Tom Green			
7240	San Antiono, TX			.9509
	Bexar	Comal	Gudalupe	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
7320	San Diego, CA	1.1426
	San Diego	
7360	San Francisco-Oakland, CA	1.3153
	Alameda Contra Costa Marin San Francisco San Mateo	
7400	San Jose, CA	1.3055
	Santa Clara	
7440	San Juan, PR	.6806
	Bayamon Canovanas Carolina Catano Guaynabo Loiza San Juan Toa Baja Trujillo Alto	
7480	Santa Barbara-Santa Marie-Lompoc, CA	1.0628
	Santa Barbara	
7485	Santa Cruz, CA	1.0985
	Santa Cruz	
7500	Santa Rosa, CA	1.4037
	Sonoma	
7510	Sarasota, FL	.9835
	Sarasota	
7520	Savannah, GA	.9414
	Bryan Chatham Effingham	
7600	Seattle-Everett, WA	1.0500
	King Snohomish	

Code	MSA and Constituent Counties or County Equivalents			Wage Index
7610	Sharon, PA			.9618
	Mercer			
7620	Sheboygan, WI			.8439
	Sheboygan			
7640	Sherman-Dension, TX			.8277
	Grayson			
7680	Shreveprt, LA			.9292
	Bossier	Caddo	Webster	
7720	Sioux City, IA-NE			.9306
	Woodbury, IA	Dakota, NE		
7760	Sioux Falls, SD			.8844
	Minnehaha			
7800	South Bend, IN			.9156
	Marshall	St. Joseph		
7840	Spokane, WA			1.0921
	Spokane			
7880	Springfield, IL			1.0230
	Menard	Sangamon		
7920	Springfield, MO			.8933
	Christian	Greene		
7960	Springfield, OH			.9821
	Champaign	Clark		

Code	MSA and Constituent Counties or County Equivalents	Wage Index
8000	Springfield-Chicopee-Holyoke, MA	1.0285
	Hampden Hampshire	
8050	State College, PA	1.1034
	Centre	
8080	Steubenville-Weirton, OH-WV	.9750
	Jefferson, OH Brooke, WV Hancock, WV	
8120	Stockton, CA	1.3046
	San Joaquin	
8160	Syracuse, NY	1.3209
	Madison Onondaga Oswego	
8200	Tacoma, WA	1.0558
	Pierce	
8240	Tallahasee, FL	.9264
	Leon Wakulla	
8280	Tampa-St. Pertersburg, FL	.9898
	Hillsborough Pasco Pinellas	
8320	Terre Haute, IN	.8734
	Clay Sullivan Vermillion Vigo	
8360	Texarkana-TX-Texarkana, AR	1.0929
	Little River, AR Miller, AR Bowie, TX	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
8400	Toledo, OH-MI	1.1157
	Monroe, MI Lucas, OH Wood, OH Fulton, OH Ottawa, OH	
8440	Topeka, KS	1.0602
	Jefferson Shawnee Osage	
8480	Trenton, NJ	1.1708
	Mercer	
8520	Tucson, AZ	.9977
	Pima	
8560	Tulsa, OK	.9626
	Creek Rogers Mays Tulsa Osage Wagoner	
8600	Tuscaloosa, AL	1.0142
	Tuscaloosa	
8640	Tyler, TX	.9481
	Smith	
8680	Utica-Rome, NY	1.0145
	Herkimer Oneida	
8720	Vallejo-Fairfield-Napa, CA	1.5862
	Napa Solano	
8750	Victoria, TX	.8356
	Victoria	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
8760	Vineland-Millville-Birdgeton, NJ	1.0083
	Cumberland	
8780	Visalia-Tulare-Portenville, CA	1.3627
	Tulare	
8800	Waco, TX	.8593
	McLennan	
8840	Washington, DC-MD-VA	1.1547
	Charles, MD Montgomery, MD Prince Georges, MD Alexandria City, VA Arlington, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Loudoun, VA Prince William, VA Manassas City, VA Manassas Park City, VA	
8920	Waterloo-Cedar Falls, IA	.8631
	Black Hawk	
8940	Wausau, WI	.9769
	Marathon	
8960	West Palm Beach-Boca Raton, FL	.9632
	Palm Beach	
9000	Wheeling, WV-OH	1.0158
	Belmont, OH Marshall, WV Ohio, WV	
9040	Wichita, KS	1.0248
	Butler Sedgwick	
9080	Wichita Falls, TX	.8282
	Clay Wichita	

Code	MSA and Constituent Counties or County Equivalents	Wage Index
9140	Williamsport, PA Lycoming	.9749
9160	Wilmington, DE-NJ-MD New Castle, DE Cecil, MD Salem, NJ	1.0917
9200	Wilmington, NC Brunswick New Hanover	.8936
9243	Worcester-Fitchburg-Leominster, MA Worcester	.9769
9260	Yakima, WA Yakima	.9523
9280	York, PA Adams York	.9884
9320	Youngstown-Warren, OH Mahoning Trumbull	1.1090
9340	Yuba City, CA Sutter Yuba	1.0726

Code	Non-MSA Area	Wage Index
01	Alabama	.8960
02	Alaska	1.5579
03	Arizona	1.0289
04	Arkansas	.8686
05	California	1.2415
06	Colorado	.8990
07	Connecticut	1.1817
08	Delaware	1.0370
10	Florida	.9980
11	Georgia	.9463
12	Hawaii	1.3452
13	Idaho	.9669
14	Illinois	.9650
15	Indiana	.9863
16	Iowa	.9220
17	Kansas	.9009
18	Kentucky	.9233
19	Louisiana	.9216
20	Maine	.9926
21	Maryland	1.1028
22	Massachusetts	1.1722
23	Michigan	1.1535
24	Minnesota	.9052
25	Mississippi	.8751
26	Missouri	.9156
27	Montana	.9595
28	Nebraska	.8130
29	Nevada	1.0790
30	New Hampshire	1.1301
31	New Jersey	1.0820
32	New Mexico	1.0073
33	New York	1.0327
34	North Carolina	.9917
35	North Dakota	.9045
36	Ohio	1.0086
37	Oklahoma	.9111
38	Oregon	1.0673
39	Pennsylvania	1.1371
40	Puerto Rico	.6438
41	Rhode Island	1/
42	South Carolina	.9180
43	South Dakota	.8237
44	Tennessee	.8779
45	Texas	.8979

Code	Non-MSA Area	Wage Index
46	Utah	.8552
47	Vermont	.9993
49	Virginia	.9792
50	Washington	1.0465
51	West Virginia	1.0123
52	Wisconsin	.9179
53	Wyoming	1.0402

1/ Not Applicable. All of Rhode Island is classified as urban.

ADDENDUM H - DME, PROSTHETICS AND ORTHOTICS HCPCS CODES AND DEFINITIONS

	PAGE
Inexpensive or Routinely Purchased	H - 2
Items Requiring Frequent Maintenance	H - 8
Prosthetics and Orthotics	H - 9
Capped Rental	H - 48
Oxygen	H - 54
Need Prescription Before Delivery	H - 57

INEXPENSIVE OR ROUTINELY PURCHASED

E0100 (b)	CANE, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIP
E0105 (b)	CANE, QUAD OR THREE PRONG, INCLUDES CANES OF ALL MATERIALS, ADJUSTABLE OR FIXED, WITH TIPS
E0110 (b)	CRUTCHES, FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS, ADJUSTABLE OR FIXED, PAIR, COMPLETE WITH TIPS AND HANDGRIPS
E0111 (b)	CRUTCH FOREARM, INCLUDES CRUTCHES OF VARIOUS MATERIALS,
E0112 (i)	CRUTCHES UNDERARM, WOOD, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS
E0113 (i)	CRUTCH UNDERARM, WOOD, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP
E0114 (i)	CRUTCHES UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED, PAIR, WITH PADS, TIPS AND HANDGRIPS
E0116 (i)	CRUTCH UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED, EACH, WITH PAD, TIP AND HANDGRIP
E0130 (i)	WALKER, RIGID (PICKUP), ADJUSTABLE OR FIXED HEIGHT
E0135 (i)	WALKER, FOLDING (PICKUP), ADJUSTABLE OR FIXED HEIGHT
E0141 (i)	WALKER WHEELED, WITHOUT SEAT
E0142 (i)	RIGID WALKER, WHEELED, WITH SEAT
E0143 (i)	FOLDING WALKER, WHEELED, WITHOUT SEAT
E0147 (r)	HEAVY DUTY, MULTIPLE BREAKING SYSTEM, VARIABLE WHEEL RESISTANCE WALKER
E0150 (b)	UNDERARM PAD, CRUTCH, REPLACEMENT, EACH
E0151 (b)	HANDGRIP, CANE, CRUTCH, OR WALKER REPLACEMENT, EACH
E0152 (b)	TIP, CANE OR CRUTCH WALKER REPLACEMENT, EACH
E0153 (i)	PLATFORM ATTACHMENT, FOREARM CRUTCH, EACH
E0154 (i)	PLATFORM ATTACHMENT, WALKER, EACH

INEXPENSIVE OR ROUTINELY PURCHASED

E0155 (b)	WHEEL ATTACHMENT, RIGID PICK-UP WALKER ATTACHMENTS
E0156 (b)	SEAT ATTACHMENT, WALKER
E0157 (i)	CRUTCH ATTACHMENT, WALKER, EACH
E0158 (b)	LEG EXTENSIONS FOR A WALKER
E0160 (i)	SITZ TYPE BATH, PORTABLE, FITS OVER COMMODE SEAT
E0161 (b)	SITZ TYPE BATH, PORTABLE, FITS OVER COMMODE SEAT, WITH FAUCET ATTACHMENTS
E0163 (i)	COMMODE CHAIR, STATIONARY, WITH FIXED ARMS
E0164 (i)	COMMODE CHAIR, MOBILE, WITH FIXED ARMS
E0167 (b)	PAIL OR PAN FOR USE WITH COMMODE CHAIR
E0184 (r)	FLOTATION MATTRESS, DRY
E0185 (i)	DECUBITUS CARE PAD, FLOTATION OR GEL PAD WITH FOAM LEVELING PAD (MATTRESS SIZE)
E0188 (b)	SYNTHETIC SHEEPSKIN PAD
E0189 (b)	LAMBSWOOL SHEEPSKIN PAD, ANY SIZE
E0195 (b)	REPLACEMENT PAID FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY THE PATIENT
E0200 (i)	HEAT LAMP, WITHOUT STAND (TABLE MODEL), INCLUDES BULB, OR INFRARED ELEMENT
E0205 (b)	HEAT LAMP, WITH STAND, INCLUDES BULB, OR INFRARED ELEMENT
E0210 (b)	ELECTRIC HEAT PAD, STANDARD
E0215 (b)	ELECTRIC HEAT PAD, MOIST
E0237 (r)	WATER CIRCULATING HEAT PAD WITH PUMP
E0238 (b)	NONELECTRIC HEAT PAD, MOIST
E0239 (b)	HYDROCOLLATOR UNIT, PORTABLE

INEXPENSIVE OR ROUTINELY PURCHASED

E0271 (r)	MATTRESS, INNERSPRING
E0275 (b)	BED PAN, STANDRAD, METAL, OR PLASTIC
E0276 (b)	BED PAN, FRACTURE, METAL OR PLASTIC
E0310 (I)	BED SIDE RAILS, FULL LENGTH
E0325 (b)	URINAL, MALE, ANY MATERIAL
E0326 (b)	URINAL, FEMALE, ANY MATERIAL
E0330 (b)	URINAL, MALE, DAY/NIGHT
E0560 (b)	HUMIDIFIER, DURABLE FOR SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENT OR OXYGEN DELIVERY, E.G., CASCADE JR.
E0605 (b)	VAPORIZER, ROOM TYPE
E0607 (r)	HOME BLOOD GLUCOSE MONITOR
E0609 (r)	BLOOD GLUCOSE MONITOR WITH SPECIAL FEATURES (EG., VOICE SYNTHESIZERS AUTOMATIC TIMERS, ECT.)
E0610 (i)	PACEMAKER MONITOR, SELF-CONTAINED, (CHECKS BATTERY DEPLETION, INCLUDED AUDIBLE AND VISIBLE CHECK SYSTEMS)
E0615 (i)	PACEMAKER MONITOR, SELF-CONTAINED, (CHECKS BATTERY DEPLETION, AND OTHER PACEMAKER COMPONENTS, INCLUDES DIGITAL/VISIBLE CHECK SYSTEMS)
E0620 (r)	SEAT LIFT CHAIR, MOTORIZED TO ASSIST PATIENT IN STANDING AND SITTING
E0621 (b)	SLING OR SEAT, PATIENT LIFT, CANVAS OR NYLON
E0650 (r)	PNEUMATIC COMPRESSOR, NONSEGMENTAL HOME MODEL, (LYMPHEDEMA PUMP)
E0651 (r)	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL, (LYMPHEDEMA PUMP) WITHOUT CALIBRATED GRADIENT PRESSURE
E0655 (i)	PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF ARM
E0660 (i)	PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL LEG

INEXPENSIVE OR ROUTINELY PURCHASED

E0665 (i)	PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, FULL ARM
E0666 (r)	PNEUMATIC APPLIANCE FOR USE WITH PNEUMATIC COMPRESSOR, HALF LEG
E0667 (r)	PNEUMATIC APPLIANCE FOR USE WITH SEGMENTAL PNEUMATIC COMPRESSOR, LEG
E0690 (r)	ULTRAVIOLET CABINET, APPROPRIATE FOR HOME USE
E0747 (r)	OSTEOGENESIS STIMULATOR (NON-INVASIVE)
E0776 (I)	IV POLE
E0782 (b)	INFUSION PUMP, IMPLANTABLE
E0840 (i)	TRACTION FRAME, ATTACHED TO HEADBOARD, SIMPLE CERVICAL TRACTION
E0850 (i)	TRACTION STAND, FREE STANDING, SIMPLE CERVICAL TRACTION
E0860 (b)	TRACTION EQUIPMENT, OVERDOOR, CERVICAL
E0870 (i)	TRACTION FRAME, ATTACHED TO FOOTBOARD, SIMPLE EXTREMITY TRACTION, (E.G., BUCK'S)
E0880 (i)	TRACTION STAND, FREE STANDING, (E.G., BUCK'S'
E0890 (i)	TRACTION FRAME, ATTACHED TO FOOTBOARD, SIMPLE PELVIC TRACTION
E0900 (i)	TRACTION STAND, FREE STANDING, SIMPLE PELVIC TRACTION (E.G., BUCK'S)
E0942 (b)	CERVICAL HEAD HARNESS/HALTER
E0944 (b)	PELVIC BELT/HARNESS/BOOT
E0945 (b)	EXTREMITY BELT/HARNESS
E0947 (b)	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX PELVIC TRACTION
E0948 (b)	FRACTURE FRAME, ATTACHMENTS FOR COMPLEX CERVICAL TRACTION

INEXPENSIVE OR ROUTINELY PURCHASED

E0953 (b)	PNEUMATIC TIRE, EACH
E0954 (b)	SEMI-PNEUMATIC CASTER, EACH
E0959 (i)	AMPUTEE ADAPTER (DEVICE USED TO COMPENSATE FOR TRANSFER OF WEIGHT DUE TO LOST LIMBS TO MAINTAIN PROPER BALANCE)
E0961 (b)	BRAKE EXTENSION, FOR WHEELCHAIR
E0962 (b)	1" CUSHION, FOR WHEELCHAIR
E0963 (b)	2" CUSHION, FOR WHEELCHAIR
E0964 (b)	3" CUSHION, FOR WHEELCHAIR
E0965 (b)	4" CUSHION, FOR WHEELCHAIR
E0966 (b)	HOOK ON HEAD REST EXTENSION
E0967 (b)	WHEELCHAIR HAND RIMS WITH 8 VERTICAL RUBBER TIPPED PROJECTIONS, PAIR
E0969 (i)	NARROWING DEVICE, WHEELCHAIR
E0970 (b)	NO. 2 FOOTPLATES, EXCEPT FOR ELEVATING LEG REST
E0971 (b)	ANTI-TIPPING DEVICE WHEELCHAIRS
E0972 (b)	TRANSFER BOARD, WHEELCHAIR
E0973 (b)	ADJUSTABLE HEIGHT DETACHABLE ARMS, DESK OR FULL LENGTH, WHEELCHAIR
E0975 (b)	REINFORCED SEAT UPHOLSTERY, WHEELCHAIR
E0976 (b)	REINFORCED BACK UPHOLSTERY, WHEELCHAIR
E0990 (b)	ELEVATING LEG REST, EACH
E0991 (b)	UPHOLSTERY SEAT
E0992 (b)	SOLID SEAT INSERT
E0993 (b)	BACK UPHOLSTERY
E0994 (b)	ARM REST, EACH

INEXPENSIVE OR ROUTINELY PURCHASED

E0995 (b)	CALF REST, EACH
E0996 (b)	TIRE, SOLID, EACH
E0997 (b)	CASTER WITH A FORK
E0998 (b)	CASTER WITHOUT FORK
E0999 (b)	PNEUMATIC TIRE WITH WHEEL
E1000 (b)	TIRE, PNEUMATIC CASTER
E1001 (b)	WHEEL, SINGLE
E1005 (b)	REPLACEMENT, BATTERIES FOR MEDICALLY NECESSARY ELECTRIC WHEELCHAIR OWNED BY THE PATIENT
E1065 (r)	POWER ATTACHMENT (TO CONVERT ANY WHEELCHAIR TO MOTORIZED WHEELCHAIR, E.G., SOLO)
E1066 (r)	BATTERY CHARGER
E1069 (b)	DEEP CYCLE BATTERY
E1226 (r)	FULL RECLINING BACK FOR CUSTOMIZED WHEELCHAIR
E1227 (r)	SPECIAL HEIGHT ARMS FOR WHEELCHAIR
E1230 (r)	POWER OPERATED VEHICLE (3WHEEL NONHIGHWAY) INDICATE BRAND NAME AND MODEL NUMBER
E1296 (r)	SPECIAL WHEELCHAIR SEAT HEIGHT FROM FLOOR
E1297 (r)	SPECIAL WHEELCHAIR SEAT DEPTH, BY UPHOLSTERY
E1298 (r)	SPECIAL WHEELCHAIR SEAT DEPTH AND/OR WIDTH, BY CONSTRUCTION
E1356 (b)	BREATHING CIRCUITS
E1372 (i)	IMMERSION EXTERNAL HEATER FOR NEBULIZER

i = INEXPENSIVE

r = ROUTINE

b = BOTH

ITEMS REQUIRING FREQUENT MAINTENANCE

E0450	VOLUME VENTILATOR
E0451	VOLUME VENTILATOR, PORTABLE
E0500	IPPB MACHINES WITH MANUAL VALVES EXTERNAL POWER SOURCE, INCLUDES CYCLINDER REGULATOR, BUILT-IN NEBULIZATION
E0505	IPPB MACHINES WITH MANUAL VALUES ELECTRICALLY DRIVEN WITH INTERNAL POWER SOURCE, BUILT-IN NEBULIZATION
E0510	IPPB MACHINES WITH AUTOMATIC VALVES, EXTERNAL POWER SOURCE INCLUDES CYLINDER REGULATOR, BUILT-IN NEBULIZATION
E0515	IPPB MACHINES WITH AUTOMATIC VALVES, ELECTRICALLY DRIVEN WITH INTERNAL COMPRESSOR, BUILT-IN NEBULIZATION
E0570	NEBULIZER, WITH COMPRESSOR E.G., DEVILBISS PULMO-AID
E0575	NEBULIZER, SELF-CONTAINED, ULTRASONIC
E0585	NEBULIZER, WITH COMPRESSOR AND HEATER
E0600	SUCTION PUMP, HOME MODEL, PORTABLE
E0601	NASAL CONTINUOUS AIRWAY PRESSURE (CPAP) DEVICE
E0674	IRON LUNG
E0935	PASSIVE MOTION EXERCISE DEVICE
E1375	NEBULIZER PORTABLE WITH SMALL COMPRESSOR, WITH LIMITED FLOW

PROSTHETICS AND ORTHOTICS

A4214	STERILE SALINE OR WATER, 30 CC VIAL
A4252	IRRIGATION KITS, NONSTERILE
A4341	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, TEFLON
A4342	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, LATEX
A4343	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, LATEX WITH TEFLON COATING
A4344	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE
A4345	INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, SILICONE WITH ELASTOMER COATING
A4346	INDWELLING CATHETER, FOLEY TYPE, THREE WAY, LATEX OR TEFLON FOR CONTINUOUS IRRIGATION
A4347	EXTERNAL CATHETER, CONDOM TYPE
A4348	URINARY COLLECTION AND RETENTION SYSTEM, DRAINAGE BAG WITH TUBE
A4349	URINARY COLLECTION AND RETENTION SYSTEM, LEG BAG WITH TUBE
A4350	CATHETER CARE KIT
A4353	CATHETER INSERTION TRAY WITH CATHETER INCLUDING TUBING AND DRAINAGE BAG
A4354	CATHETER INSERTION TRAY WITHOUT CATHETER INCLUDING TUBING AND DRAINAGE BAG
A4355	3-WAY IRRIGATION SET FOR CATHETER EXTERNAL URINARY SUPPLIES
A4356	INCONTINENCE CLAMP
A4357	URINARY DRAINAGE BAG
A4358	URINARY LEG BAG
A4359	URINARY SUSPENSORY
A4360	COLOSTOMY SET

PROSTHETICS AND ORTHOTICS

A4361	OSTOMY FACE PLATE
A4362	OSTOMY SKIN BARRIER
A4363	OSTOMY LIQUID BARRIER
A4364	OSTOMY SKIN BOND OR CEMENT
A4365	OSTOMY BAG, DISPOSABLE/CLOSED
A4366	OSTOMY BAG, REUSEABLE OR DRAINABLE
A4367	OSTOMY BELT
A4368	STOMA WICKS
A4369	TAIL CLOSURES
A4370	OSTOMY SKIN BOND OR CEMENT, REMOVER
A4380	ILEOSTOMY SET
A4390	ILEAL BLADDER SET
A4400	IRRIGATION SET FOR IRRIGATION OF OSTOMY
A4402	OSTOMY LUBRICANT
A4404	OSTOMY RINGS
A4421	NOT OTHERWISE CLASSIFIED OSTOMY SUPPLIES
A4430	URETEROSTOMY SET
A4440	NOT OTHERWISE CLASSIFIED URETEROSTOMY SUPPLIES
E0720	TENS, TWO LEAD, LOCALIZED STIMULATION
E0730	TENS, FOUR LEAD, LARGER, AREA/MULTIPLE NERVE STIMULATION
E0740	REPLACEMENT BATTERIES FOR MEDICALLY NECESSARY TENS OWNED BY THE PATIENT
E1373	TRACHEOTOMY MASK OR COLLAR
L0100	CERVICAL, CRANIOSTENOSIS, HELMET MOLDED TO PATIENT MODEL
L0110	CERVICAL, CRANIOSTENOSIS, HELMET, NONMOLDED

PROSTHETICS AND ORTHOTICS

L0120	CERVICAL, FLEXIBLE, NONADJUSTABLE (FOAM COLLAR)
L0130	CERVICAL, FLEXIBLE, THERMOPLASTIC COLLAR, MOLDED TO PATIENT
L0140	CERVICAL, SEMI-RIGID, ADJUSTABLE (PLASTIC COLLAR)
L0150	CERVICAL, SEMI-RIGID, ADJUSTABLE MOLDED CHIN CUP (PLASTIC COLLAR WITH MANDIBULAR/OCCIPITAL PIECE)
L0160	CERVICAL, SEMI-RIGID, WIRE FRAME OCCIPITAL/MANDIBULAR SUPPORT
L0170	CERVICAL, COLLAR, MOLDED TO PATIENT MODEL
L0172	CERVICAL, COLLAR, SEMI-RIGID THERMOPLASTIC FOAM, TWO PIECE
L0174	CERVICAL, COLLAR, SEMI-RIGID, THERMOPLASTIC FOAM, TWO PIECE WITH THORACIC EXTENSION
L0180	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE
L0190	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MADNIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS (SOMI, GUILFORD, TAYLOR TYPES)
L0200	CERVICAL, MULTIPLE POST COLLAR, OCCIPITAL/MANDIBULAR SUPPORTS, ADJUSTABLE CERVICAL BARS AND THORACIC EXTENSION
L0210	THORACIC, RIB BELT, CUSTOM FITTED
L0220	THORACIC, RIB BELT, CUSTOM FABRICATED
L0300	THORACIC-LUMBAR-SACRAL-ORTHOSIS (TLSO), FLEXIBLE (DORSO-LUMBAR SURGICAL SUPPORT), CUSTOM FITTED
L0310	TLSO, FLEXIBLE, (DORSO-LUMBAR SURGICAL SUPPORT), CUSTOM FABRICATED
L0320	TLSO, ANTERIOR-POSTERIOR CONTROL (TAYLOR TYPE), WITH APRON FRONT
L0330	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (KNIGHT-TAYLOR TYPE) WITH APRON FRONT
L0340	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL (ARNOLD, MAGNUSON, STEINDLER TYPES), WITH APRON FRONT

PROSTHETICS AND ORTHOTICS

L0350	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL, FLEXION COMPRESSION JACKET, CUSTOM FITTED
L0360	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL, FLEXION COMPRESSION JACKET MOLDED TO PATIENT MODEL
L0370	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL, HYPEREXTENSION (JEWETT, LENNOX, BAKER, CASH TYPES)
L0380	TLSO, ANTERIOR-POSTERIOR-LATERAL-ROTARY CONTROL, WITH ANTERIOR EXTENSIONS
L0390	TLSO, ANTERIOR-POSTERIOR-LETERAL CONTROL (BODY JACKET) MOLDED TO PATIENT MODEL
L0400	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET) MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL
L0410	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), TWO PIECE CONSTRUCTION, MOLDED TO PATIENT MODEL
L0420	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), TWO PIECE CONSTRUCTION, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL
L0430	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), WITH INTERFACE MATERIAL CUSTOM FITTED
L0440	TLSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), WITH OVERLAPPING FRONT SECTION, SPRING STEEL FRONT, CUSTOM FITTED
L0500	LUMBAR-SACRAL-ORTHOSIS (LSO), FLEXIBLE, (LUMBO-SACRAL SURGICAL SUPPORT), CUSTOM FITTED
L0510	LSO, FLEXIBLE (LUMBO-SACRAL SURGICAL SUPPORT), CUSTOM FABRICATED
L0515	LSO, FLEXIBLE, (LUMBO-SACRAL SURGICAL SUPPORT) ELASTIC TYPE, WITH RIGID POSTERIOR PANEL
	ANTERIOR-POSTERIOR-LATERAL CONTROL
L0520	LSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (KNIGHT, WILCOX TYPES), WITH APRON FRONT

PROSTHETICS AND ORTHOTICS

L0530	LSO, ANTERIOR-POSTERIOR CONTROL (MACAUSLAND TYPE), WITH APRON FRONT
L0540	LSO, LUBMAR FLEXION (WILLIAMS FLEXION TYPE) ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET)
L0550	LSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), MOLDED TO PATIENT MODEL
L0560	LSO, ANTERIOR-POSTERIOR LATERAL CONTROL (BODY JACKET), MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL
L0565	LSO, ANTERIOR-POSTERIOR-LATERAL CONTROL (BODY JACKET), CUSTOM FITTED
L0600	SACROILIAC, FLEXIBLE (SACROILIAC SURGICAL SUPPORT), CUSTOM FITTED
L0610	SACROILIAC, FLEXIBLE (SACROILIAC SURGICAL SUPPORT), CUSTOM FABRICATED
L0620	SACROILIAC, SEMI-RIGID (GOLDTHWAITE, OSGOOD TYPES), WITH APRON FRONT
L0700	CERVICAL-THORACIC-LUMBAR-SACRAL-ORTHOSES (CTLSO), ANTERIOR-POTERIOR-LATERAL CONTROL, MOLDED TO PATIENT MODEL, (MINERVA TYPE)
L0710	CTLSO, ANTERIOR-POSTERIOR-LATERAL-CONTROL, MOLDED TO PATIENT MODEL, WITH INTERFACE MATERIAL, (MINERVA TYPE)
L0810	HALO PROCEDURE, CERVICAL HALO INCORPORATED INTO JACKET VEST
L0820	HALO PROCEDURE, CERVICAL HOLO INCORPORATED INTO PLASTER BODY JACKET
L0830	HALO PROCEDURE, CERVICAL HALO INCORPORATED INTO MILWAUKEE TYPE ORTHOSIS
L0900	TORSO SUPPORT, PTOSIS SUPPORT, CUSTOM FITTED
L0910	TORSO SUPPORT, PTOSIS SUPPORT, CUSTOM FABRICATED
L0920	TORSO SUPPORT, PENDULOUS ABDOMEN SUPPORT, CUSTOM FITTED

PROSTHETICS AND ORTHOTICS

L0930	TORSO SUPPORT, PENDULOUS ABDOMEN SUPPORT, CUSTOM FABRICATED
L0940	TORSO SUPPORT, POST SURGICAL SUPPORT, CUSTOM FITTED
L0950	TORSO SUPPORT, POST SURGICAL SUPPORT, CUSTOM FABRICATED
L0960	TORSO SUPPORT, POST SURGICAL SUPPORT, PADS FOR POST SURGICAL SUPPORT
L0970	TLSO, CORSET FRONT
L0972	LSO, CORSET FRONT
L0974	TLSO, FULL CORSET
L0976	LSO, FULL CORSET
L0978	AXILLARY CRUTCH EXTENSION
L0980	PERONEAL STRAPS, PAIR
L0982	STOCKING SUPPORTER GRIPS, SET OF FOUR (4)
L1000	CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) (MILWAUKEE), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS, INCLUDING MODEL
L1010	ADDITION TO CERVICAL-THORACIC-LUMBAR-SACRAL ORTHOSIS (CTLSO) OR SCOLIOSIS ORTHOSIS, AXILLA SLING
L1020	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD
L1025	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, KYPHOSIS PAD, FLOATING
L1030	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR BOLSTER PAD
L1040	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR OR LUMBAR RIB PAD
L1050	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, STERNAL PAD
L1060	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, THORACIC PAD
L1070	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, TRAPEZE SLING
L1080	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER
L1085	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, OUTRIGGER, BILATERAL WITH VERTICAL EXTENSIONS

PROSTHETICS AND ORTHOTICS

L1090	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, LUMBAR SLING
L1100	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER
L1110	ADDITION TO CTLSO OR SCOLIOSIS ORTHOSIS, RING FLANGE, PLASTIC OR LEATHER, MOLDED TO PATIENT MODEL
L1120	ADDITION TO CTLSO, SCOLIOSIS ORTHOSIS, COVER FOR UPRIGHT, EACH
L1200	THORACIC-LUMBAR-SACRAL-ORTHOSIS (TLSO), INCLUSIVE OF FURNISHING INITIAL ORTHOSIS ONLY
L1210	ADDITION TO TLSO, (LOW PROFILE), LATERAL THORACIC EXTENSION AWAY DETACHABLE FOOT RESTS
L1220	ADDITION TO TLSO, (LOW PROFILE), ANTERIOR THORACIC EXTENSION
L1230	ADDITION TO TLSO, (LOW PROFILE), MILWAUKEE TYPE SUPERSTRUCTURE
L1240	ADDITION TO TLSO (LOW PROFILE), LUMBAR DEROTATION PAD
L1250	ADDITION TO TLSO (LOW PROFILE), ANTERIOR ASIS PAD
L1260	ADDITION TO TLSO (LOW PROFILE), ANTERIOR THORACIC DEROTATION PAD
L1270	ADDITION TO TLSO (LOW PROFILE), ABDOMINAL PAD
L1280	ADDITION TO TLSO (LOW PROFILE), RIB GUSSET (ELASTIC), EACH
L1290	ADDITION TO TLSO (LOW PROFILE), LATERAL TROCHANTERIC PAD
L1300	OTHER SCOLIOSIS PROCEDURE, BODY JACKET MOLDED TO PATIENT MODEL
L1310	OTHER SCOLIOSIS PROCEDURE, OST-OPERATIVE BODY JACKET
L1499	UNLISTED PROCEDURE FOR SPINAL ORTHOSIS
L1500	THORACIC-HIP-KNEE-ANKLE ORTHOSIS (THKAO), MOBILITY FRAME (NEWINGTON, PARAPODIUM TYPES)
L1510	THKAO, STANDING FRAME
L1520	THKAO, SWIVEL WALKER

PROSTHETICS AND ORTHOTICS

L1600	HIP ORTHOSIS (HO), ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA TYPE WITH COVER
L1610	HO, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, FREJKA COVER ONLY
L1620	HO, ABDUCTION CONTROL OF HIP JOINTS, FLEXIBLE, PAVLIK HARNESS
L1630	HO, ABDUCTION CONTROL OF HIP JOINTS, SEMI-FLEXIBLE (VON ROSEN TYPE)
L1640	HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PELVIC BAND OR SPREADER BAR, THIGH CUFFS
L1650	HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, ADJUSTABLE, CUSTOM FITTED (ILFLED TYPE)
L1660	HO, ABDUCTION CONTROL OF HIP JOINTS, STATIC, PLASTIC, CUSTOM FITTED
L1670	HO, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, ATTACHED TO SHOE (CRAIG TYPE)
L1680	HO, ABDUCTION CONTROL OF HIP JOINTS, DYNAMIC, PELVIC CONTROL, ADJUSTABLE HIP MOTION CONTROL, THIGH CUFFS (RANCHO HIP ACTION TYPE)
L1685	HO, ABDUCTION CONTROL OF HIP JOINTS, POST-OPERATIVE HIP ABDUCTION TYPE
L1700	LEGG PERTHES ORTHOSIS, TORONTO TYPE
L1710	LEGG PERTHES ORTHOSIS, NEWINGTON TYPE
L1720	LEGG PERTHES ORTHOSIS, TRILATERAL, (TACHDIJAN TYPE)
L1730	LEGG PERTHES ORTHOSIS, SCOTTISH RITE TYPE
L1750	LEGG PERTHES ORTHOSIS, LEGG PERTHES SLING (SAM BROWN TYPE)
L1755	LEGG PERTHES ORTHOSIS, PATTEN BOTTOM TYPE
L1800	KNEE ORTHOSIS (KO), ELASTIC WITH STAYS
L1810	KO, ELASTIC WITH JOINTS

PROSTHETICS AND ORTHOTICS

L1815	KO, ELASTIC WITH CONDYLAR PADS
L1820	KO, ELASTIC WITH CONDYLAR PADS AND JOINTS
L1825	KO, ELASTIC KNEE CAP
L1830	KO, IMMOBILIZER CANVAS LONGITUDINAL
L1840	KO, DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED TO PATIENT MODEL
L1845	KO, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT, MEDIAL-LATERAL AND ROTATION CONTROL, CUSTOM FITTED
L1846	KO, DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT, MEDIAL-LATERAL AND ROTATION CONTROL, MOLDED TO PATIENT MODEL
L1850	KO, SWEDISH TYPE
L1855	KO, MOLDED PLASTIC, THIGH AND CALF SECTIONS, WITH DOUBLE UPRIGHT KNEE JOINTS, MOLDED TO PATIENT MODEL
L1858	KO, MOLDED PLASTIC, POLYCENTRIC KNEE JOINTS, PNEUMATIC KNEE PADS (CTI)
L1860	KO, MODIFICATION OF SUPRACONDYLAR PROSTHETIC SOCKET, MOLDED TO PATIENT MODEL (SK)
L1870	KO, DOUBLE UPRIGHT, THIGH AND CALF LACERS, MOLDED TO PATIENT MODEL WITH KNEE JOINTS
L1880	KO, DOUBLE UPRIGHT, NONMOLDED THIGH AND CALF CUFFS/LACERS WITH KNEE JOINTS
L1900	ANKLE-FOOT ORTHOSIS (AFO), SPRING WIRE, DORSIFLEXION ASSIST CALF BAND
L1902	AFO, ANKLE GUANTLET, CUSTOM FITTED
L1904	AFO, MOLDED ANKLE GAUNTLET, MOLDED TO PATIENT MODEL
L1906	AFO, MULTILIGAMENTUS ANKLE SUPPORT
L1910	AFO, POSTERIOR, SINGLE BAR, CLASP ATTACHMENT TO SHOE COUNTER
L1920	AFO, SINGLE UPRIGHT WITH STATIC OR ADJUSTABLE STOP (PHELPS OR PERLSTEIN TYPE)

PROSTHETICS AND ORTHOTICS

L1930	AFO, CUSTOM FITTED, PLASTIC
L1940	AFO, MOLDED TO PATIENT MODEL, PLASTIC
L1950	AFO, SPIRAL, MOLDED TO PATIENT MODEL (IRM TYPE), PLASTIC
L1960	AFO, POSTERIOR SOLID ANKLE, MOLDED TO PATIENT MODEL, PLASTIC
L1970	AFO, PLASTIC MOLDED TO PATIENT MODEL, WITH ANKLE JOINT
L1980	AFO, SINGLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR "BK" ORTHOSIS)
L1990	AFO, DOUBLE UPRIGHT FREE PLANTAR DORSIFLEXION, SOLID STIRRUP, CALF BAND/CUFF (SINGLE BAR "BK" ORTHOSIS)
NOTE:	L2000, L2020, and L2036 ARE BASE PROCEDURES TO BE USED WITH ANY KNEE JOINT, L2010 and L2030 ARE TO BE USED ONLY WITH NO KNEE JOINT
L2000	KNEE-ANKLE-FOOT-ORTHOSES (KAFO), SINGLE STIRRUP, FREE KNEE, FREE ANGLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR "AK" ORTHOSIS)
L2010	KAFO, SINGLE UPRIGHT, FREE ANGLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (SINGLE BAR "AK" ORTHOSIS) WITHOUT KNEE JOINT
L2020	KAFO, DOUBLE UPRIGHT, FREE KNEE, FREE ANGLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS (DOBULE BAR "AK" ORTHOSIS)
L2030	KAFO, DOUBLE UPRIGHT, ANKLE, SOLID STIRRUP, THIGH AND CALF BANDS/CUFFS, (DOUBLE BAR "AK" ORTHOSIS), WITHOUT KNEE JOINT
L2036	KAFO, FULL PLASTIC, MOLDED TO PATIENT MODEL
L2040	HIP-KNEE-ANKLE-FOOT-ORTHOSIS (HKAFO) TORSION CONTROL, BILATERAL ROTATION STRAPS, PELVIC BAND/BELT
L2050	HKAFO TORSION CONTROL, BILATERAL TORISON CABLES, HIP JOINT, PELVIC BAND/BELT
L2060	HKAFO TORSION CONTROL, BILATERAL TORISON CABLES, BALL BEARING HIP JOINT, PELVIC BAND/BELT
L2070	HKAFO TORSION CONTROL, UNILATERAL ROTATION STRAPS, PELVIC BAND/BELT

PROSTHETICS AND ORTHOTICS

L2080	HKAFO TORSION CONTROL, UNILATERAL TORISON CABLE, HIP JOINT, PELVIC BAND/BELT
L2090	HKAFO TORSION CONTROL, UNILATERAL TORISON CABLE, BALL BEARING HIP JOINT PELVIC BAND/BELT
L2102	ANKLE-FOOT-ORTHOSIS (AFO), FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, PLASTER TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2104	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, SYNTHETIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2106	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2108	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL
L2112	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, SOFT CUSTOM FITTED
L2114	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, SEMI-RIGID CUSTOM FITTED
L2116	AFO, FRACTURE ORTHOSIS, TIBIAL FRACTURE CAST ORTHOSIS, RIGID CUSTOM FITTED
L2122	KNEE-ANGLE-FOOT-ORTHOSIS, (KAFO), FRACTURE FEMORAL FRACTURE CAST ORTHOSIS, PLASTIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2124	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SYNTHETIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2126	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, THERMOPLASTIC TYPE CASTING MATERIAL, MOLDED TO PATIENT
L2128	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, MOLDED TO PATIENT MODEL
L2132	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SOFT CUSTOM FITTED
L2134	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, SEMI-RIGID CUSTOM FITTED
L2136	KAFO, FRACTURE ORTHOSIS, FEMORAL FRACTURE CAST ORTHOSIS, RIGID CUSTOM FITTED

PROSTHETICS AND ORTHOTICS

L2180	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, PLASTIC SHOE INSERT WITH ANKLE JOINTS
L2182	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, DROP LOCK KNEE JOINTS
L2184	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, LIMITED MOTION KNEE JOINT
L2186	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, ADJUSTABLE MOTION KNEE JOINT, LERMAN TYPE
L2188	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, QUADRILATERAL BRIM
L2190	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, WAIST BELT
L2192	ADDITION TO LOWER EXTREMITY FRACTURE ORTHOSIS, HIP JOINT, PELVIC BAND, THIGH FLANGE, AND PELVIC BELT
L2200	ADDITION TO LOWER EXTREMITY, LIMITED ANKLE MOTION, EACH JOINT
L2210	ADDITION TO LOWER EXTREMITY, DORSIFLEXION ASSIST (PLANTAR FLEXION RESIST), EACH JOINT
L2220	ADDITION TO LOWER EXTREMITY, DORSIFLEXION AND PLANTAR FLEXION ASSIST/RESIST, EACH JOINT
L2230	ADDITION TO LOWER EXTREMITY, SPLIT FLAT CALIPER STIRRUPS AND PLATE ATTACHMENT
L2240	ADDITION TO LOWER EXTREMITY, ROUND CALIPER AND PLATE ATTACHMENT
L2250	ADDITION TO LOWER EXTREMITY, FOOT PLATE, MOLDED TO PAITENT MODEL, STIRRUP ATTACHMENT
L2260	ADDITION TO LOWER EXTREMITY, REINFORCED SOLID STIRRUP (SCOTT-CRAIG TYPE)
L2270	ADDITION TO LOWER EXTREMITY, VARUS/VALGUS CORRECTION ("T") STRAP, PADDED/LINED OR MALLELUS PAD
L2280	ADDITION TO LOWER EXTREMITY, MOLDED INNER BOOT

PROSTHETICS AND ORTHOTICS

L2300	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR (BILATERAL HIP INVOLVEMENT), JOINTED, ADJUSTABLE
L2310	ADDITION TO LOWER EXTREMITY, ABDUCTION BAR-STRAIGHT
L2320	ADDITION TO LOWER EXTREMITY, NON-MOLDED LACER
L2330	ADDITION TO LOWER EXTREMITY, LACER MOLDED TO PATIENT MODEL
L2335	ADDITION OT LOWER EXTREMITY, ANTERIOR SWING BAND
L2340	ADDITION TO LOWER EXTREMITY, PRE-TIBIAL SHELL, MOLDED TO PATIENT MODEL
L2350	ADDITION TO LOWER EXTREMITY, PROSTHETIC TYPE, (BK) SOCKET, MOLDED TO PATIENT MODEL, (USED FOR 'PTB' 'AFO' ORTHOSES)
L2360	ADDITION TO LOWER EXTREMITY, EXTENDED STEEL SHANK
L2370	ADDITION TO LOWER EXTREMITY, PATTEN BOTTOM
L2375	ADDITION TO LOWER EXTREMITY, TORSION CONTROL, ANKLE JOINT AND HALF SOLID STIRRUP
L2380	ADDITION TO LOWER EXTREMITY, TORSION CONTROL, STRAIGHT KNEE JOINT, EACH JOINT
L2385	ADDITION TO LOWER EXTREMITY, STRAIGHT KNEE JOINT, HEAVY DUTY, EACH JOINT
L2390	ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, EACH JOINT
L2395	ADDITION TO LOWER EXTREMITY, OFFSET KNEE JOINT, HEAVY DUTY, EACH JOINT
L2405	ADDITION TO KNEE JOINT, DROP LOCK, EACH JOINT
L2415	ADDITION TO KNEE JOINT, CAM LOCK (SWISS, FRENCH, BAIL TYPES) EACH JOINT
L2425	ADDITION TO KNEE JOINT, DISC OR DIAL LOCK FOR ADJUSTABLE KNEE FLEXITON, EACH JOINT
L2435	ADDITION TO KNEE JOINT, POLYCENTRIC JOINT, EACH JOINT
L2475	ADDITION TO KNEE JOINT, BAIL LOCK, EACH JOINT

PROSTHETICS AND ORTHOTICS

L2492	ADDITION TO KNEE JOINT, LIFT LOOP FOR DROP LOCK RING
L2500	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, GULTEAL/ISCHIAL WEIGHT BEARING, RING
L2510	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUANDRILATERAL BRIM, MOLDED TO PATIENT MODEL
L2520	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, QUANDRILATERAL BRIM, CUSTOM FITTED
L2530	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, LACER, NON-MOLDED
L2540	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, LACER, MOLDED TO PATIENT MODEL
L2550	ADDITION TO LOWER EXTREMITY, THIGH/WEIGHT BEARING, HIGH ROLL CUFF
L2560	ADDITION TO LOWER EXTREMITY, GLUTEAL/ISCHIAL WEIGHT BEARING
L2570	ADDITION TO LOWER EXTREMITY, GLUTEAL/ISCHIAL WEIGHT BEARING, TWO POSITION HIP JOINT
L2580	ADDITION TO LOWER EXTREMITY, GLUTEAL/ISCHIAL WEIGHT BEARING, PELVIC SLING
L2600	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE, OR THRUST BEARING, FREE, EACH
L2610	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, CLEVIS TYPE, OR THRUST BEARING, LOCK, EACH
L2620	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, HEAVY DUTY, EACH
L2622	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, EACH
L2624	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, HIP JOINT, ADJUSTABLE FLEXION, ABDUCTION CONTROL, EACH
L2626	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, RECIPROCATING HIP JOINTS, AND CABLES
L2630	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, UNILATERAL

PROSTHETICS AND ORTHOTICS

L2640	ADDITION TO LOWER EXTREMITY, PELVIC CONTROL, BAND AND BELT, BILATERAL
L2650	ADDITION TO LOWER EXTREMITY, PELVIC AND THORACIC CONTROL, GLUTEAL PAD, EACH
L2660	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, THORACIC BAND
L2670	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, PARASPINAL UPRIGHTS
L2680	ADDITION TO LOWER EXTREMITY, THORACIC CONTROL, LATERAL SUPPORT UPRIGHTS
L2750	ADDITION TO LOWER EXTREMITY ORTHOSIS, PLATING CHROME OR NICKEL, PER BAR
L2760	ADDITION TO LOWER EXTREMITY ORTHOSIS, EXTENSION, PER EXTENSTION, PER BAR (FOR LINEAL ADJUSTMENT FOR GROWTH)
L2770	ADDITION TO LOWER EXTREMITY ORTHOSIS, STAINLESS STEEL-PER BAR OR JOINT
L2780	ADDITION TO LOWER EXTREMITY ORTHOSIS, NONCORROSIVE FINISH, PER BAR
L2785	ADDITION TO LOWER EXTREMITY ORTHOSIS, DROP LOCK RETAINER, EACH
L2795	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, FULL KNEECAP
L2800	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, KNEE CAP, MEDICAL OR LATERAL PULL
L2810	ADDITION TO LOWER EXTREMITY ORTHOSIS, KNEE CONTROL, CONDYLAR PAD
L2820	ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, BELOW KNEE SECTION
L2830	ADDITION TO LOWER EXTREMITY ORTHOSIS, SOFT INTERFACE FOR MOLDED PLASTIC, ABOVE KNEE SECTION
L2999	UNLISTED PROCEDURES FOR LOWER EXTERMITY ORTHOSES

PROSTHETICS AND ORTHOTICS

L3650	SHOULDER ORTHOSIS, (SO), FIGURE OF "8" DESIGN ABDUCTION RESTRAINER
L3660	SO, FIGURE OF "8" DESIGN ABDUCTION RESTRAINER, CANVAS AND WEBBING
L3670	SO, ACROMIO/CLAVICULAR (CANVAS AND WEBBING TYPE)
L3700	ELBOW ORTHOSES (EO), ELASTIC WITH STAYS
L3710	EO, ELASTIC WITH METAL JOINTS DOUBLE UPRIGHT
L3720	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, FREE MOTION
L3730	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, EXTENSION/FLEXION ASSIST
L3740	EO, DOUBLE UPRIGHT WITH FOREARM/ARM CUFFS, ADJUSTABLE POSITION LOCK WITH ACTIVE CONTROL
L3800	WRIST-HAND-FINGER-ORTHOSES (WHFO), SHORT OPPENTS, NO ATTACHMENTS
L3805	WHFO, LONG OPPONENS, NONATTACHMENT
L3810	WHFO, ADDITION TO SHORT AND LONG OPPONENS, THUMB ABDUCTION ("C") BAR
L3815	WHFO, ADDITION TO SHORT AND LONG OPPONENS, SECOND M.P. ABDUCTION ASSIST
L3820	WHFO, ADDITION TO SHORT AND LONG OPPONENS, I.P. EXTENSION ASSIST, WITH M.O. EXTENSION STOP
L3825	WHFO, ADDITION OT SHORT AND LONG OPPONENS, M.P. EXTENSION
L3830	WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. EXTENSON ASSIST
L3835	WHFO, ADDITION TO SHORT AND LONG OPPONENS, M.P. SPRING EXTENSION ASSIST
L3840	WHFO, ADDITION TO SHORT AND LONG OPPONENS, SPRING SWIVEL THUMB
L3845	WHFO, ADDITION TO SHORT AND LONG OPPONENS, THUMB I.P. EXTENSION ASSIST, WITH M.P. STOP

PROSTHETICS AND ORTHOTICS

L3850	WHFO, ADDITION TO SHORT AND LONG OPPONENS, ACTION WRIST, WITH DORSIFLEXION ASSIST
L3855	WHFO, ADDITION TO SHORT AND LONG OPPONENS, ADJUSTABLE M.P. FLEXION CONTROL
L3860	WHFO, ADDITION TO SHORT AND LONG OPPONENS, ADJUSTABLE M.P. FLEXION CONTROL AND I.P.
L3900	WHFO, DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/FLEXION, FINGER FLEXION/EXTENSION WRIST OR FINGER DRIVEN
L3901	WHFO, DYNAMIC FLEXOR HINGE, RECIPROCAL WRIST EXTENSION/FLEXION, FINGER FLEXION/EXTENSION, CABLE DRIVEN
L3902	WHFO, EXTERNAL POWER, COMPRESSED GAS
L3904	WHFO, EXTERNAL POWER, ELECTRIC
L3906	WHFO, WRIST GAUNTLET, MOLDED TO PATIENT MODEL
L3907	WHFO, WRIST GAUNTLET WITH THUMB SPICA, MOLDED TO PATIENT MODEL
L3908	WHFO, WRIST EXTENSION CONTROL COCK-UP, CANVAS OR LEATHER DESIGN, NON-MOLDED
L3910	WHFO, SWANSON DESIGN
L3912	WHFO, FLEXION GLOVE WITH ELASTIC FINGER CONTROL
L3914	WHFO, WRIST EXTENSION COCK-UP
L3916	WHFO, WRIST EXTENSION COCK-UP, WITH OUTRIGGER
L3918	WHFO, KNUCKLE BENDER
L3920	WHFO, KNUCKLE BENDER, WITH OUTRIGGER
L3922	WHFO, KNUCKLE BENDER, TWO SEGMENT TO FLEX JOINTS
L3924	WHFO, OPPENHEIMER
L3926	WHFO, THOMAS SUSPENSION
L3928	WHFO, FINGER EXTENSION, WITH CLOCK SPRING

PROSTHETICS AND ORTHOTICS

L3930	WHFO, FINGER EXTENSION, WITH WRIST SUPPORT
L3932	WHFO, SAFETY PIN, SPRING WIRE
L3934	WHFO, SAFETY PIN, MODIFIED
L3936	WHFO, PALMER
L3938	WHFO, DORSAL WRIST
L3940	WHFO, DORSAL WRIST, WITH OUTRIGGER ATTACHMENT
L3942	WHFO, REVERSE KNUCKLE BENDER
L3944	WHFO, REVERSE KNUCKLE BENDER, WITH OUTRIGGER
L3946	WHFO, COMPOSITE ELASTIC
L3948	WHFO, FINGER KNUCKLE BENDER
L3950	WHFO, COMBINATION OPPENHEIMER, WITH KNUCKLE BENDER AND TWO ATTACHMENTS
L3952	WHFO, COMBINATION OPPENHEIMER, WITH REVERSE KNUCKLE BENDER AND TWO ATTACHMENTS
L3954	WHFO, SPREADING HAND
L3960	SHOULDER-ELBOW-WRIST-HAND ORTHOSIS, (SEWHO), ABDUCTION
L3962	SEWHO, ABDUCTION POSITIONING, ERBS PALSEY DESIGN
L3963	SEWHO, MOLDER SHOULDER, ARM, FOREARM, AND WRIST, WITH ARTICULATING ELBOW JOINT
L3964	SEWHO, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED AND FITTED TO PATIENT, ADJUSTABLE
L3965	SEWHO, SEMI-RADIAL ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED AND FITTED TO PATIENT, ADJUSTABLE RANCHO TYPE
L3966	SEWHO, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED AND FITTED TO PATIENT, RECLINING
L3968	SEWHO, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED AND FITTED TO PATIENT, FRICTION ARM SUPPORT (FRICTION DAMPENING TO PROXIMAL AND DISTAL JOINTS)

PROSTHETICS AND ORTHOTICS

L3969	SEWHO, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, VOKE TYPE ARM SUSPENSION SUPPORT
L3970	SEWHO, ADDITION TO MOBILE ARM SUPPORT, ELEVATING PROMXIMAL ARM
L3972	SEWHO, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL
L3974	SEWHO, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR
L3980	UPPER EXTREMITY FRACTURE ORTHOSIS, HUMERAL
L3982	UPPER EXTREMITY FRACTURE ORTHOSIS, RADIUS/ULNAR
L3984	UPPER EXTREMITY FRACTURE ORTHOSIS, WRIST
L3985	UPPER EXTREMITY FRACTURE ORTHOSIS, FOREARM, HAND WITH WRIST HINGE
L3986	UPPER EXTREMITY FRACTURE ORTHOSIS, COMBINATION OF HUMERAL, RADIUS/ULNAR, WRIST, (EXAMPLE--COLLES FRACTURE)
L3999	UNLISTED PROCEDURES FOR UPPER LIMB ORTHOSIS
L4000	REPLACE GRIDLE FOR MILWAUKEE ORTHOSIS
L4010	REPLACE TRILATERAL SOCKET BRIM
L4020	REPLACE QUADRILATERAL SOCKET BRIM, MOLDED TO PATIENT MODEL
L4030	REPLACE QUARDRILATERAL SOCKET BRIM, CUSTOM FITTED
L4040	REPLACE MOLDED THIGH LACER
L4045	REPLACE NONMOLDED THIGH LACER
L4050	REPLACE MOLDED CALF LACER
L4055	REPLACE NONMOLDED CALF LACER
L4060	REPLACE HIGH ROLL CUFF
L4070	REPLACE PROXIMAL AND DISTAL UPRIGHT FOR KAFO
L4080	REPLACE METAL BANDS KAFO, PROXIMAL THIGH

READEX FICHE best copy available

PROSTHETICS AND ORTHOTICS

L4090	REPLACE METAL BANDS KAFO-AFO, CALF OR DISTAL THIGH
L4100	REPLACE LEATHER CUFF KAFO, PROXIMAL THIGH
L4110	REPLACE LEATHER CUFF KAFO-AFO, CALF OR DISTAL THIGH
L4130	REPLACE PRETIBIAL SHELL
L4200	REPAIR OF ORTHOTIC DEVICE, HOURLY RATE
L4210	REPAIR OF ORTHOTIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L5000	PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER
L5010	PARTIAL FOOT, MOLDED SOCKET, ANKLE HEIGHT, WITH TOE FILLLER
L5020	PARTIAL FOOT, MOLDED SOCKET, TIBIAL TUBERCLE HEIGHT, WITH TOE FILLER
L5050	ANKLE, SYMES, MOLDED SOCKET, SACH FOOT
L5060	ANKLE, SYMES, METAL FRAME, MOLDED LEATHER SOCKET, ARTICULATED ANKLE/FOOT
L5100	BELOW KNEE, MOLDED SOCKET, SHIN, SACH FOOT
L5110	BELOW KNEE, WOOD SOCKET, JOINTS AND THIGH LACER, SACH FOOT
L5150	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT
L5160	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, BENT KNEE CONFIGURATION, EXTERNAL KNEE JOINTS, SHIN, SACH FOOT
L5200	ABOVE KNEE, MOLDED SOCKET, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT
L5210	ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT ("STUBBIES"), WITH FOOT BLOCKS, NO ANKLE JOINTS, EACH
L5220	ABOVE KNEE, SHORT PROSTHESIS, NO KNEE JOINT ("STUBBIES"), WITH ARTICULATED ANKLE/FOOT, DYNAMICALLY ALIGNED, EACH
L5230	ABOVE KNEE, FOR PROXIMAL FEMORAL FOCAL DEFICIENCY, CONSTANT FRICTION KNEE, SHIN, SACH FOOT

PROSTHETICS AND ORTHOTICS

L5250	HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT
L5270	HIP DISARTICULATION, TILT TABLE TYPE; MOLDED SOCKET, LOCKING HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT
L5280	HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, HIP JOINT, SINGLE AXIS CONSTANT FRICTION KNEE, SHIN, SACH FOOT
L5300	BELOW KNEE, MOLDED SOCKET, SACH FOOT, ENDOSKELETAL SYSTEM, INCLUDING SOFT COVER AND FINISHING
L5310	KNEE DISARTICULATION (OR THROUGH KNEE), MOLDED SOCKET, SACH FOOT ENDOSKELETAL SYSTEM, INCLUDING SOFT COVER AND FINISHING
L5320	ABOVE KNEE, MOLDED SOCKET, OPEN END, SACH FOOT, ENDOSKELETAL SYSTEM, SINGLE AXIS KNEE, INCLUDING SOFT COVER AND FINISHING
L5330	HIP DISARTICULATION, CANADIAN TYPE; MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH FOOT, INCLUDING SOFT COVER AND FINISHING
L5340	HEMIPELVECTOMY, CANADIAN TYPE; MOLDED SOCKET, ENDOSKELETAL SYSTEM, HIP JOINT, SINGLE AXIS KNEE, SACH FOOT, INCLUDING SOFT COVER AND FINISHING
L5400	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGNMENT, SUSPENSION, AND ONE CAST CHANGE, BELOW KNEE
L5410	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGNMENT AND SUSPENSION, BELOW KNEE, EACH ADDITIONAL CAST CHANGE AND REALIGHMENT
L5420	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING, ALIGHMENT AND SUSPENSION AND ONE CAST CHANGE "AK" OR KNEE DISARTICULATION
L5430	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING, FITTING, ALIGNMENT AND SUPENSION, "AK" OR KNEE DISARTICULATION, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT

PROSTHETICS AND ORTHOTICS

L5450	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, BELOW KNEE
L5460	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF NON-WEIGHT BEARING RIGID DRESSING, ABOVE KNEE
L5500	INITIAL, BELOW KNEE "PTB" TYPE SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, DIRECT FORMED
L5505	INITIAL, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, 'USMC' OR EQUAL PYLON, NO COVER, SACH FOOT PLASTER SOCKET, DIRECT FORMED
L5510	PREPARATORY, BELOW KNEE "PTB" TYPE SOCKET, 'USMC' OR EQUAL PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, MOLDED TO MODEL
L5520	PREPARATORY, BELOW KNEE "PTB" TYPE SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, DIRECT FORMED
L5530	PREPARTORY, BELOW KNEE "PTB" TYPE SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLDED TO MODEL
L5540	PREPARATORY, BELOW KNEE "PTB" TYPE SOCKET "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO MODEL
L5560	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, PLASTER SOCKET, MOLDED TO MODEL
L5570	PREPARATORY, ABOVE KNEE-KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, DIRECT FORM
L5580	PREPARATORY, ABOVE KNEE-KNEE DISARTICULATION ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, THERMOPLASTIC OR EQUAL, MOLED TO MODEL
L5585	PREPARATORY, ABOVE KNEE - KNEE DISARTICULATION, ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON, NO COVER, SACH FOOT, PREFABRICATED ADJUSTABLE OPEN END SOCKET
L5590	PREPARATORY, ABOVE KNEE-KNEE DISARTICULATON ISCHIAL LEVEL SOCKET, "USMC" OR EQUAL PYLON NO COVER, SACH FOOT, LAMINATED SOCKET, MOLDED TO MODEL

PROSTHETICS AND ORTHOTICS

L5610	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, HYDRACADENCE SYSTEM
L5616	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, UNIVERSAL MULTIPLEX SYSTEM, FRICTION SWING PHASE CONTROL
L5618	ADDITION TO LOWER EXTREMITY, TEST SOCKET, SYMES
L5620	ADDITION TO LOWER EXTREMITY, TEST SOCKET, BELOW KNEE
L5622	ADDITION TO LOWER EXTREMITY, TEST SOCKET, KNEE DISARTICULATION
L5624	ADDITION TO LOWER EXTREMITY, TEST SOCKET, ABOVE KNEE
L5626	ADDITION TO LOWER EXTREMITY, TEST SOCKET, HIP DISARTICULATION
L5628	ADDITION TO LOWER EXTREMITY, TEST SOCKET, HEMIPELVECTOMY
L5630	ADDITION TO LOWER EXTREMITY, SYMES TYPE, EXPANDABLE WALL SOCKET
L5632	ADDITION TO LOWER EXTREMITY, SYMES TYPE, "PTB" BRIM DESIGN SOCKET
L5634	ADDITION TO LOWER EXTREMITY, SYMES TYPE, POSTERIOR OPENING (CANADIAN) SOCKET
L5636	ADDITION TO LOWER EXTREMITY, SYMES TYPE, MEDIAL OPENING SOCKET
L5638	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LEATHER SOCKET
L5640	ADDITION TO LOWER EXTREMITY, KNEE DISARTICULATION, LEATHER SOCKET
L5642	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, LEATHER SOCKET
L5643	ADDITION TO LOWER EXTREMITY, HIP DISARTICULATION, FLEXIBLE INNER SOCKET, EXTERNAL FRAME
L5644	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, WOOD SOCKET
L5645	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME

PROSTHETICS AND ORTHOTICS

L5646	ADDITION TO LOWER EXTREMITY, BELOW KNEE, AIR CUSHION SOCKET
L5647	ADDITION TO LOWER EXTREMITY, BELOW KNEE SUCTION SOCKET
L5648	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, AIR CUSHION SOCKET
L5649	ADDITION TO LOWER EXTREMITY, CAT-CAM SOCKET
L5650	ADDITIONS TO LOWER EXTREMITY, TOTAL CONTACT, ABOVE KNEE OR KNEE DISARTICULATION SOCKET
L5651	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, FLEXIBLE INNER SOCKET, EXTERNAL FRAME
L5652	ADDITION TO LOWER EXTREMITY, SUCTION SUSPENSION, ABOVE KNEE OR KNEE DISARTICULATION SOCKET
L5653	ADDITIONS TO LOWER EXTREMITY, KNEE DISARTICULATION, EXPLANDABLE WALL SOCKET
L5654	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, SYMES, (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)
L5655	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, BELOW KNEE (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)
L5656	ADDITION TO LOWER EXTEREMITY, SOCKET INSERT, KNEE DISARTICULATION, (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)
L5658	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, ABOVE KNEE (KEMBLO, PELITE, ALIPLAST, PLASTAZOTE OR EQUAL)
L5660	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, SYMES, SILICONE GEL OR EQUAL
L5661	ADDITION OT LOWER EXTREMITY, SOCKET INSERT, MULTI-DUROMETER SYMES
L5662	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, BELOW KNEE, SILICONE GEL OR EQUAL
L5663	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, KNEE DISARTICULATION, SILICONE GEL OR EQUAL
L5664	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, ABOVE KNEE, SILICONE GEL OR EQUAL

PROSTHETICS AND ORTHOTICS

L5665	ADDITION TO LOWER EXTREMITY, SOCKET INSERT, MULTI-DUROMETER, BELOW KNEE
L5666	ADDITION TO LOWER EXTREMITY, BELOW KNEE, CUFF SUSPENSION
L5668	ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED DISTAL CUSHION
L5670	ADDITION TO LOWER EXTREMITY, BELOW KNEE, MOLDED SUPRACONDYLAR SUSPENSION ("PTS" OR SIMILAR)
L5672	ADDITION TO LOWER EXTREMITY, BELOW KNEE, REMOVABLE MEDIAL BRIM SUSPENSION
L5674	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LATEX SLEEVE SUSPENSION OR EQUAL, EACH
L5675	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LATES SLEEVE SUSPENSION OR EQUAL, HEAVY DUTY, EACH
L5676	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, SINGLE AXIS, PAIR
L5677	ADDTIONS TO LOWER EXTREMITY, BELOW KNEE, KNEE JOINTS, POLYCENTRIC, PAIR
L5678	ADDITIONS TO LOWER EXTREMITY, BELOW KNEE, JOINT COVERS, PAIR
L5680	ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACER NON-MOLDED
L5682	ADDITION TO LOWER EXTREMITY, BELOW KNEE, THIGH LACER, GLUTEAL/ISCHIAL, MOLDED
L5684	ADDITION TO LOWER EXTREMITY, BELOW KNEE, FORK STRAP
L5686	ADDITION TO LOWER EXTREMITY, BELOW KNEE, BACK CHECK (EXTENSION CONTROL)
L5688	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WAIST BELT, WEBBING

PROSTHETICS AND ORTHOTICS

L5690	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WAIST BELT, PADDED AND LINED
L5692	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL BELT, LIGHT
L5694	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, PELVIC CONTROL BELT, PADDED AND LINED
L5696	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, PELVIC JOINT
L5697	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, PELVIC BAND
L5698	ADDITION TO LOWER EXTREMITY, ABOVE KNEE OR KNEE DISARTICULATION, SILESIAN BANDAGE
L5699	ALL LOWER EXTREMITY PROSTHESES, SHOULDER HARNESS
L5700	ALL LOWER EXTREMITY PROSTHESES, FOOT, EXTERNAL KEEL, SACH FOOT
L5701	ALL LOWER EXTREMITY PROSTHESES, SAFE FOOT
L5702	ALL LOWER EXTREMITY PROSTHESES, FOOT, SINGLE AXIS ANKLE/FOOT
L5703	ALL LOWER EXTREMITY PROSTHESES, ENERGY STORING FOOT (SEATTLE, STEN, CARBON COPY II OR EQUAL)
L5704	ALL LOWER EXTREMITY PROSTHESES, FOOT, MULTIAXIAL ANKLE/FOOT (GREISSINGER OR EQUAL)
L5705	ALL LOWER EXTREMITY PROSTHESES, FLEX FOOT SYSTEM
L5706	ALL EXOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT
L5707	ALL ENDOSKELETAL LOWER EXTREMITY PROSTHESES, AXIAL ROTATION UNIT

PROSTHETICS AND ORTHOTICS

L5709	ALL LOWER EXTREMITY PROSTHESES, MULTI-AXIAL ROTATION UNIT ('MCP' OR EQUAL)
L5710	ADDITION, EXOSKELETAL KNEE-SHIN SYTEM, SINGLE AXIS, MANUAL LOCK
L5711	ADDITONS EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL
L5712	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FRICTION SWING AND STAND PHASE CONTROL (SAFETY KNEE)
L5714	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, VARIABLE FRICTION SWING PHASE CONTROL
L5716	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK
L5718	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRACTION SWING, AND STANCE PHASE CONTROL
L5722	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL
L5724	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL
L5726	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, EXTERNAL JOINTS FLUID SWING PHASE CONTROL
L5728	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
L5780	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/HYDRA PNEUMATIC SWING PHASE CONTROL
L5785	ADDITION, EXOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL
L5790	ADDITION, EXOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANTIUM, CARBON FIBER OR EQUAL)
L5795	ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)

PROSTHETICS AND ORTHOTICS

L5810	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK
L5811	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, MANUAL LOCK, ULTRA-LIGHT MATERIAL
L5812	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGEL AXIS, FRICTION SWING AND STANCE PHASE CONTROL (SAFETY KNEE)
L5814	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, VARIABLE FRICTION SWING PHASE CONTROL
L5816	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, MECHANICAL STANCE PHASE LOCK
L5818	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, POLYCENTRIC, FRICTION SWING, AND STANCE PHASE CONTROL
L5822	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL
L5824	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL
L5828	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING AND STANCE PHASE CONTROL
L5830	ADDITION, ENDOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PHEUMATIC/HYDRAPNEUMATIC SWING PHASE CONTROL
L5850	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, KNEE EXTENSION ASSIST
L5910	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ALIGNABLE SYSTEM
L5920	ADDITION ENDOSKELETAL SYSTEM, ABOVE KNEE OR HIP DISARTICULATION, ALIGNABLE SYSTEM
L5940	ADDITION, ENDOSKELETAL SYSTEM, BELOW KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)
L5950	ADDITION, ENDOSKELETAL SYSTEM, ABOVE KNEE, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)
L5960	ADDITION, ENDOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)

PROSTHETICS AND ORTHOTICS

L5999	UNLISTED PROCEDURES FOR LOWER EXTREMITY PROSTHESIS
L6000	PARTIAL HAND, ROBIN-AIDS, THUMB REMAINING (OR EQUAL)
L6010	PARTIAL HAND, ROBIN-AIDS, LITTLE AND/OR RING FINGER REMAINING (OR EQUAL)
L6020	PARTIAL HAND, ROBIN-AIDS, NO FINGER REMAINING (OR EQUAL)
L6050	WRIST DISARTICULATION, MOLDED SOCKET, FLEXIBLE ELBOW HINGES, TRICEPS PAD
L6055	WRIST DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, FLEXIBLE ELBOW HINGES, TRICEPS PAD
L6100	BELOW ELBOW, MOLDED SOCKET, FLEXIBLE ELBOW HINGE, TRICEPS PAD
L6110	BELOW ELBOW, MOLDED SOCKET, (MUENSTER OR NORTHWESTERN SUSPENSION TYPES)
L6120	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF
L6130	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF
L6200	ELBOW DISARTICULATION, MOLDED SOCKET, OUTSIDE LOCKING HINGE FOREARM
L6205	ELBOW DISARTICULATION, MOLDED SOCKET WITH EXPANDABLE INTERFACE, OUTSIDE LOCKING HINGES, FOREARM
L6250	ABOVE ELBOW, MOLDED DOUBLE WALL SOCKET, INTERNAL LOCKING ELBOW, FOREARM
L6300	SHOULDER DISARTICULATION, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW, FOREARM
L6310	SHOULD DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROSTHESIS)
L6320	SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)
L6350	INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION, INTERNAL LOCKING ELBOW, FOREARM

PROSTHETICS AND ORTHOTICS

L6360	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)
L6370	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (SHOULDER CAP ONLY)
L6380	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITAL RIGID DRESSING, INCLUDING FITTING ALIGNMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, WRISTS DISARTICULATION OR BELOW ELBOW
L6382	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING, INCLUDING FITTING ALINGMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, ELBOW DISARTICULATION OR ABOVE ELBOW
L6384	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF INITIAL RIGID DRESSING INCLUDING FITTING ALIGNMENT AND SUSPENSION OF COMPONENTS, AND ONE CAST CHANGE, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC
L6386	IMMEDIATE POST SURGICAL OR EARLY FITTING, EACH ADDITIONAL CAST CHANGE AND REALIGNMENT
L6388	IMMEDIATE POST SURGICAL OR EARLY FITTING, APPLICATION OF RIGID DRESSING ONLY
L6400	BELOW ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6450	ELBOW DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6500	ABOVE ELBOW, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6550	SHOULDER DISARTICULATION, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6570	INTERSCAPULAR THORACIC, MOLDED SOCKET, ENDOSKELETAL SYSTEM, INCLUDING SOFT PROSTHETIC TISSUE SHAPING
L6580	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, FLEXIBLE ELBOW HINGES, FIGURE OF EIGHT HARNESS, HUMERAL CUFF, BOWDEN CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL

PROSTHETICS AND ORTHOTICS

L6582	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, FLEXIBLE ELBOW HINGES, FIGURE OF EIGHT HARNESS, HUMERAL CUFF, BOWDEN CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
L6584	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL PLASTIC SOCKET, FRICTION WRIST, LOCKING ELBOW, FIGURE OF EIGHT HARNESS, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL
L6586	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, LOCKING ELBOW, FIGURE OR EIGHT HARNESS, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
L6588	PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGE WALL PLASTIC SOCKET, SHOULDER JOINT, LOCKING ELBOW, FRICTION WRIST, CHEST STRAP, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL
L6590	PREPARATORY, SHOULD DISARTICULATION OR INTERSCAPULAR THRACIC, SINGLE WALL SOCKET, SHOULDER JOINT, LOCKING ELBOW, FRICTION WRIST, CHEST STRAP, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
L6600	UPPER EXTREMITY ADDITIONS, POLYCENTRIC HINGE, PAIR
L6605	UPPER EXTREMITY ADDITIONS, SINGLE PIVOT HINGE, PAIR
L6610	UPPER EXTREMITY ADDITIONS, FLEXIBLE METAL HINGE, PAIR
L6615	UPPER EXTREMITY ADDITION, DISCONNECT LOCKING WRIST UNIT
L6620	UPPER EXTREMITY ADDITION, FLEXION-FRICTION WRIST UNIT
L6623	UPPER EXTREMITY ADDITION, SPRING ASSISTED ROTATIONAL WRIST UNIT WITH LATCH
L6625	UPPER EXTREMITY ADDITION, ROTATION WRIST UNIT WITH CABLE LOCK
L6628	UPPER EXTREMITY ADDITION, QUICK DISCONNECT HOOK ADAPTER, OTTO BOCK OR EQUAL
L6629	UPPER EXTREMITY ADDITION, QUICK DISCONNECT LAMINATION COLLAR WITH COUPLING PIECE, OTTO BOCK OR EQUAL

PROSTHETICS AND ORTHOTICS

L6630	UPPER EXTREMITY ADDITION, STAINLESS STEEL, ANY WRIST
L6632	UPPER EXTREMITY ADDITION, LATEX SUSPENSION SLEEVE, EACH
L6635	UPPER EXTREMITY ADDITION, LIFT ASSIST FOR ELBOW
L6637	UPPER EXTREMITY ADDITION, NUDGE CONTROL ELBOW LOCK
L6640	UPPER EXTREMITY ADDITIONS, SHOULDER ABDUCTION JOINT, PAIR
L6641	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, PULLEY TYPE
L6642	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, LEVER TYPE
L6645	UPPER EXTREMITY ADDITION, SHOULDER FLEXION-ABDUCTION JOINT, EACH
L6650	UPPER EXTREMITY ADDITION, SHOULDER UNIVERSAL JOINT, EACH
L6655	UPPER EXTREMITY ADDITION, STANDARD CONTROL CABLE, EXTRA
L6660	UPPER EXTREMITY ADDITION, HEAVY DUTY CONTROL CABLE
L6665	UPPER EXTREMITY ADDITION, TEFLON, OR EQUAL, CABLE LINING
L6670	UPPER EXTREMITY ADDITION, HOOK TO HANK, CABLE ADAPTER
L6672	UPPER EXTREMITY ADDITION, HARNESS, CHEST OR SHOULDER, SADDLE TYPE
L6675	UPPER EXTREMITY ADDITION, HARNESS, FIGURE OF ("8") EIGHT TYPE, FOR SINGLE CONTROL
L6676	UPPER EXTREMITY ADDITION, HARNESS, FIGURE OF ("8") EIGHT TYPE, FOR DUAL CONTROL
L6680	UPPER EXTREMITY ADDITION, TEST SOCKET, WRIST DISARTICULATION OR BELOW ELBOW
L6682	UPPER EXTREMITY ADDITION, TEST SOCKET, ELBOW DISARTICULATION OR ABOVE ELBOW
L6684	UPPER EXTREMITY ADDITION, TEST SOCKET, SHOULDER DISARTICULATION OR INTERSCAPULAR THRACIC

PROSTHETICS AND ORTHOTICS

L6686	UPPER EXTREMITY ADDITION, SUCTION SOCKET
L6687	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, BELOW ELBOW
L6688	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, ABOVE ELBOW
L6689	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, SHOULDER DISARTICULATION
L6690	UPPER EXTREMITY ADDITION, FRAME TYPE SOCKET, INTERSCAPULAR-THORACIC
L6691	UPPER EXTREMITY ADDITION, REMOVABLE INSERT, EACH
L6700	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #3
L6705	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5
L6710	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5X
L6715	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #5XA
L6720	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #6
L6725	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #7
L6730	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #7LO
L6735	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #8
L6740	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #8X
L6745	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #88X
L6750	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #10P
L6755	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #10X
L6760	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #10AW
L6765	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #12P
L6770	TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #99X

PROSTHETICS AND ORTHOTICS

L6775 TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #555

L6780 TERMINAL DEVICE, HOOK, DORRANCE, OR EQUAL, MODEL #SS555

L6785 TERMINAL DEVICE, HOOK, DORRANCE OR EQUAL, MODEL #SSS555

L6790 TERMINAL DEVICE, HOOK-ACCU HOOK, OR EQUAL

L6795 TERMINAL DEVICE, HOOK-2 LOAD, OR EQUAL

L6800 TERMINAL DEVICE, HOOK-APRL VC, OR EQUAL

L6805 TERMINAL DEVICE, MODIFIER WRIST FLEXION UNIT

L6806 TERMINAL DEVICE, HOOK, TRS, GRIP, VC

L6807 TERMINAL DEVICE, HOOK, TRS, ADEPT, CHILD, VC

L6808 TERMINAL DEVICE, HOOK, TRS, ADEPT, INFANT, VC

L6809 TERMINAL DEVICE, HOOK, TRS, SUPER SPORT, PASSIVE

L6810 TERMINAL DEVICE, PINCHER TOOL, OTTO BOCK OR EQUAL

HANDS

L6825 TERMINAL DEVICE, HAND, DORRANCE, VO

L6830 TERMINAL DEVICE, HAND, APRL, VC

L6835 TERMINAL DEVICE, HAND, SIERRA, VO

L6840 TERMINAL DEVICE, HAND, BECKER IMPERIAL

L6845 TERMINAL DEVICE, HAND, BECKER LOCK GRIP

L6850 TERMINAL DEVICE, HAND, BECKER PLYLITE

L6855 TERMINAL DEVICE, HAND, ROBIN-AIDS, VO

L6860 TERMINAL DEVICE, HAND, ROBIN-AIDS, VO SOFT

L6865 TERMINAL DEVICE, HAND, PASSIVE HAND

PROSTHETICS AND ORTHOTICS

L6867	TERMINAL DEVICE, HAND, DETROIT INFANT HAND (MECHANICAL)
L6868	TERMINAL DEVICE, HAND, PASSIVE INFANT HAND (STEEPER, HOSMER OR EQUAL)
L6869	TERMINAL DEVICE, HAND, PASSIVE INFANT HAND HOSMER OR EQUAL
L6870	TERMINAL DEVICE, HAND, CHILD MITT
L6872	TERMINAL DEVICE, HAND, NYU CHILD HAND
L6873	TERMINAL DEVICE, HAND, MECHANICAL INFANT HAND STEEPER OR EQUAL
L6875	TERMINAL DEVICE, HAND, BOCK, VC
L6880	TERMINAL DEVICE, HAND, BOCK, VO
L6890	TERMINAL DEVICE, GLOVE FOR ABOVE HANDS, PRODUCTION GLOVE
L6890	TERMINAL DEVICE, GLOVE FOR ABOVE HANDS, CUSTOM GLOVE
L6900	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, THUMB OR LINE FINGER REMAINING
L6905	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, MULTIPLE FINGERS REMAINING
L6910	HAND RESTORATION (CASTS, SHADING AND MEASUREMENTS INCLUDED), PARTIAL HAND, WITH GLOVE, NO FINGERS REMAINING
L6915	HAND RESTORATION (SHADING AND MEASUREMENTS INCLUDED), REPLACEMENT GLOVE FOR ABOVE
L6920	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL, SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6925	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL, ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6930	BELOW, ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE

PROSTHETICS AND ORTHOTICS

L6935	BELOW, ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6940	ELBOW DISARTICULATION, EXTERNAL POWER, MOLD INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6945	ELBOW DISARTICULATION, EXTERNAL POWER, MOLD INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6950	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, INTERNAL LOCKING BELOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6955	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, INTERNAL LOCKING ELBOW, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6960	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
L6965	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L6970	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE

PROSTHETICS AND ORTHOTICS

L6975	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL,SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
L7010	ELECTRONIC HAND, OTTO BOCK, STEEPER OR EQUAL, SWITCH CONTROLLED
L7015	ELECTRONIC HAND, SYSTEM TEKNIK, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
L7020	ELECTRONIC GREIFER, OTTO BOCK OR EQUAL, SWITCH CONTROLLED
L7025	ELECTRONIC HAND, OTTO BOCK, MYOELECTRONICALLY CONTROLLED
L7030	ELECTRONIC HAND, SYSTEM TEKNIK, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7035	ELECTRONIC GREIFER, OTTO BOCK OR EQUAL, MYOELECTRICALLY CONTROLLED
L7040	PREHENSILE ACTUATOR, HOSMER OR EQUAL, SWITCHED CONTROLLED
L7045	ELECTRONIC HOOK, CHILD, MICHIGAN OR EQUAL, SWITCH CONTROLLED
L7160	ELECTRONIC ELBOW, BOSTON OR EQUAL, SWITCH CONTROLLED
L7165	ELECTRONIC ELBOW, BOSTON OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7170	ELECTRONIC ELBOW, HOSMER OR EQUAL, SWITCH CONTROLLED
L7180	ELECTRONIC ELBOW, UTAH OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7185	ELECTRONIC ELBOW, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
L7190	ELECTRONIC ELBOW, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
L7260	ELECTRONIC WRIST ROTATOR, OTTO BOCK OR EQUAL

PROSTHETICS AND ORTHOTICS

L7261	ELECTRONIC WRIST ROTATOR, FOR UTAH ARM
L7266	SERVO CONTROL, STEEPER, OR EQUAL
L7272	ANALOGUE CONTROL, UNB OR EQUAL
L7274	PROPORTIONAL CONTROL, 12 VOIT, UTAH OR EQUAL
L7360	SIX VOLT BATTERY, OTTO BOCK OR EQUAL, EACH
L7362	BATTERY CHARGER, SIX VOLT BATTERY, OTTO BOCK OR EQUAL
L7364	TWELVE VOLT BATTERY, OTTO BOCK OR EQUAL, EACH
L7366	BATTERY CHARGER, TWELVE VOLT BATTERY, UTAH OR EQUAL
L7499	UNLISTED PROCEDURES FOR UPPER EXTREMITY PROSTHESIS
L7500	REPAIR OF PROSTHETIC DEVICE, HOURLY RATE
L7510	REPAIR PROSTHETIC DEVICE, REPAIR OR REPLACE MINOR PARTS
L8000	BREAST PROSTHESIS, MASTECTOMY BRA
L8010	BREAST PROSTHESIS, MASTECTOMY SLEEVE
L8020	BREAST PROSTHESIS, MASTECTOMY FORM
L8300	TRUSS, SINGLE WITH STANDARD PAD
L8310	TRUSS, DOUBLE WITH STANDARD PADS
L8320	TRUSS, ADDITION TO STANDARD PAD, WATER PAD
L8330	TRUSS, ADDITION TO STANDARD PAD, SCROTAL PAD
L8400	PROSTHETIC SHEATH, BELOW KNEE, EACH
L8410	PROSTHETIC SHEATH, ABOVE KNEE, EACH
L8415	PROSTHETIC SHEATH, UPPER LIMB, EACH
L8420	PROSTHETIC SOCK, WOOL, BELOW KNEE, EACH
L8430	PROSTHETIC SOCK, WOOL, ABOVE KNEE, EACH

PROSTHETICS AND ORTHOTICS

L8435	PROSTHETIC SOCK, WOOL, UPPER LIMB, EACH
L8440	PROSTHETIC SHRINKER, BELOW KNEE, EACH
L8460	PROSTHETIC SHRINKER, ABOVE KNEE, EACH
L8465	PROSTHETIC SHRINGER, UPPER LIMB, EACH
L8470	STUMP SOCK, SINGLE PLY, FITTING, BELOW KNEE, EACH
L8480	STUMP SOCK, SINGLE PLY, FITTING, ABOVE KNEE, EACH
L8499	UNLISTED PROCEDURES FOR MISCELLANEOUS PROSTHEIC SERVICES
L9999	SALES TAX, ORTHOTIC/PROSTHETIC/OTHER
V2620	PROSTHETIC, EYE, GLASS, STOCK
V2621	PROSTHETIC, EYE, PLASTIC, STOCK
V2622	PROSTHETIC, EYE, GLASS, CUSTOM
V2623	PROSTHETIC, EYE, PLASTIC, CUSTOM

CAPPED RENTAL

E0145	WALKER, WHEELED, WITH SEAT AND CRUTCH ATTACHMENTS
E0146	WALKER, WHEELED, WITH SEAT
E0165	COMMODE CHAIR, STATIONARY, WITH DETACHABLE ARMS
E0166	COMMODE CHAIR, MOBILE, WITH DETACHABLE ARMS
E0180	PRESSURE PAD, ALTERNATING WITH PUMP
E0181	PRESSURE PAD, ALTERNATING WITH PUMP, HEAVY DUTY
E0182	PUMP FOR ALTERNATING PRESSURE PAD
E0183	FLOTATION PAD FOR WHEELCHAIR
E0190	DECUBITUS CARE MATTRESS, INCLUDES FLOTATION OR GEL MATTRESS
E0192	LOW PRESSURE AND POSITIONING EQUALIZATION PAID FOR WHEELCHAIR
E0202	PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER
E0235	PARAFFIN BATH UNIT, PORTABLE
E0236	PUMP FOR WATER CIRCULATING PAD
E0250	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITH MATTRESS
E0251	HOSPITAL BED, WITH SIDE RAILS, FIXED HEIGHT, WITHOUT MATTRESS
E0252	HOSPITAL BED, FIXED HEIGHT, WITH MATTRESS
E0255	HOSPITAL BED, WITH SIDE RAILS VARIABLE HEIGHT, HI-LO WITH MATTRESS
E0260	HOSPITAL BED, WITH SIDE RAILS, SEMI-ELECTRIC, HEAD AND FOOT ADJUSTMENT, WITH MATTRESS
E0265	HOSPITAL BED, TOTAL ELECTRIC WITH SIDERAILS, (HEAD, FOOT AND HEIGHT ADJUSTMENTS, WITH MATTRESS)
E0266	HOSPITAL BED, WITH SIDE RAILS, TOTAL ELECTRIC HEAD, FOOT AND HEIGHT ADJUSTMENTS, WITHOUT MATTRESS

CAPPED RENTAL

E0305	BED SIDE RAILS, HALF LENGTH
E0456	CHEST CURASS, WITH PUMP
E0480	PERCUSSOR, ELECTRIC OR PNEUMATIC, HOME MODEL
E0550	HUMIDIFIER, DURABLE FOR EXTENSIVE SUPPLEMENTAL HUMIDIFICATION DURING IPPB TREATMENTS OR OXYGEN DELIVERY, E.G., CASCADE
E0565	COMPRESSOR, AIR POWER SOURCE FOR EQUIPMENT WHICH IS NOT SELF-CONTAINED OR CYLINDER DRIVEN
E0606	POSTURAL DRAINAGE BOARD MONITORING EQUIPMENT (E0607 - E0619)
E0608	APNEA MONITOR
E0630	PATIENT LIFT, HYDRAULIC, WITH SEAT OR SLING
E0635	PATIENT LIFT, ELECTRIC WITH SEAT OR SLING
E0652	PNEUMATIC COMPRESSOR, SEGMENTAL HOME MODEL (LYMPHEDEMA PUMP) WITH CALIBRATED GRADIENT PRESSURE
E0668	PNEUMATIC APPLIANCE FOR USE WITH SEGMENTAL PNEUMATIC COMPRESSOR, ARM
E0745	NEUROMUSCULAR STIMULATOR, ELECTRONIC SHOCK UNIT, NON-CLINICAL MODEL
E0749	OSTEOGENESIS STIMULATOR (SURGICALLY IMPLANTED)
E0781	EXTERNAL AMBULATORY INFUSION PUMP WITH ADMINISTRATIVE EQUIPMENT
E0910	TRAPEZE BARS, A/K/A PATIENT HELPER, ATTACHED TO BED, WITH GRAB BAR
E0920	FRACTURE FRAME, ATTACHED TO BED, INCLUDES WEIGHTS
E0930	FRACTURE FRAME, FREE STANDING, INCLUDES WEIGHTS
E0940	TRAPEZE BAR, FREE STANDING, COMPLETE WITH GRAB BAR

CAPPED RENTAL

E0941	GRAVITY ASSISTED TRACTION DEVICE, ANY TYPE
E0946	FRACTURE, FRAME, DUAL WITH CROSS BARS, ATTACHED TO BED, (E.G. BALKEN, 4 POSTER)
E0958	WHEELCHAIR ATTACHMENT TO CONVERT ANY WHEELCHAIR TO ONE ARM DRIVE
E0968	COMMODE SEAT, WHEELCHAIR
E1030	ROLLABOUT CHAIR, WITHOUT ARMS
E1035	GERIATRIC CHAIR
E1036	POSITIONING CHAIR (SUBMIT BRAND NAME, MODEL NUMBER AND SPECIFICATIONS)
E1040	ROLLABOUT CHAIR, WITH FIXED OR REMOVABLE ARMS
	WHEELCHAIR - FULLY-RECLINING
E1050	FULLY-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1060	FULLY-RECLINING WHEELCHAIR, DETACHBLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1070	FULLY-RECLINING WHEELCHAIR, DETACHBLE ARMS, (DESK OR FULL LENGTH), SWING AWAY DETACHABLE FOOTREST
E1083	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1084	HEMI-WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1085	HEMI-WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOT RESTS
E1086	HEMI-WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS
E1087	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1088	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE ELEVATING LEG RESTS

CAPPED RENTAL

E1089	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, FIXED LENGTH ARMS, SWING AWAY DETACHABLE FOOTREST
E1090	HIGH STRENGTH LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOT RESTS
E1091	YOUTH WHEELCHAIR, ANY TYPE
E1092	WIDE HEAVY DUTY WHEEL CHAIR, DETACHABLE ARMS DESK OF FULL LENGHT, SWING AWAY DETACHABLE ELEVATING LEG RESTS
E1093	WIDE HEAVY DUTY WHEEL CHAIR, DETACHABLE ARMS DESK OR FULL LENGHT, SWING AWAY DETACHABLE FOOTRESTS
	WHEELCHAIR - SEMI-RECLINING
E1100	SEMI-RECLINING WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1110	SEMI-RECLINGING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELVATING LEGREST
E1130	STANDARD WHEELCHAIR, FIXED FULL LENGTH ARMS, FIXED FOR FULL SWING AWAY DETACHABLE FOOTRESTS
E1140	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH, SWING AWAY DETACHABLE FOOTRESTS
E1150	WHEELCHAIR, DETACHABLE ARMS, DESK OR FULL LENGTH SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1160	WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
	WHEELCHAIR-AMPUTEE
E1170	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1171	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, WITHOUT FOOTRESTS OR LEGRESTS
E1172	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) WITHOUT FOOTRESTS OR LEGRESTS

CAPPED RENTAL

E1180	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTRESTS
E1190	AMPUTEE WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1195	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1200	AMPUTEE WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE FOOTRESTS
	WHEELCHAIR-POWER
E1210	MOTORIZED WHEELCHAIR WITH MICROSWITCH CONTROL, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE ELEVATING LEGRESTS
E1211	MOTORIZED WHEELCHAIR WITH MICRO-SWITCH CONTROL, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY, DETACHABLE ELEVATING LEG RESTS
E1212	MOTORIZED WHEELCHAIR WITH MICRO-SWITCH CONTROL, FIXED FULL LENGTH ARMS, SWING AWAY, DETACHABLE FOOT RESTS
E1213	MOTORIZED WHEELCHAIR WITH MICRO-SWITCH CONTROL, DETACHABLE ARMS DESK OR FULL LENGTH, SWING AWAY, DETACHABLE FOOT RESTS
	WHEELCHAIR - SPECIAL SIZE
E1221	WHEELCHAIR WITH FIXED ARM, FOOTRESTS
E1222	WHEELCHAIR WITH FIXED ARM, ELEVATING LEGRESTS
E1223	WHEELCHAIR WITH DETACHED ARMS, FOOTRESTS
E1224	WHEELCHAIR WITH DETACHED ARMS, ELEVATING LEWRESTS
E1225	SEMI-RECLINING BACK FOR CUSTOMIZED WHEEL CHAIR
E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR POWER OPERATED VEHICLE
E1240	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS, (DESK OR FULL LENGTH) SWING AWAY DETACHABLE, ELEVATING LEGREST

CAPPED RENTAL

E1250	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE, FOOTREST
E1260	LIGHTWEIGHT WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ARMS, SWING AWAY DETACHABLE, FOOTREST
E1270	LIGHTWEIGHT WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY DETACHABLE, ELEVATING LEGREST
	WHEELCHAIR - HEAVY DUTY
E1280	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGREST
E1285	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS, SWING AWAY
E1290	HEAVY DUTY WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) SWING AWAY DETACHABLE FOOTREST
E1295	HEAVY DUTY WHEELCHAIR, FIXED FULL LENGTH ARMS ELEVATING LEGREST
E1310	WHIRLPOOL, NONPORTABLE (BUILT-IN TYPE)

OXYGEN

* Q0036	OXYGEN CONCENTRATOR, HIGH HUMIDITY
* Q0037	OXYGEN AND WATER VAPOR ENRICHING SYSTEM
** Q0038	OXYGEN CONTENTS, GASEOUS PER UNIT (FOR USE WITH OWNED GASEOUS STATIONARY SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE GASEOUS SYSTEM ARE OWNED; 1 UNIT = 50 CUBIC FT.)
** Q0039	OXYGEN CONTENTS, LIQUID PER UNIT (FOR USE WITH OWNED STATIONARY LIQUID SYSTEMS OR WHEN BOTH A STATIONARY AND PORTABLE LIQUID SYSTEM ARE OWNED; 1 UNIT = 10 LBS.)
** Q0040	PORTABLE OXYGEN CONTENTS, GASEOUSPER UNIT (FOR USE WITH OWNED PROTABLE GASEOUS SYSTEMS WHEN NO STATIONARY GAS SYSTEM IS USED; 1 UNIT = 5 CUBIC FT.)
** Q0041	PORTABLE OXYGEN CONTENTS, LIQUID, PER UNIT, (FOR USE ONLY WITH OWNED PORTABLE LIQUID SYSTEMS WHEN NO STATIONARY LIQUID SYSTEM IS USED; 1 UNIT = 1 LB.)
* Q0042 (Rental Only)	STATIONARY COMPRESSED GAS SYSTEM RENTAL, INCLUDES (Rentals Only) CONTENTS (PER UNIT), REGULATOR WITH FLOW GAUGE, HIMIDIFIER, NEBULIZER, CANNULA OR MASK AND TUBING; 1 UNIT = 50 CUBIC FT.)
* Q0043 (Rental Only)	STATIONARY LIQUID OXYGEN SYSTEM RENTAL, INCLUDES (Rentals Only) CONTENTS (PER UNIT), USE OF RESERVOIR, CONTENTS INDICATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK AND TUBING; 1 UNIT OF CONTENTS = 10 LBS.)
E0425 (Purchase)	STATIONARY COMPRESSED GAS SYSTEM, INCLUDES REGULATOR WITH FLOW GAUGE, HUMIDIFIER, CANNULA OR MASK AND TUBING
E0430	PORTABLE GASEOUS OXYGEN SYSTEM INCLUDES REGULATOR WITH FLOW GAUGE, HUMIDIFIER, CANNULA OR MASK AND TUBING

OXYGEN

E0435	OXYGEN SYSTEM, LIQUID, PORTABLE, INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, FLOW HUMIDIFIER
**** E0440 (Purchase)	OXYGEN SYSTEM, LIQUID, STATIONARY, INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK AND TUBING
*** E0455	OXYGEN TENT, EXCLUDING GROUP OR PEDIATRIC TENTS
*** E0555	HUMIDIFER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
*** E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
*** E1351	CANNULA
*** E1352	TUBING, UNSPECIFIED LENGTH
*** E1353	REGULATOR
*** E1354	MOUTH PIECE
*** E1371	FACE TENT
*** E1374	VARIABLE CONCENTRATOR MASK
E1400	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MANIMUM FLOW RATE DOES NOT EXCEED 2 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION
E1401	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MAXIMUM FLOW RATE GREATER THAN 2 LITERS PER MINUTE, DOES NOT EXCEED 3 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION

OXYGEN

E1402	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MAXIMUM FLOW RATE GREATER THAN 3 LITERS PER MINUTE, DOES NOT EXCEED 4 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION
E1403	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MAXIMUM FLOW RATE GREATER THAN 4 LITERS PER MINUTE, DOES NOT EXCEED 5 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION
E1404	OXYGEN CONCENTRATOR, MANUFACTURER SPECIFIED MAXIMUM FLOW RATE GREATER THAN 5 LITERS PER MINUTE, AT 85 PERCENT OR GREATER CONCENTRATION

*	FOR BILLING GAS AND LIQUID SYSTEM RENTALS AND CONCENTRATOR RENTALS OR PURCHASE
**	FOR MONTHLY BILLING OF CONTENTS USED WITH PURCHASED GAS OR LIQUID OXYGEN DELIVERY SYSTEMS (I.E., NO STATIONARY SYSTEM IS BEING RENTED)
***	FOR BILLING OF REPLACEMENT ITEMS FOR PURCHASED DELIVERY SYSTEMS
****	FOR BILLING OF SYSTEM PURCHASES ONLY

NEED PRESCRIPTION BEFORE DELIVERY

E0180	PRESSURE PAD, ALTERNATING WITH PUMP
E0181	PRESSURE PAD, ALTERNATING WITH PUMP, HEAVY DUTY
E0182	PUMP FOR ALTERNATING PRESSURE PAD
E0183	FLOTATION PAD FOR WHEELCHAIR
E0184	FLOTATION MATTRESS, DRY
E0185	DECUBITUS CARE PAD, FLOTATION OR GEL WITH FOAM LEVELING PAD
E0188	SYNTHETIC SHEEPSKIN PAD
E0189	LAMBSWOOL, SHEEPSKIN PAD, ANY SIZE
E0190	DECUBITUS CARE MATTRESS, INCLUDES FLOTATION OR GEL MATTRESS
E0192	LOW PRESSURE AND POSITIONING EQUALIZATION PAD FOR WHEELCHAIR
E0195	REPLACEMENT PAD FOR USE WITH MEDICALLY NECESSARY ALTERNATING PRESSURE PAD OWNED BY PATIENT
E0620	SEAT LIFT CHAIR, MOTORIZED TO ASSIST PATIENT IN STANDING AND SITTING
E0720	TENS, TWO LEAD, LOCALIZED STIMULATION
E0730	TENS, FOUR LEAD, LARGER, AREA/MULTIPLE NERVE STIMULATION
E1230	POWER OPERATED VEHICLE (3 WHEEL NONHIGHWAY) INDICATE BRAND NAME AND MODEL NUMBER

CHAPTER VII

BILL REVIEW

FOR INTERIM MANUAL INSTRUCTIONS

Section

Implementation of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (IM-88-3)........................... IM 3600

New Part A Provisions under Catustrophic Insurance................ IM 3629

Planning for Implementing of HCPCS for Hospital Outpatient Radiology Services.. IM 3629

IM 3600 IMPLEMENTATION OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987 (P.L. 100-203)

On December 22, 1987, the President signed into law the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). It provides for a number of changes that affect Medicare coverage and reimbursement. This instruction describes the provisions that affect your bill processing operations and provides interim instructions until appropriate manual revisions are distributed.

1. Extension of Reductions Under Sequester Order (§4001).—The sequester order issued by the President for a 2.324 percent reduction (see Program Memorandum No. A-87-17) remains in effect through:

- o March 31, 1988 for Part A inpatient hospital services and all services rendered under Part B (hospital outpatient department Part B, SNF services, Part B home health, clinical diagnostic laboratory fee schedule, ESRD, CORF, etc.). Included are Part A payments for pass-through costs attributable to PPS hospitals.

- o December 31, 1987 for Part A home health, hospice, and SNF services.

Make appropriate changes in payment calculation for bills for these services.

2. Rate of Increase in Payment for Inpatient Hospital Services (§4002).—The law establishes separate standardized payment amounts for large urban areas, other urban areas and rural areas. For discharges occurring on or after April 1, 1988 and before October 1, 1988 the update percentages for Medicare payments are set at:

- o One point five (1.5) percent for hospitals in large urban areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. A listing of urban areas meeting this criteria is in your new Pricer program.

- o One point zero (1.0) percent for hospitals in other urban areas, and

- o Three point zero (3.0) percent for hospitals in rural areas.

- o The increase in the hospital specific portion of payment for sole community hospitals is:

  — Zero (0) percent for the first 51 days of the cost reporting period;
  — Two point seven (2.7) percent for the next 132 days; the remainder of the cost reporting period will be subject to the applicable percentage increase as described above.

- o The 25 percent national component of the Puerto Rico DRG - specific rate is the discharge - weighted average of the large urban, other urban, and rural DRG - specific rates.

o For PPS excluded hospitals, the update to the rate of increase limits is deemed to be 0 percent for the first 51 days of their cost reporting periods beginning during FY 1988. The rate of increase for the remainder of this period is 2.7 percent.

Regional floors for the PPS standardized amounts are established. It is equal to the higher of the national standardized amount, or the sum of 85 percent of the national standardized and 15 percent of the regional standardized amounts. They are effective for discharges occurring on or after April 1, 1988 and before September 30, 1990.

HCFA will include these changes in Pricer 7.2. You have no special action to take other than to install Pricer 7.2. (See Program Memoranda A-87-12 and A-87-17 for payments prior to April 1, 1988.)

3. Increase in Disproportionate Share Adjustments and Reduction in Indirect Medical Education Payments (§4003).—The indirect medical education adjustment is reduced to approximately 7.7 percent for each 0.1 in the ratio of interns and residents to beds.

This provision extends the DSH adjustment to include hospital discharges prior to October 1, 1990. The DSH adjustment for large urban hospitals meeting the State and local indigent care revenue test is increased to 25 percent. The maximum adjustment of 15 percent for qualifying urban hospitals with over 100 beds is eliminated. Review your provider specific data to determine whether providers now subject to the 15 percent limit are eligible for a higher DSH adjustment. Adjust the DSH field where appropriate. Eliminate the 15 percent limit in your edits for the provider specific file you send HCFA. (See §3850.2, Item 14.)

Effective date: Discharges occurring on or after October 1, 1988.

4. Rural Hospitals (§4005).—This provides the following changes affecting hospitals in rural areas:

Expansion of Swing-Bed Program - This allows rural hospitals with fewer than 100 beds to participate. Payment for extended care services furnished by hospitals with 50-99 beds is subject to additional conditions. First, if there is an available SNF bed in the geographic area, the extended care patient must be transferred within 5 week days (excluding weekends and holidays), unless the patient's physician certifies that the transfer is not medically appropriate. Second, payment is prohibited for days of Medicare covered extended care at the hospital during a cost reporting period which exceed 15 percent of the product of the number of days in the period and the average number of beds.

This provision will be handled through the cost settlement process. Advise hospitals that wish to be certified as swing-bed facilities under this provision to contact the RO. Additional instructions will be issued describing the requirements for notice by SNFs to hospitals of the availability of beds.

Effective Date: Agreements entered into after March 31, 1988.

Clarification of Sole Community Provider Status - Hospitals meeting the criteria for sole community hospital status may receive a payment adjustment without assuming the status of a sole community hospital. The volume adjustment provision is extended through cost reporting periods beginning before October 1, 1990. Additional payments to the hospital that qualify for a volume adjustment under this provision, but are not designated sole community hospitals, are capped at 5 million in FY 1988 and 10 million in FY 1989.

Hospitals must apply for this status in the same manner as hospitals with "sole community hospital" status.

Effective date: Cost reporting periods beginning on or after October 1, 1987.

Rural Referral Centers - This changes the bed size requirement for designation as a rural referral center from 500 to 275 beds. The other related requirements remain unchanged.

Effective Date: Discharges occurring on or after April 1, 1988.

5. Payments for Hospital Capital (§4006).—The reduction in capital payments for inpatient hospital services is increased according to the following schedule:

3.5 percent through 11/20/87
7 percent from 11/21/87 through 12/31/87
12 percent from 1/1/88 through 9/30/88
15 percent from 10/1/88 through 9/30/89

The Secretary of HHS must establish a PPS for capital related costs for PPS hospitals for hospital cost reporting periods beginning in FY 1992. This system must provide for payment on a per discharge basis with appropriate weighting for the type of discharge.

Effective Date: The increased FY 1988 reduction is applicable for discharges or portions of cost reporting periods occurring on or after January 1, 1988. Adjust your capital pass-through rate to reflect the new reduction percent. Also, see Item 1 of this instruction regarding the reduction for capital payments under the sequester order. Apply the capital reduction first.

6. Other Related Provisions (§4008).—The following are other provisions relating to inpatient hospital services.

Massachusetts Medicare Payment - This provides that Medicare payments may not be recouped, or otherwise reduced, from hospitals in the State of Massachusetts because of alleged Medicare overpayments. This is applicable to overpayments that occurred during the period of the Medicare statewide hospital reimbursement demonstration program conducted between October 1, 1982 and June 30, 1986.

Clarification of §1814(b) Waiver Authority - This modifies the criteria under which the Secretary may continue payment to hospitals under an alternative State hospital reimbursement system. These alternative reimbursement systems were established as demonstrations under §402 of the Social Security Admendments of 1967 or §222 of the Social Security Amendments of 1972. They may be continued until the Secretary determines that:

o A third party payer reimburses a hospital in that State on a basis other than the alternative system;

o The rate of increase in Part A costs per inpatient hospital admission is greater than the national rate of increase in such costs. In comparing the rate of increase in Medicare costs per admission for the alternative reimbursement system with the rate of increase for all hospitals, the comparison is made for the period from October 1, 1983 to the end of the most recent date for which annual data are available.

Effective Date: Enactment.

Hospital Outlier Payments - This increases payments for outlier cases classified in DRGs relating to burns by changing the percentage factor applied in determining outlier payments from 60 to 90 percent. Thus, burn cases which stay beyond the appropriate day outlier threshold will receive 90 percent of the applicable per diem for each outlier day. Cost outliers in burn DRGs will receive 90 percent of the cost of care above the cost outlier threshold. This reimbursement level applies to discharges occurring during the period April 1, 1988 through September 30, 1988 and FY 1989. This provision will be implemented in a manner to ensure that total payments under PPS are neither increased nor decreased because of this adjustment.

This provision will be included in Pricer 7.2 without the need for special action by intermediaries.

7. Miscellaneous Provisions (§4009).—This contains the following provisions relating to intermediary claims processing.

Waiver of Inpatient Limitation for Connecticut Hospice, Inc. - This permanently extends the waiver from the 20 percent/60 percent inpatient/home care day requirement for Connecticut Hospice, Inc.

Effective Date: Enactment.

Psychologists Services Furnished to Hospital Inpatients - This provides coverage under Part A for inpatient hospital services of clinical psychologists. It specifies that Medicare coverage for "other diagnostic or therapeutic items or services" furnished to hospital inpatients by "others under arrangements with them made by the hospital" includes the services of clinical psychologists. Hospitals are to report these services under revenue code 91x, psychiatric/psychological services. No additional action is required by you.

Effective Date: Services furnished on or after April 1, 1988

8. Payment for HMO Hospital Services (§4012).—Repeals the provision allowing intermediary payment of HMO/CMP hospital and SNF charges for TEFRA risk HMOs only. Also, hospitals and SNFs are required to accept as payment in full from HMO/CMPs the amount that would have been paid for the same services furnished to nonenrollees under Medicare reimbursement principles.

Effective for admission dates of April 1, 1988, HCFAs query reply R trailer messages will be modified to show the appropriate HMO status. There will be no more A status codes. There will be B status codes for:

- H2603 - Total Health Care - Kansas City, MO
- H5001 - Group Health Coop of Puget Sound - Seattle, WA

Continue to follow §3555 for determining payment jurisdiction. This will prevent the payment of TEFRA risk HMO/CMP inpatient or emergency/urgently needed claims with admission dates of April 1, 1988 or thereafter. Process these claims as described in §3654.1 as HMO paid bills and inform the providers to request payment from the HMO. Also, this provision does not release you from the requirements of processing HMO paid bills for TEFRA risk HMOs.

The Secretary is required to provide to HMO/CMPs Medicare DRG rates for payments and data on cost pass-through items for all inpatient services. HCFA expects to modify the "provider specific file" to obtain the data needed by HMOs to implement this provision, and will furnish data direct to HMOs. It is not anticipated that you will have any direct data exchange with HMO/CMPs.

Effective Date: Admissions occurring on or after April 1, 1988, or if later, the earliest date the Secretary can provide the required information in a machine readable form. HCFA anticipates notifying you in March 1988 of changes for the April/May/June provider file due in July 1988.

9. Requirement That Individual be Confined to Home (§4024).—This legislates existing policy on interpretation of an individual confined to home for purposes of receiving home health services. An individual is considered to be "confined to his home" if he or she meets the following criteria:

- Has a condition, due to an illness or injury that restricts his/her ability to leave home except with the assistance of another individual or the aid of a supportive device (such as cruches, a cane, a wheelchair, or walker); or

- If the individual has a condition such that leaving his/her home is medically contraindicated.

While the individual does not have to be bedridden to be considered "confined to his home," his/her condition should be such that there exists a normal inability to leave home. Moreover, leaving home requires a considerable and taxing effort by the individual. Any absences from home are infrequent, of relatively short duration, or are attributable to the need to receive medical treatment.

Effective Date: Items and services provided on or after January 1, 1988.

10. HHA Cost Limits (§4026).—This requires that in establishing HHA cost limits, the Secretary utilize a wage index based on audited wage data obtained from HHAs. These limits must be based on the most recent audited wage data available, which may be for cost reporting periods beginning no earlier that July 1, 1985.

Additional instructions will be provided.

Effective Date: Cost reporting periods beginning on or after July 1, 1988.

11. Payment Cycle Standards (§4031).—This establishes a minimum payment time of 10 days for claims received July 1, 1988 through September 30, 1988; and 14 days for claims received after September 30, 1988. All claims are to be paid or denied no later than 26 days from the date of their receipt, but no earlier than the applicable minimum time.

Separate instructions are now in process describing these requirements.

Effective Date: Claims received on or after July 1, 1988.

12. Denials and Reconsiderations of Claims for Home Health Services, Extended Care Services, and Post-Hospital Extended Care Services (§4032).—This provides that each Medicare contractor agreement must require that if a Medicare claim for home health services, extended care services, or post-hospital extended care services is denied, you must:

- Furnish the provider and the Medicare beneficiary a written explanation of the denial and of its statutory or regulatory basis.

- Promptly notify the Medicare beneficiary and the provider of the disposition of the reconsideration.

The provision also provides that the performance standards for contractors include an assessment of whether they were able to:

- Process 66 percent of reconsiderations within 60 days during FY 1989.

- Process 75 percent of reconsiderations within 60 days during subsequent years.

- Process 90 percent of reconsiderations within 90 days.

- They must also be assessed on the extent to which their determinations are reversed upon appeal.

HCFA has established a workgroup including representatives from RHHAs and appropriate CO components to develop recommendatios for the content of denial letters. We expect to issue related specifications in 60-90 days. In the interim, issue a written explanation to both the beneficiary and the provider. Sending the provider a copy of the letter to the beneficiary is acceptable. Coding on a provider remittance record is not acceptable.

Effective Date: The notification requirements apply with respect to claims received on or after January 1, 1988. However, it is not necessary to search denial files to provide additional notice on claims that you have processed. Your new performance criteria apply with respect to claims filed on or after October 1, 1988.

13. Application of Secondary Payer Provision to Governmental Entities (§4034).--This clarifies that the Medicare secondary payer provision relating to the disabled (§1862(b)4 of the Act) also applies to governmental entities. (See §3492 of Part 3.) The tax penalty imposed under §5000(d) of the Internal Revenue Code of 1986 does not apply to government entities.

Effective Date: January 1, 1987. The provision is effective as if it were included in the enactment of §9319(a) of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509).

14. Publication and Notification of Policies (§4035).—Beginning June 1, 1988, you must make available to the public all interpretive materials, guidelines, and clarification of policies that relate to payment for SNF and HHA claims and DME. We will provide you with definitive instructions. In the interim, begin identifying and collecting in one location, all applicable internal guidelines and HCFA manuals, Program Memorandum and RO letters relating to payment of these benefits.

Effective Date: June 1, 1988

15. ESRD Amendment (§4036(a)).—This provides that providers and facilities must bill the EGHP first before billing Medicare when there is an indication of other insurance coverage. They no longer have the option of billing Medicare first.

Effective Date: Services and items furnished on and after January 21, 1988.

16. Miscellaneous and Technical Provisions (§4039).—This contains two provisions that affect your claims processing.

Recovery of Payment for Certain Pacemaker Devices - This requires that information reported to the registry include any amounts paid to providers under an express or implied warranty under contract or State law. In addition, the Secretary has the option of requiring, by regulation, that providers repay Medicare any amounts received under warranty for replaced pacemakers. The Secretary may deny payments to providers with respect to the implantation or replacement of pacemaker devices or leads if the provider fails to make required repayments.

You will be provided further instructions. No changes are appropriate until you receive them.

Effective Date: January 1, 1988.

17. Payments for DME, Prosthetic Devices, Orthotics, and Prosthetics (§4062).--This imposes new limitations on allowable charges and frequency of payments for DME, prosthetic devices, orthotics, and prosthetics. This section applies to all contractors, but for you, it applies only to DME furnished by a HHA as part of home health services.

Additional instructions will be issued.

Effective Date: January 1, 1989.

18. Clinical Diagnostic Laboratory Tests (§4064).—This provides the following related to Medicare payments for clinical diagnostic laboratory tests:

o Delays until April 1988 changes in fee schedules planned for January 1, 1988.

o Eliminates any CPI increases in 1988.

o Reduces the national limitation amount from 115 percent to 100 percent of the median fee established by Medicare carriers effective for services provided April 1, 1988.

o Reduces the fee schedule amounts payable for automated tests and tests previously subject to a limit based upon the lowest charge levels. (The carrier will furnish you affected HCPCS codes and their new applicable rates at least 30 days before the effective date.)

o Eliminates the 2 percent payment differential between the fee schedule for hospital outpatients and other services. The fee schedule will be based upon 60 percent of the prevailing charge. For sole community hospitals with qualified laboratories (as defined in §3628A) the fee schedule will be based on 62 percent of the prevailing charge.

Use the same determination you used for PPS purpose to determine whether a hospital qualifies as a sole community hospital. Sole community hospitals are indicated as codes 01 and 11 in your PPS Pricer file. (See §3656.3D, "Provider Type Field.")

Effective Date: April 1, 1988 for provisions related to clinical lab fee schedules and payment limits. The HCPCS update for 1988 is rescheduled for April 1, 1988. Carriers will provide fee schedules for new HCPCS codes by March 11, 1988.

19. Payments to Hospital Outpatient Departments for Radiology (§4066).—Provides for a limit to the aggregate payment for outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine, CAT scan procedures, magnetic resonance imaging services and diagnostic ultra-sound and other imaging procedures). The payment limit includes both noncapital and capital costs.

The limit is based upon a blended amount of the costs and the prevailing charges that would apply if the services had been performed in a physician's office in the same locality. The term "cost proportion" is defined as 65 percent for cost reporting periods beginning in FY 1989 and 50 percent for subsequent years. The term "charge proportion" is defined as 35 percent for cost reporting periods beginning FY 1989 and 50 percent in subsequent years.

The "blend amount" for radiology services is the sum of:

o The hospital's reasonable costs or customary charges for providing the radiologic services (net of deductible and coinsurance) times the cost proportion; and

o Sixty two (62) percent of 80 percent of the prevailing charges for participating physicians for the same services, times the charge proportion.

Beginning October 1, 1989, payment for other outpatient diagnostic procedures (excluding diagnostic radiology and diagnostic lab tests) are included under a similar aggregate limit. The limit for these additional procedures is based upon 42 percent of the prevailing charge or upon other appropriate percentage(s) if determined by the Secretary to be appropriate or by carriers (acting pursuant to guidelines issued by the Secretary). Such alternative percentage(s) would be based upon the technical component for the service as a percent of the total charge for the service.

You will be provided additional instructions.

Effective Date: This provision is effective for radiology services rendered on or after October 1, 1988 and other diagnostic procedures for services rendered on or after October 1, 1989.

20. Maximum Payment Per Visit For Independent RHCs (§4067).—Medicare reimburses independent RHCs (i.e., those that are not part of a hospital, SNF or HHA) based upon the clinic's reasonable cost incurred in furnishing RHC services to Medicare beneficiaries. Payments to clinics are based on an all-inclusive rate for each visit by a Medicare beneficiary for covered services. As a result of this provision, the payment limit for services provided on or after April 1, 1988 is established at $46 per visit. In subsequent years, the 1988 limit will be increased by the percentage increase in the Medicare economic index applicable to physicians' services furnished as of the first day of the year.

The Medicare economic index is set in accordance with §1842(b)(3) of the Act.

Since the statute requires that the payment limit apply to services provided as of a specific date, different payment limits may apply during one cost reporting period. Costs and visits that apply to different payment limits should be identified separately on the cost report, Worksheet 3, Part B, lines 1-5 of Form HCFA-222.

Effective date: Services provided on or after April 1, 1988.

21. Payment for Ambulatory Surgery At Eye, and Eye and Ear Speciality Hospitals (§4068).—This modifies §9343 of OBRA (1986) to provide for the application of a separate payment limitation for ASC covered outpatient surgery procedures in the case of a hospital that:

o Specializes in eye or eye and ear surgical procedures (as determined by the Secretary);

o Receives more than 30 percent of its total revenues from outpatient procedures; and

o Was an eye and ear speciality hospital or an eye hospital on October 1, 1987.

For a hospital meeting these requirements, the 75/25 blend of a hospital's reasonable costs and the ASC rate applies only to cost reporting periods beginning in FYs 1989 and 1990, reverting to a 50/50 blend for cost reporting periods beginning after October 1, 1990.

Additional instructions will be issued.

22. Coverage for Mental Health Services (§4070).—This increases the calendar year limitation on reimbursable expenses under Part B for the treatment of a mental, psychoneurotic or personality disorder from $312.50 for 1987 to $562.50 for 1988 and $1,375 for 1989. In 1988 the maximum Medicare payment is increased from $250 to $450. The maximum payment for 1989 and subsequent years is $1,100.

Incorporate the appropriate changes in your outpatient bill and query/reply processing systems. Do not submit any queries or bills for psychiatric services that exceed the $562.50 maximum until March 28, 1988. The query and bill processing systems will be modified to accept the higher psychiatric maximum on that date. For queries that have already been submitted prior to the March 28, 1988 implementation date, where the psychiatric limit remaining in the reply is less than the amount queried, submit a void query and pend the claim until March 28, 1988.

23. Clarification of Coverage of Drugs Used in Immunosuppressive Therapy (§4075).—This clarifies the current provision that coverage for outpatient immunosuppressive drugs under Part B includes all prescription drugs used in immunosuppressive therapy.

Effective Date: Drugs dispensed on or after December 22, 1987.

24. Psychologist Services in Clinics (§4077).--This includes clinical psychologist services in the definition of Medicare covered RHC services even when they are not provided under the supervision of a physician. It also authorizes coverage of, and direct payment for, psychologist's services furnished at a community mental health center.

Payments will be made for "qualified psychologist services" on the basis of a fee schedule to be established by the Secretary. The term "qualified psychologist services" is a service furnished by a mental health center, which the psychologist is legally authorized to perform under State law (or State regulations).

Additional instructions will be issued.

Effective Date: Services performed on or after July 1, 1988.

25. Provision of Offsite CORF Services (§4078).--Amends the requirement that a CORF must provide all services at the CORF site. CORFs can now provide occupational therapy, speech and physical therapy offsite. Additional implementing instructions will be issued.

26. Prompt Payment for CORF (§4085(d)).--This adds CORFs and rehabilitation agencies to the list of providers eligible to receive prompt pay interest for clean claims not paid within certain time limits. The Secretary is required to provide for amendments to contracts with you in order to implement the provision.

Instructions now in effect provide for paying interest for late payments to CORFs and rehabilitation agencies, therefore, no changes are anticipated.

Effective Date: Applies to claims received on or after December 22, 1987.

27. Limitation of Beneficiary Liability for PRO Denied Services (§4096).--

a. Indemnification.--For services furnished beginning January 1, 1988, the provider may not charge the beneficiary for deductible and/or coinsurance when services are denied and the provider is liable. In addition, when a review results in denial of a claim for which the provider is liable, do not charge any utilization, credit deductible, or update psychiatric services limit. Continue to recover the incorrect payment from the provider, using the changes in coding instructions described below. The denial notice from the PRO will inform the provider of its obligation to refund deductible and/or coinsurance amounts paid by the beneficiary. Handle any indemnification requests from beneficiaries (when the provider does not make appropriate refund to the beneficiary) using the procedure in §3446.

When you or the PRO deny the entire bill and payment has been made, submit the adjustment bill to HCFA and to the PRO as a code N nonpayment bill. If you have not made payment, and you deny the entire admission, submit the bill with a nonpayment code of N. If the beneficiary is liable for any of the days denied, identify these days with occurrance span code 76.

When you or the PRO deny a portion of the bill for which the provider is liable, identify such portion or portions with an occurrence span code 77 showing the span of dates for each portion denied. If you have sent the original bill to HCFA, submit an adjustment, inserting a P in the third position of the type of bill code if the PRO requested the adjustment, or an I if you initiated the adjustment. If you have not sent the bill to HCFA, do not charge utilization to the beneficiary for the provider liable portion and require the provider to refund any copayments related to the "provider liable" portion that it collected from the beneficiary.

For bills reflecting inpatient stays beginning before January 1, 1988 and ending after December 31, 1987, be sure that no utilization is charged and no copayments are collected from the beneficiary for any days denied after December 31, 1987 for which the provider is liable. Conversely, charge utilization and copayments for provider liable days that occur prior to January 1, 1988.

HCFA CO will implement the following consistency edit:

9905	H&S	This inpatient nonpayment bill spans 1987 calendar year end, and the utilization days exceed the number of year 1987 days in the stay, less any year 1987 days reported as patient liable days (occurrence span code 76). This is applicable to original inpatient bills and debit adjustment inpatient bills with a P or an I in the units position of the Type of Bill code.

Final nonpayment bills are identified by the presence of a valid nonpayment code in field 73 (inpatient hospital and SNF, including CS). Editing of final nonpayment bills is limited to the edits described by return codes 0401, 0701, 0702, 1501, 2101, 2102, 2201, 2202, 2203, 2303, 2401, 2502, 33X1, 33X2, 33X3, 33X4, 51X4, 51X5, 94G1, 94G2, 94G3, (except for nonpayment code "R"), 94G4 (nonpayment code "R" only), 9904, and 9905.

b. Notice to Beneficiary of PRO Review of Discharge.--When a hospital decides a beneficiary no longer requires inpatient hospital care, the case must be referred to the PRO for review if the attending physician disagrees. At the time of the referral, the hospital must provide notice of the referral for MR to the beneficiary.

Intermediaries have no special action relating to this provision.

Effective Date: Services provided on or after January 1, 1988.

IM 3622. DESCRIPTION OF PART A PROVISIONS

A. Inpatient Hospital.—

1. Prior Provision.—A benefit period begins with the first day (not included in a previous benefit period) on which the patient is furnished inpatient hospital or extended care services by a qualified provider in a month in which the patient is entitled to hospital insurance benefits. It ends with the close of the period of 60 consecutive days during which the patient is neither an inpatient of a hospital nor an SNF (§3025). For each benefit period, the beneficiary is responsible for a cash deductible, and coinsurance of 1/4 the deductible for the 61st through the 90th days. The beneficiary may elect up to 60 lifetime reserve days with a coinsurance of 1/2 the deductible.

2. New Provision.—

a. Inpatient Hospital Deductible.—The inpatient hospital deductible will apply only to a beneficiary's first period of hospitalization beginning in a calendar year.

However, if a beneficiary incurs a deductible during December of a calendar year, the beneficiary will not be required to pay a deductible for hospitalization beginning in January of the following year. Admission in February through December will require a deductible. This "carryover" provision is applicable to the December 1988 through January 1989 period as well as to subsequent December through January periods. The special provision in subsection F provides additional protection to the beneficiary against too frequent application of the inpatient hospital deductible during the transition from the old to the new provisions.

Under the new provisions, even if the customary charges for the hospital stay are less than the specified dollar amount of the inpatient hospital deductible for that year, they satisfy the deductible. The beneficiary does not have to make up the difference during a subsequent hospital stay, as he does under the present provisions.
(See chart, next page.)

An individual's period of hospitalization begins on the first day the individual is furnished inpatient hospital services and ends on the date of discharge from the hospital or death. A transfer from one hospital to another is not a discharge even if the transfer is considered a discharge under PPS, e.g., where the transfer is from a prospective payment hospital to a hospital not under PPS or an approved Statewide cost control system or demonstration. A leave of absence is not a discharge.

EXAMPLE: A patient is admitted to a hospital on 11/29/89 and transferred to another hospital on 1/15/90. He is discharged from the second hospital on 2/15/90. He incurs only one inpatient hospital deductible for the single period of hospitalization from 11/29/89 to 2/15/90.

In the case of a same-day admission and transfer, the inpatient hospital deductible for a period of hospitalization is imposed on the hospital to which the beneficiary is transferred. In the case of a transfer subsequent to the day of admission, the inpatient hospital deductible for the period of hospitalization is imposed on the transferring hospital. In all transfer cases, the deductible is limited to the lesser of the dollar amount of the deductible or the actual charges at the hospital on which the deductible is imposed. The charges at the other hospital will not be considered in this connection.

INPATIENT DEDUCTIBLE EXAMPLES

1st Admission Stay Dates	Deductible Incurred on Admission	2nd Admission Stay Dates	Deductible Due	3rd Admission Stay Dates	Deductible Due	Remarks
11/15/88 - 11/20/88	Yes	01/05/89 - 01/10/89	No	05/05/89 - 02/20/90	Yes	No deductible due for 2nd admission because 1988 spell continues. Deductible due for 3rd admission-spell broken. (Hold harmless provision.)
12/15/89 - 12/19/89	Yes	01/20/90 - 01/25/90	No	02/15/90 - 02/20/90	Yes	No deductible due on 2nd admission because deductible was paid in December and readmission was the following January. Deductible due on 3rd admission in February.
11/15/89 - 12/15/89	Yes	01/10/90 01/12/90	Yes	02/25/90 02/26/90	No	New calendar year deductible due on 2nd admission. None due on 3rd admission because only one deductible per calendar year.
12/15/89 - 01/15/90	Yes	02/03/90 02/08/90	Yes			Second admission must be in January for December-January rule to apply.

b. Elimination of Day Limitation on Inpatient Hospital Services.--The Medicare limits on payment for inpatient hospital care (90 days plus a lifetime reserve of 60 days) are eliminated. Medicare will pay for an unlimited number of hospital days for covered services.

The 190-day lifetime limit on inpatient psychiatric hospital services is retained, and the guarantee of payment provision remains applicable in connection with this limit, but only with this limit. In addition, the preentitlement psychiatric limit (§3104) is retained. However, for purposes of this limit, the concept of the benefit period has been replaced by the concept of 60 consecutive days in which the beneficiary does not receive inpatient mental health services, i.e., after 60 such consecutive days the preentitlement psychiatric limit will no longer apply. "Inpatient mental health services" include inpatient psychiatric hospital services, and inpatient hospital services for a beneficiary who is an inpatient of a non-psychiatric hospital primarily for diagnosis and treatment of mental illness.

c. Elimination of Coinsurance Amounts for Inpatient Hospital Services.--The current hospital inpatient coinsurance amounts for days 61 through 90 and coinsurance for the 60 lifetime reserve days are eliminated. No coinsurance amounts will apply to inpatient hospital services.

d. Elimination of "Spell of Illness".--The "spell of illness" concept is eliminated for determining the number of hospital and SNF days Medicare will cover, the hospital and SNF coinsurance days and the Part A blood deductible.

e. Adjustments in P ments of Inpatient Hospital Services.--When adjusting the Medicare hospital pay t amounts, the Secretary of Health and Human Services (HHS) is required to take account the reductions in beneficiary payments to hospitals because of the elimination of the day limitation. Any adjustments for PPS hospitals will be built into the appropriate Pricer update.

B. Inpatient SNF.--

1. Prior Provision.--The beneficiary is entitled to 20 days of full coverage followed by 80 coinsurance days. The coinsurance for each coinsurance day is equal to 1/8 of the inpatient hospital cash deductible, or the actual total SNF charge per day, whichever is less. The stay must be preceded by a qualifying inpatient hospital stay and a timely transfer of the SNF.

2. New Provision.--

a. Coinsurance on First Eight Days.--Beneficiaries are required to pay coinsurance amounts for the first 8 days of SNF services in a calendar year (on SNF bills spanning 2 calendar years, value codes 9 and 11, and the related coinsurance rates are required).

b. Coinsurance Equal to 20 Percent.--The coinsurance amounts per day equal 20 percent of the national average per diem Medicare reasonable cost for SNF services. The coinsurance amount for 1989 is $25.50 per day.

c. Cover 150 Days of Care.--The Medicare program will cover up to 150 days of skilled nursing care services in a calendar year. The level of care requirements remain the same.

d. Prior Hospitalization and Transfer Requirements.--The prior hospitalization, transfer, and other requirements for benefits (including the requirement that the extended care services must be for a condition for which the beneficiary was receiving inpatient hospital services or a condition which arose while he was in the SNF for treatment of a condition for which he was previously hospitalized) are eliminated for admissions that occur on or after January 1, 1989.

C. Christian Science Inpatient SNF.--

1. Prior Provision.--If the beneficiary elects to have his services in a Christian Science Sanatorium treated as post-hospital extended-care services, the beneficiary is entitled to a maximum of 30 days, each of which is subject to the same coinsurance amount that is applicable to regular SNF days after the 20th day. A beneficiary cannot use regular SNF days and Christian Science SNF days in the same benefit period.

2. New Provision.--If the beneficiary elects to have his services in a Christian Science Sanatorium treated as extended care services, the beneficiary is entitled up to 45 days per year, each of which is subject to the same coinsurance that is applicable to the first 8 days of regular SNF coverage (20 percent of the national average SNF per diem rate). A beneficiary cannot use regular SNF days and Christian Science SNF days in the same calendar year.

D. Hospice.--

1. Prior Provision.--Benefits are limited to 210 days. Hospices are required to provide care, but may not be paid for care after 210 days.

2. New Provision.--The Medicare program will extend the hospice benefit, and reimburse a hospice, beyond the current 210-day benefit period if the beneficiary's physician or hospice director recertifies that the beneficiary is still terminally ill. There is no day limit to the length of this subsequent extension period, although the current-law cap on hospice reimbursement is maintained.

E. Blood Deductible.--

1. Prior Provision.--The beneficiary is responsible for a three-pint blood deductible for each benefit period.

2. New Provision.--A Medicare beneficiary will be responsible for payment of a deductible equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of red blood cells) furnished during each calendar year. A provider may charge the beneficiary, or a third party, its customary charge for the blood (or units of packed red cells) or the blood deductible can be met by replacing the blood in

accordance with the regulations. The 3-pint Part A blood deductible for the year is reduced to the extent that the Part B blood deductible for that year has already been satisfied. Similarly, the 3-pint Part B deductible for the year is reduced to the extent that Part A blood for the year has been satisfied. Blood deductible pints count toward meeting both deductibles whether a charge is made for them or they are replaced. See subsection F for special blood deductible transitional provisions.

F. Transition Provisions.--The new provisions are generally effective January 1, 1989. However, there are special transition provisions as follows:

1. Inpatient Hospital.—In the case of a beneficiary who has a benefit period in effect on December 31, 1988, the new inpatient hospital deductible provisions do not apply, and no further inpatient hospital deductible will be charged during 1989 or 1990 while that benefit period continues. The first period of hospitalization that begins after the end of that benefit period, during 1989 or 1990, will be the first period of hospitalization in that year for imposing the inpatient hospital deductible for that year under the new provisions.

2. Part A Blood Deductible.—In the case of a beneficiary who has a benefit period in effect on December 31, 1988, a Part A blood deductible required for 1989 or 1990 under the new provisions will be reduced, to the extent that the Part A blood deductible was satisfied before 1989 in that benefit period, while that benefit period continues in effect. This reduction applies whether or not the Part A blood furnished in 1989 or 1990 is replaced. However, before this reduction is applied to the Part A blood furnished in 1989 or 1990, the Part A blood deductible for that year is first reduced to the extent that the Part B blood deductible has already been satisfied for that year. (See subsection E2.)

If the benefit period that began before 1989 ends in 1989 or 1990, any part of the reduced Part A blood deductible satisfied for the year based on Part A or Part B blood furnished during that year and during that benefit period will not have to be met again in that year after the benefit period ends. However, any reduction in the Part A blood deductible for that year based on Part A blood furnished before 1989 will not apply for that year after that benefit period ends and will not reduce the Part B blood deductible either during, or after the end of, that benefit period.

EXAMPLE 1: A beneficiary fully satisfies his 3-pint Part A blood deductible in a hospital stay in 1988, during a benefit period that begins in 1988 and ends in 1990. In 1989 and 1990, the beneficiary incurs Part A expenses for 1 and 3 pints of blood respectively. The 3 pints of pre-1989 blood which satisfied his deductible for the benefit period reduce his Part A blood deductible for 1989 to zero. Medicare pays for the 1 pint of Part A blood received in 1989. None of the 3 pints of pre-1989 blood are available to reduce his Part A blood deductible for 1990, so he is responsible for paying for, or replacing, the 3 pints of Part A blood he receives in 1990. (If no Part A blood expenses were incurred in 1989, the 3 pre-1989 pints would reduce the Part A blood deductible for 1990 to zero and Medicare would pay for 3 pints of Part A blood in 1990).

EXAMPLE 2: Same facts as in EXAMPLE 1 except that the beneficiary satisfies only 1 pint of the Part A blood deductible in 1988. In this case, the beneficiary's Part A blood deductible is reduced from 3 to 2 for 1989, remains 3 for 1990, and Medicare makes no payment for blood in either year. (If no Part A blood expenses were incurred in 1989, the 1 pre-1989 pint would reduce the Part A blood deductible for 1990 to 2 pints and Medicare would pay for 1 pint of Part A blood in 1990.)

EXAMPLE 3: A beneficiary fully satisfies the 3-pint Part A blood deductible in a hospital stay occurring in 1988, during a benefit period that begins in 1988 and ends in 1990. Early in 1989, the beneficiary incurs Part B expenses for 1 pint of blood, thus meeting 1 pint of the Part B blood deductible for 1989. Subsequently, the beneficiary incurs Part A expenses for 5 pints of blood during a hospital stay in 1989, for 3 pints of blood during a hospital stay in 1990 while the benefit period continues, and for 3 pints of blood during a hospital stay in 1990 after the end of the benefit period. Thereafter, during 1990, he incurs Part B expenses for three additional pints of blood. The Part A and Part B blood expenses incurred during 1989 and 1990 are reimbursable as follows:

The 1 pint applied toward the Part B blood deductible for 1989 reduces the Part A blood deductible for 1989 to 2 pints.

The pints of Part A blood received during 1988 (which met the Part A blood deductible for the benefit period which began in 1988):

reduce the remaining 2 pint Part A blood deductible for 1989 to zero.

reduce the 3-pint Part A blood deductible for 1990 to 2 pints while the benefit period continues. After the end of the benefit period, the Part A blood deductible for 1990 is restored to 3 pints (2 pints of which have been met based on blood previously furnished in 1990.)

The 2 pints of Part A blood furnished in 1990 during the benefit period and 1 of the 3 pints of Part A blood furnished in the hospital stay after the end of benefit period reduce the Part B blood deductible for 1990 to zero.

Thus, all Part A and Part B blood expenses for 1989 and 1990 are reimbursable except for 1 pint of Part B blood received in 1989 and 3 pints of Part A blood received in 1990 (2 during the first hospitalization, and 1 during the second hospitalization).

3. SNF.--Beginning on January 1, 1989, there is no spell of illness limitation for Part A SNF benefits, and Medicare covers up to 150 SNF days for a beneficiary per calendar year. The "post-hospital" coverage requirements are eliminated for SNF admissions that occur after 1988, but continue to apply with respect to SNF admissions that occurred before 1989. Part A payments may be made in connection with a SNF admission that occurred before 1989 only if the prior hospitalization, transfer, and other requirements for payment for post-hospital extended care services are met.

Use the following rules to establish whether the post-hospital requirements are to be applied:

a. Admission after 1988 (No post-hospital requirements).--For care furnished with respect to SNF admissions that occur after 1988, the post-hospital requirements for SNF coverage do not apply. An admission to a SNF takes place after 1988 when any of the following events occurs on or after January 1, 1989:

- Actual admission to the facility.
- Transfer from a noncertified to a certified part of the facility.
- The SNF's Medicare participation (or that of the distinct part in which the beneficiary is residing) becomes effective.
- Deemed admissions.--There are two situations in which a patient whose stay in a participating SNF bed continued from 1988 into 1989 is deemed to be admitted after 1988:
    - If a beneficiary did not require a covered level of SNF care at the end of 1988 but begins to require a covered level of care on or after January 1, 1989, he is deemed to be admitted at that point.
    - When a beneficiary who was admitted to a participating SNF bed before 1989, and thus was subject to the post-hospital requirements, ceases to need a covered level of care at some point after 1988, he is no longer considered to be a SNF patient at that time. If the beneficiary later begins to need a covered level of care again, at that point he will be deemed to be admitted to the SNF after 1988, and the post-hospital coverage requirements will no longer apply.

b. Admission before 1989 (Post-hospital requirements continue to apply).--SNF care provided on or after January 1, 1989 still must meet the post-hospital requirements if the admission occurred before 1989. In most cases, your current records will show whether the post-hospital requirements are met. The occurrence of a qualifying prior hospital stay and timely initial transfer to the SNF is a matter of record and must be verified, unless the assumption discussed below applies. (Establishing that a beneficiary was receiving Part A SNF coverage on a given date serves to verify that the prior hospital stay and timely transfer requirements were met as of that date.) However, it may not always be readily apparent whether the post-hospital requirements are met in connection with a SNF admission that occurred some distance in the past. For example, it may be difficult to determine if a covered level of care continued to be needed throughout a lengthy stay. In order to determine that a beneficiary continues to meet the post-hospital requirements when he had met them at some point in the past and has exhausted his 100 days of post-hospital extended care services during his current SNF stay (however long ago that stay may have begun), make the following assumption:

- If the beneficiary, during the 90 days preceding January 1, 1989, has received a covered level of care without an interruption of 30 consecutive days or more, assume that he still meets the post-hospital requirements as of January 1, 1989, in the absence of evidence to the contrary.

If a Medicare beneficiary's eligibility for SNF coverage after 1988 is dependent upon a new admission after 1988, the discharge from the prior stay and the new admission must be reflected on UNIBILLS.

G. Query/Reply.—For admissions after December 31, 1988, the following changes to HCFA query reply processing will apply.

- HCFA will no longer keep open items.

- HCFA will no longer return an amount of deductible to be met. The inpatient deductible is limited to the lesser of either the prevailing deductible dollar amount or the total charges for the first period of hospitalization in the calendar year. Only a met or not met indicator will be returned, since no additional deductible can be imposed in any subsequent hospitalization that year.

- It will no longer be necessary to query subsequent periods of hospice election. Query the first period only. HCFA will not terminate hospice benefits for a Medicare-entitled individual unless a termination (Type 7 hospice query) is received.

If HCFA receives a termination, you must send in the proper query to re-enroll the beneficiary in the hospice program. Subsequent hospice periods will be updated at HCFA based on utilization received on UNIBILL. Continue to obtain proper evidence of recertifications, including recertification to the new unlimited extension of benefits after the 30th day of the third hospice period. Continue to send changes in hospice and/or intermediary to HCFA.

- The following changes will be made to query reply disposition codes.

Disposition Code	Prior Condition	Change
01	Approval. The beneficiary has never used Part A services. This is an initial admission for this beneficiary.	This disposition code means that the beneficiary is entitled to Part A.

		Base payment on the content of the utilization fields in the reply.
02	Approval. Some prior Part A utilization. Last recorded date of discharge is within 60 days of this date of admission and there are no query-related open items on HCFA's records.	Since spell of illness concept is eliminated, eliminate code.
03	Acknowledgment. HCFA has processed a query code 2 (cancel) and deleted the admission.	Since it will no longer be necessary for HCFA to keep open items, eliminate code.
25	Qualified Approval. An admission date was received for this beneficiary prior to the current query, and the date of the current admission is 60 days or more after the last discharge date from a posted bill. According to HCFA's records, the current admission starts a new benefit period. The remaining Part A benefits given in the code 25 are always as of the last bill posted. There may be an earlier or later stay for which no bill has been accepted.	Since spell of illness is eliminated, eliminate code.
27	Qualified Approval. The admission date on the current query precedes the last recorded discharge date or the date on the last processed interim bill shown on HCFA's records. This reply shows the utilization remaining as of the date of last billing action. Determine if your admission falls within the current benefit period, a prior benefit period, or links two benefit periods. This may require a code 6 query (§3507.3) to obtain a Bill Retrieval Listing. (Bill History). Apply the utilization remaining within the applicable benefit period to your current admission.	Since it will no longer be necessary to link benefit periods, this code will not be needed. Eliminate.

41	Qualified Approval. Query-related benefit, including 60-day lifetime reserve for inpatient hospital stays, is exhausted. No benefits are available unless this stay begins a new spell of illness or home health services are involved.	Since beneficiaries will have unlimited hospital days, this code will never apply. Eliminate.
46	Qualified Approval. A reply with code 46 means that the individual had admission to a Christian Science SNF and the current admission is to a regular SNF, or he had a prior admission to a regular SNF and the current admission is to a Christian Science SNF, and both admissions may be in the same spell of illness. After an individual has received covered extended care services in a Christian Science sanatorium, he cannot, during the same spell of illness, receive covered extended care services in a regular SNF. Also, after he has received covered extended care services in a regular SNF, he cannot, during the same spell of illness, receive covered extended care services in a Christian Science sanatorium.	Spell of illness is eliminated. Beneficiaries cannot receive extended care services in a regular and a Christian Science SNF in the same calendar year. The definition of the disposition code will be changed to conform.
47	Reply to Duplicate Admission Query. HCFA replied based upon a prior query. There is only one admission on HCFA's records. Treat as any other approval. An "L" trailer code containing the original disposition code is furnished.	Since open items will no longer be kept, HCFA will not identify duplicate queries. Eliminate code.
49	Rejection. HCFA cannot delete the admission because there is no matching admission on the file and an interim bill has been posted. The data submitted are shown on the reply.	Since HCFA will no longer keep admissions, this code will be obsolete. Eliminate code.

Trailer Code G	Lifetime Reserve Benefit Days. This trailer is furnished when the number of lifetime reserve benefit days remaining are fewer than 60 as of the last recorded date of discharge or interim bill. It is given only when one or more lifetime reserve days have been used.	Since lifetime reserve days are eliminated, eliminate trailer.
Trailer Code L	Original Disposition Code. This trailer is furnished with a disposition code 47 reply (which is a reply to a duplicate admission). The purpose of the L trailer is to give the disposition code that was furnished in the original response.	Since code 47 replies are eliminated, eliminate trailer.

REPLY FORMAT

Type 1 reply.--The example below is a typical reply to a hospital notice of admission. The list of data beneath it explains what each item of data means.

1.01212.021102011D.01.081581.00.00.190.150.100.00001.2.3.0000.0766.
.0766.00.

Reply Code
Intermediary #
HICN
Disposition Code
* Date of Admission
* Hospital Days (Full)
* Hospital Days (Co-Pay)
Psychiatric Days
* SNF Days
HHA Visits Part A
* In-Patient Hospital Deductible
Part B Deductible
Blood Deductible
* Last Discharge Date
Part A Effective Date
Part B Effective Date
* Year Benefit Period Began

o The query reply format remains the same. However, the fields annotated with an asterisk change in the following manner:

Hospital days (full) - will be zeroes.

Hospital days (co-pay) - will be zeroes.

SNF Days - will contain the number of SNF days remaining for the calendar year up to a maximum of 150.

Inpatient Hospital Deductible - will contain a met/not met indicator in the fifth position of the field. A "1" denotes met, a "2" not met. The first four positions of the field will be zeroes.

Last Discharge Date - will be zeroes.

Year Benefit Period Began - will be zeroes.

All other fields remain the same.

H. UNIBILL.--The UNIBILL format and data set remain the same with one exception. If you are sending an inpatient hospital bill without deductible because you know the deductible was previously taken on a stay for which the bill has not been processed by HCFA, code the bill with a "B" in field 65. HCFA will process the bill without deductible and diary the bill. If the bill taking deductible is not processed at the end of six months, HCFA sends the intermediary submitting the bill with the B in position 65 an L1001 to collect the deductible. If you are sending UNIBILL for a SNF stay where the beneficiary's eligibility to SNF benefits after 1988 is dependent on an admission after 1988, this admission must be reflected on UNIBILLS.

Some fields will be edited differently. A summary of UNIBILL processing changes follows:

Code	Change
	Consistency Edits
1503	Qualifying hospital stay not within 30 days of SNF admission. Will no longer apply.
2301	Utilization days over maximum for a spell. Hospital days maximum will go from 150 to 365 (366 in leap year). SNF days maximum will go from 100 to 150 (30 to 45 for Christian Science).
2501	Coinsurance days exceed maximum. Will no longer apply to hospital bills, except psychiatric hospital bills which will be 190 days maximum. It will apply to SNFs, but 8 days maximum (instead of 80) will be permitted. (45 will be permitted for Christian Science SNF).
2502	Coinsurance days exceed utilization days. Will no longer apply to hospital bills - only SNF.
2503	Full days overutilized. Will no longer apply to hospital bills - only SNF. SNF maximum will be 142.
2504	Coinsurance rate is incorrect. Will no longer apply to hospital bills - only SNF.
2505	Coinsurance rate exceeds applicable rate. Will no longer apply to hospital bills - only SNF.
2506	Coinsurance amount missing. Will no longer apply to hospital bills - only SNF.

2507	Coinsurance days plus lifetime reserve days exceeds days on statement covers period. Will no longer apply.
2508	Coinsurance days or lifetime reserve days have been applied for utilization days for billing dates after 12/31/88.
2601	Lifetime reserve days exceed 60. Will no longer apply/
2602	Lifetime reserve days shown, but no amount shown for lifetime reserve coinsurance. Will no longer apply.
2603	Lifetime reserve rate exceeds maximum for applicable period. Will no longer apply.
2604	PPS bill containing lifetime reserve days does not include a day outlier. Will no longer apply.
28X3 - 28X5	Date of guarantee of payment began....Will apply to inpatient psychiatric hospital only.
28x6	Date of guarantee of payment is earlier than date benefit exhausted. Will apply to psychiatric hospital only.
28x7	Date of guarantee of payment began + utilization days - (coinsurance days + nonutilization days) cannot exceed statement covers period. Will apply to psychiatric hospital only and coinsurance days will be removed.
28x0	Benefits exhausted - this date is outside the "statement covers date". Will no longer apply to hospital bills (will apply to SNF and inpatient psychiatric).
28xA	Utilization days are greater than number of days from date to date benefits exhausted. Will no longer apply to hospital bills. (SNF or inpatient psychiatric only).
28xC	Date benefits exhausted - a date is shown for other than Part B I/P bill. Will apply only to inpatient psychiatric hospital.
33x1	Qualifying stay dates. Will be eliminated.
33x2	Qualifying stay dates. Will be eliminated.
33x3	Qualifying stay dates. Will be eliminated.
33x4	Qualifying stay dates. Will be eliminated.

94C3	Utilization days plus days used exceed 150. Will be (for psychiatric raised to 190. Will not be applied to inpatient hospital.
9904	Occurrence span code 70 - qualifying stay dates not present. Will be eliminated.

Utilization Edits

The following utilization edits will be modified or eliminated when catastrophic is implemented.

5500	Inpatient days overutilized. Will not apply to hospitals.
5501	Underutilized full coverage days. Will no longer apply.
5510	Overutilized coinsurance days. No longer applies to hospitals. First 8 days per/year for SNFs. (45 for Christian Science SNF).
5511	I/P coinsurance days underutilized. Now applies to hospitals only. Will be eliminated for hospitals. Will be used for SNFs.
5520	Lifetime reserve days overutilized. No longer applicable.
5703	This bill links two benefit periods. Eliminate.
5704	Links two benefit periods. Eliminate.
5705	Noncovered stay or qualifying stay overlaps previously posted bills. No qualifying stay dates needed.
5901	Kron bill does not meet Kron bill criteria. Eliminate.

Automatic Notices

7400	See 5400.
7500	Full reimbursement days have been changed to coinsurance days where reserve days are not involved. No coinsurance days for hospitals. No lifetime reserve days. Will no longer apply. Eliminate.
7511	Part A inpatient nonlifetime coinsurance days have been increased. Can be used for SNFs only. Eliminate nonlifetime.

I. Medicare Benefit Notices, Form HCFA-1533.—Notices are still required in the same situations described in 3718. However, for discharges on or after January 1, 1989, do not include in item 2, Payment Status, either of the following:

- ($ AMOUNT) for the (XX) days of hospital care after first 60 days;
- ($ AMOUNT) for the (XX) days of skilled nursing facility care after first 20 days.

For SNF services after 1988, add the following message:

- ($ AMOUNT) for the first (XX) days of skilled nursing facility care during the calendar year.

IM 3629 Planning for Implementation of HCPCS for Hospital Outpatient Radiology Services.--

A. General.--This provides you with HCFA's current planning for implementing §4066 of the Omnibus Budget Reconciliation Act of 1987 which establishes payment limitations for radiology and other diagnostic services furnished by a hospital on an outpatient basis. That section enacted §1833(a)(2)(E) and §1833(n) of the Social Security Act.

Use this transmittal for your planning and systems development.

B. Definitions and Effective Dates.--HCPCS must be used for billing radiology services provided after September 30, 1988 and for other diagnostic procedures as soon as they are identified by HCFA. Radiology services include diagnostic and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging services, ultra-sound, and other imaging procedures.

Although payment limitations are not required for other diagnostic procedures until October 1, 1989, be prepared to accept HCPCS for them when HCPCS is implemented for radiology services. HCFA will identify other diagnostic procedures subject to §4066. This will permit hospitals and you to make one systems redesign to handle both provisions.

C. Billing.--The billing format is similar to that for clinical diagnostic laboratory tests.

The list of acceptable HCPCS codes for radiology is taken from the CPT-4 portion of HCPCS and is included in subsection J. HCPCS modifiers are not necessary. When other diagnostic procedures are defined, you will be informed of the need for modifiers, if any.

HCPCS codes for radiology are required for the following revenue codes but may be reported with any revenue code since the payment limitation applies to charges for radiology regardless of the revenue code used and/or applicable cost center.

32x Radiology - Diagnostic
33x Radiology - Therapeutic
34x Nuclear Medicine
35x CT Scan
40x Other Imaging Services
61x MRI

For services on or after 10/1/88, if you receive a bill with one of the above revenue codes, edit it to ensure that you receive an HCPCS code within the radiology range (70000-79999). Note that 33x contains chemotherapy subcategories. Apply the edit to revenue code 333 in the 33x series.

We are instructing hospitals to:

- o Revise their chargemaster systems to include HCPCS codes for radiology or provide a crosswalk from their chargemasters to HCPCS;
- o Assign a HCPCS code to every radiology service on their chargemasters;
- o Report the HCPCS code for radiology services in Item 50 to the right of the dotted line adjacent to the revenue code;
- o Use current instructions in revenue coding level;
- o Report units for each HCPCS code in Item 52; and
- o Use bill type 13x or 83x according to whether an ASC procedure is on the same bill.

There is no need for a separate bill.

D. Unlisted Service or Procedure.--In revising their chargemasters to include HCPCS codes for radiology, hospitals may find radiology services for which a corresponding code in subsection J may not be found. These are typically services that are rarely provided, unusual, or new. Hospitals have been instructed to assign the appropriate "unlisted procedure" code from the following list to any such service:

76499	Unlisted diagnostic radiologic procedure
76999	Unlisted ultrasound procedure
77299	Unlisted procedure, therapeutic radiology clinical treatment planning
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices
77499	Unlisted procedure, therapeutic radiology clinical treatment management
77799	Unlisted procedure, clinical brachytherapy
78099	Unlisted endocrine procedure, diagnostic nuclear medicine
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine
78599	Unlisted respiratory procedure, diagnostic nuclear medicine
78699	Unlisted nervous system procedure, diagnostic nuclear medicine
78799	Unlisted genitoruinary procedure, diagnostic nuclear medicine
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine
79999	Unlisted radionuclide therapeutic procedure

It is expected that the number of "unlisted procedures" will be small. Because payment limitations will not be applied to "unlisted procedures," hospitals have been instructed to forward to you by September 1, 1988 a complete list of every radiology procedure on their chargemaster to which they have assigned an "unlisted procedure" code. Included will be a narrative definition of the procedure and a description of the nature, extent and need for the procedure and the time, effort, and equipment necessary to perform it. Determine if the hospital has correctly identified the procedure as "unlisted." If not, inform the hospital of the correct HCPCS code from subsection J to assign to the procedures in the hospital's chargemaster. Where the hospital has correctly identified the service as "unlisted," refer the information reported by the hospital to the HCPCS coordinator in the RO. Initial reports are due October 1 or as soon as hospitals begin providing services for which there are no codes.

E. EMC Formats.--

1. Standard Tape Format.--Use record type 61 (Addendum A) to report outpatient services. Record type, sequence number, patient control number (if used), revenue code, HCPCS code, units and charges are required. Modifiers and dates of service are not needed. The from and through dates of the bill are included in another record in the EMC format.

2. Direct Data Entry.--Accept HCPCS codes for radiology in the same location used for clinical lab HCPCS codes.

F. Reimbursement Methodology.--The payment change for radiology services is effective for services furnished on or after October 1, 1988, and the payment change for other diagnostic procedures is effective for procedures furnished on or after October 1, 1989. Aggregate payments are the lesser of the amount that would be paid under the law prior to enactment of §4066 or a blended amount based in part on prevailing charges for the same services performed in physicians' offices in the same locality. Final payment is based upon the hospital's cost report.

For outpatient radiology services, calculate the blended payment amount according to a formula that sums the "cost proportion" and the "charge proportion."

The "cost proportion" is the amount that would be paid under the law prior to enactment of §4066, i.e., the lesser of reasonable costs or customary charges, after subtracting deductible and coinsurance.

The "charge proportion" is 62 percent of 80 percent of the prevailing charges (after application of deductible) paid to participating physicians for the same services as if they were performed in a physician's office in the same locality.

For radiology services provided October 1, 1988 through September 30, 1989, the blended amount is 65 percent "cost proportion" and 35 percent "charge proportion."

Beginning with radiology services provided on or after October 1, 1989, the blended amount is 50 percent "cost proportion" and 50 percent "charge proportion."

The payment limits for other outpatient diagnostic services do not apply until October 1, 1989. Calculate the blended payment amount by the same formula used to calculate outpatient radiology services, except that the "charge proportion" is 42 percent of 80 percent of the prevailing charges of participating physicians in the same locality or some other appropriate percentage which may be determined later. The blended amount is based on 65 percent "cost proportion" and 35 percent "charge proportion" for other diagnostic services provided on or after October 1, 1989 and before October 1, 1990; and 50 percent "cost proportion" and 50 percent "charge proportion" for such services on or after October 1, 1990.

We will furnish a computer program that utilizes records from the PS&R to determine the applicable reimbursement. This will be run in conjunction with cost settlement.

G. Coordination With Carriers.--The carrier(s) in your area will furnish you tapes containing prevailing charge amounts by HCPCS code for the radiology services listed in subsection J except for the "unlisted procedures." We will give you details later about the file structure. It will be broken out by locality (geographic area) within the State if the carrier uses different localities. The carrier will supply maps which delineate them. The prevailing charge applicable to a hospital is determined by the locality of the hospital.

H. HCFA Software Support.--HCFA will supply a closed callable subroutine to calculate the reimbursement limitation. In addition, the OCE program will be modified for September 1 implementation to include a list for radiology HCPCS codes not billable by hospitals because they are physician's services only. A new error type will be added. Other OCE interface requirements will not change, except as described in subsection I.

I. Assistance to Hospitals in Implementation.--Assist hospitals in implementation:

o Ensure that they receive the related Hospital Manual issuance as soon as it is available;

o Alert appropriate management of the billing changes required;

o Work with hospitals and carriers before October 1 to identify services for which no codes are established; and

o Use the OCE and the edit related to the revenue codes listed in subsection C to identify and report their billing errors for educational purposes during September. Do not return bills for coding errors if there is enough information for processing. Beginning October 1, 1988, return bills for necessary coding corrections. See the insert in the Outpatient Code Editor (OCE), Software Installation Guide, Fourth Revision, for instructions on how to identify errors for analysis in September 1988 and for return beginning in October 1988.

J. HCPCS Codes for Radiology.--In some instances the description of a CPT-4 code states whether a contrast agent is included or excluded. Where a hospital includes contrast media in the radiology cost center, the hospital uses the CPT-4 code with contrast. If the hospital bills the contrast agent under a cost center other than radiology, (e.g., pharmacy) the CPT-4 code without contrast is appropriate.

Hospitals should use only those codes for radiology services that are included on the following list:

Copyright material has been
deleted, not available for
Microfiche Edition.

	Section	Page
Request Filed with Social Security Office	3785.2	262.12A
Request for Hearing Filed with Resident or Reconsideration Intermediary	3785.3	262.12B
Request for Hearings Received by the Intermediary Pertaining to PRO or HMO	3785.4	262.12B
Resident Intermediary Action on Incoming Requests	3785.5	262.12C
Reconsideration Intermediary Action on Incoming Requests	3785.6	262.12C
Request for Claim File (Sent by Hearing Office)	3785.7	262.12C
Reconsideration Intermediary Prescreening and Documentation of Hearing Request	3785.8	262.12C
Assembling the Hearing Claim File	3785.9	262.12C
Examination of Claim File	3785.10	262.12C
Prehearing Case Review	3785.11	262.12E
Regional Office Action on Receipt of Recommended Revision	3785.12	262.12E
Reconsideration Intermediary Action on Hearing Request after Recommended Revision from the Regional Office	3785.13	262.12F
Routing the Hearing Claim File to the Hearing Office	3785.14	262.12F
Inquiries or Status Requests Received by the Reconsideration Evaluation Branch	3785.15	262.12G
Instructions for Completing Form HCFA-353 Part A Pre-Hearing Input Record	3785.16	262.12G
Standard Exhibits Referred to in Section 3785. - 3785.16	3785.17	262.12J
Scope and Effect of OHA, SSA Administrative Law Judge Decisions Under Part A	3786	262.13
Effectuation of Reversal of Decision by Intermediary, OHA, or Federal Court Where There Is Subsequent Utilization of Benefits in the Same Benefit Period	3787	262.13B
Effect of Court Decisions	3788	262.13C

Rights of Representation Under Part A

Beneficiary's Right to Representation Under Part A	3789	262.13D
Beneficiary Incapable of Pursuing His Own Appeal	3789.1	262.14
Beneficiary Deceased	3789.2	262.14
Fees Charged for Services Rendered by a Representative	3789.3	262.15

PRO Appeals Rights

Reconsiderations, Hearings, and Appeals Where a PRO Has Review Responsibility	3790	262.17A
Appeals	3790.1	262.17B
Reconsiderations	3790.2	262.17B
Hearings--General	3790.3	262.17D
Professional Consultation	3790.4	262.17E

Section Page

Appeals Under Part B

Protests, Review, and "Fair Hearing"--Medical Insurance..... 3791 262.17F
Review.. 3792 262.17F
What Constitutes a Request for Review - Handling Beneficiary Inquiries.................................. 3792.1 263
Elements of a Review...................................... 3792.2 263.2
The Hearing... 3794 263.3
Request for Hearing....................................... 3794.1 263.3A
Notice of Time and Place of Hearing....................... 3794.2 264
Hearing Officer... 3794.3 264
Disqualification of Hearing Officer....................... 3794.4 264
Hearing Procedures.. 3794.5 265
Issues for Determination at a Part B Hearing.............. 3794.6 265.2
Hearing Decision.. 3794.7 265.3
HCFA RO Examination of Hearing Records.................... 3794.8 265.3
Request for Hearing--Impractical for Servicing Intermediary's Hearing Officer to Hold Hearing...... 3794.9 265.5
Filing Part B Appeal Requests on HCFA-1964 and HCFA-1962.. 3795 265.6
Authorized Representative-Part B.............................. 3797 266.3

Hospital Appeals Under the Medicare Prospective Payment System (PPS)

Appeals by Hospitals of Diagnosis-Related Group (DRG) Assignment Under PPS.................................... 3798 266.3

Reopenings and Revisions

Reopening and Revision of Determinations and Decisions on Claims--General.. 3799 266.6
How Issues May Arise...................................... 3799.1 266.6
Summary of Conditions under Which a Determination or Decision May be Reopened............................ 3799.2 266.6
Date of Initial, Revised, Reconsidered, or Reviewed Determination, or Hearing Officer's Decision........ 3799.3 266.7
Who May Reopen an Initial, Revised, Reconsidered, or Reviewed Determination, or Hearing Officer's Decision.. 3799.4 266.7
Actions Necessary to Permit Reopening Within the 1-Year or 4-Year Period........................... 3799.5 266.7
Good Cause for Reopening.................................. 3799.6 267
"New and Material Evidence"............................... 3799.7 267
"Clerical Error".. 3799.8 267
"Error on the Face of the Evidence"....................... 3799.9 267
"Unfavorable Determination"............................... 3799.10 267.1
"Change of Position" 3799.11 267.1
Unrestricted Reopening - Fraud or Similar Fault........... 3799.12 267.1

Elements Where Initial Determinations are Reopened........................ 3799.13 267.2
Results of Reopening.................................. 3799.14 267.2
Exception to Sending Notice of Revision to Parties--Cases Involving Limitation on Recovery from Beneficiary.................................... 3799.15 267.3
Refusal to Reopen Is Not an "Initial Determination"............................ 3799.16 267.3
Revised Determination or Decision...................... 3799.17 267.3

Automatic Data Processing Systems Controls

3700. INTERNAL CONTROLS OVER AUTOMATIC DATA PROCESSING SYSTEMS.

It is essential that you maintain adequate internal controls over title XVIIII automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments.

The following hypothetical cases illustrate the necessity for their establishment:

CASE 1: A modification of the address routine results in the address intended for a beneficiary being printed on the checks of all beneficiaries. The problem is detected after the checks have been printed but, prior to their insertion into envelopes.

The defective routine was inserted by a careless employee.

CASE 2: A modification of the address routine results in the address intended for check number 2038 being printed on check number 2037, the address intended for check number 2039 being printed on check number 2038, etc. The problem is after all the checks have been mailed.

The defective routine was inserted by a disgruntled employee.

In general, the best protection against careless or intentional error is a set of formal procedures requiring two or more individuals' involvement in each program change. Adopt safeguards as follows:

- Specific individuals or an organizational segment should have the exclusive right to authorize changes to title XVIII EDP programs. The authorization should be in writing and should describe, in lay language, the reason(s) for the change.

- Keep the source and/or object decks, as appropriate, in a locked cabinet. Grant access to a program deck on the basis of a written authorization for the program change or written statement of the emergency requirement for a change. Obtain an authorization for each emergency change as soon as possible.

- Prepare code sheets for each program change. They should be signed by the programmer making the change and the individual reviewing the change.

See Part II, Systems Security—Appendix for mandatory safeguards.

- Prepare a transmittal for each updated program deck released to the EDP operating personnel. The transmittal should include a description, in lay language, of the reason for the change.

- File all documentation in some logical manner so that it will be easy to ascertain when an improvement, correction, or other modification was made. This documentation will also facilitate pinpointing when errors were introduced, who was responsible, etc.

- Establish procedures to insure that EDP systems changes are scheduled and approved by responsible parties representing both the claims and EDP areas. These procedures should insure that the responsible parties are aware of the nature of the changes and their import.

The establishment and enforcement of these internal controls over program changes does not negate the need for audit activity to insure that the automatic data processing system is functioning properly. Continue to develop techniques for validating each EDP run.

Benefit Checks and Provider Notices

3701. MEDICARE IDENTIFICATION ON ALL WRITTEN COMMUNICATIONS.

All written Medicare communications must contain Medicare identification to distinguish Medicare claims correspondence from your private business correspondence and to establish program identity with providers and beneficiaries. The word "Medicare" must be at least as large as your own organization identification and in a location that gives it at least equal prominence. Summary vouchers and checks must contain Medicare identification as should any forms, letterheads, or envelopes which are used in the Medicare part of your operation. Any notices or letters sent to beneficiaries must be identified as Medicare. (See Part 2, § 2955, for additional guidelines on Medicare identification of written communications.)

3702. NOTICE OF PAYMENT TO PROVIDERS. (REMITTANCE ADVICE)

Make payments to providers not less often than monthly. Send a notice of payment to the provider describing the payment. Minimum data acceptable is identification of the patient, period and type of service, charges, deductions payment, and DRG if applicable. You may include additional data. The method and format of the notice is up to you. Electronic media is preferable where it is cost effective. (For notices to beneficiaries, see §§ 3717ff.)

3703. BENEFIT CHECKS.

Checks must contain the legend: "For Health Insurance--Social Security Act."

Combine payment checks wherever feasible, for all services for which payments are being made to a single provider. Combine checks for separate claims as well as separate services.

Do not combine title XVIII benefits with complementary coverage benefits in a single check. (See Part 1,§ 1412.)

3703.1 Provider Payments to the Home Office of a Chain Organization.—Reimbursement amounts for providers of a chain organization may be forwarded to a central location of the home office when it has set up a lock box or special bank account and you have secured a written assignment or other authorization from the respective provider(s) that payment may be sent to the home office. The payments must be made out in the individual provider's name and they must be made by check.

Establishment of internal controls and other related administrative details necessary to effect these payments is left to the individual contractors involved. However, be sure that the individual signing the assignment can legally bind the provider.

3703.2 Cancellation of Outstanding Checks Resulting from Contractor Follow-Up or Beneficiary Allegations.—HCFA has not set a time limit within which a benefit check must be cashed. This is due to the varied commercial practices of contractors and the banks with which they deal, as well as variances in State laws. However, with the exception of large settlement checks (see Part 1, § 1412.7A), allow at least 6 months for benefit checks to be negotiated. The following aged check cancellation procedures are recommended in disposing of checks which are outstanding beyond 6 months:

- Where an existing Medicare bank account is being terminated and a new account opened with a different commercial bank, follow the check voiding and reissuance instructions in Part 1, § 1406.2.

- Where a check is not presented for payment within 1 year from date of issue, cancel the check.

In all other instances it is within your discretion to determine when checks beyond the 6-month minimum should be cancelled. Make this determination in light of your usual practices and the commercial practices in your area.

Establish a system of contacting providers and beneficiaries to whom outstanding checks have been issued. The period for follow-up on outstanding checks should be flexible, depending upon your experience as to the normal time required for clearance of checks, e.g., when the check has been outstanding 90 days. (Contact need not be made for outstanding checks of $5 or less.) The contact should disclose why the check was not negotiated, such as non-receipt, loss, theft, destruction, etc. On the basis of the beneficiary's signed statement, the original check can immediately be voided and a duplicate issued. Do not require the beneficiary to undergo the expense of having the statement notarized. Where the beneficiary cannot be reached, do not void the check for at least 6 months.

When you learn of the non-receipt, loss, theft, destruction, etc., of a check as the result of a beneficiary-initiated report (i.e., not resulting from your follow-up), check your records to determine whether the original check is unnegotiated. If the check has not been negotiated, obtain the beneficiary's signed statement that the check was lost, stolen, etc., if you do not already have such a signed statement. Proceed to void the original and to issue a duplicate. (If the check has been negotiated, follow § 3476.)

Establish a system of control to document the cancellation of outstanding checks; e.g., annotate the beneficiary's claim file, maintenance of a cancelled check listing.

Social Security Office--Intermediary Contacts

3706. SOCIAL SECURITY OFFICE-INTERMEDIARY CONTACTS VIA FORMS HCFA-1980 AND HCFA-1938

A. Requesting Social Security Assistance.-- Form HCFA-1980 (Carrier or Intermediary Request for SSA Assistance, is a standard form for requesting social security office (SSO) assistance. Use it for requesting assistance in all cases except where arrangements with the RO require other procedures.

The HCFA-1980 is a three-part snap-out set. The original is for the servicing SSO (the SSO servicing the beneficiary), the first copy is for the parallel SSO (the SSO servicing you), and the second copy is your control copy. Submit the original and first copy simultaneously to the parallel SSO except when dealing directly with the beneficiary's servicing SSO. In this case, discard the parallel SSO copy.

When the form is sent to the servicing SSO through a parallel SSO, the parallel SSO makes appropriate follow-up requests and notifies you of any delay in replying to the request. When you send the request directly to the servicing SSO, make appropriate follow-up requests as specified by regional procedures.

B. Requests for Assistance from Social Security Offices.-- Inquiries about claims may be received from a claimant directly or via an SSO. Some SSOs use form HCFA-1938 (SSA Request for Carrier or Intermediary Assistance) for submitting claimant requests for the status of their claims, or for information about the initial determination on their claims.

When an inquiry is received on a form HCFA-1938, complete Item 13 when the SSO checks the block "Reply to this office only" in Item 12. When either of the other blocks is checked, furnish the inquirer or beneficiary, as appropriate, a written reply. Return a copy of the reply with the HCFA-1938. Return all HCFA-1938s through the parallel SSO to the requesting SSO, unless a procedure permitting direct contact has been established.

Refer requests for assistance involving service by a provider under the jurisdiction of another intermediary to that intermediary and notify the SSO in the reply section of a photocopy of the form.

Overpayments

3707. OVERPAYMENTS FOR PROVIDER SERVICES--GENERAL

The term "overpayment" as used in this chapter refers to an incorrect payment for provider services made under title XVIII and to payments made under the "guarantee of payment" provision. (See §§ 3714ff.)

Sections 3708-3708.6 contain the rules for determining liability for overpayments for items and services furnished beneficiaries.

Sections 3709-3714 contain instructions for the recovery of individual overpayment cases. Examples of individual overpayment cases are:

- o Payment for provider services after benefits have been exhausted, or where the individual was not entitled to benefits.
- o Incorrect application of the deductible or coinsurance.
- o Payment for noncovered items and services, including medically unnecessary services or custodial care furnished an individual.

Instructions for recovering the following types of overpayments from the provider are contained in Part II, §§ 2220-2231.3.

- o The provider fails to repay accelerated payments.
- o The provider fails to file cost reports.
- o You made excessive interim payments.
- o Payments on behalf of a large group of beneficiaries for noncovered services which the provider knew, or should have known, were not covered in accordance with the liability rules in §§ 3708.1 and 3708.2. (The rules on notifying beneficiaries where the overpayment was determined on the basis of a sample are in § 3710.3).

You are not liable for overpayments you make, in the absence of fraud or gross negligence on your part. However, once it is determined an overpayment has been made, the amount so determined is a debt owed to the United States Government. The Federal Claims Collection Act of 1966 requires each Federal agency to take timely and aggressive action to recover overpayments arising out of the activities of the agency.

The Medicare law contains two provisions (Sec. 1870 and Sec. 1879) dealing with liability for, and recovery of, overpayments. These provisions are reflected in §§3708 -3709.5. The following paragraphs summarize the provisions dealing with liability for overpayments to providers, and waiver of recovery of overpayments to providers and beneficiaries.

A. Overpaid Provider Not Liable Because It Was Without Fault (Section 1870(b) of the Act.)—If a provider was without fault with respect to an overpayment it received (or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the third calendar year after the year of payment) it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved. You make these determinations. This provision forms the basis for policies and instructions in §§3708, 3708.1, 3708.2, 3708.4, and 3708.6.

B. Beneficiary Liable for Overpayments to Provider Which Was Without Fault With Respect to the Overpayment (Sections 1870(a) and (b) of the Act).—If an overpaid provider was without fault, or is deemed without fault and therefore not liable for refund, liability shifts to the beneficiary. (If the overpayment involves medically unnecessary or custodial services, you may waive the beneficiary's liability for the overpayment in accordance with C below. If the overpayment does not involve medically unnecessary or custodial services, HCFA or SSA may waive recovery from the beneficiary in accordance with D below.) This provision forms the basis for the policies and instructions in §§3708.3, 3708.4 and 3708.6.

C. Contractor Waiver of Liability Where Provider and Beneficiary Are Without Fault with Respect to Overpayment for Medically Unnecessary or Custodial Services (Section 1879 of the Act).—When both the provider and the beneficiary are without fault with respect to an overpayment for medically unnecessary or custodial services, waive liability for the overpayment, i.e., take no action to recover the overpayment. This provision forms the basis for the policies and instructions in §§3708, 3708.3 and 3709.2C. (Refer to §§3432ff. for instructions regarding implementation of Section 1879.)

D. HCFA or SSA Waiver of Recovery from Beneficiary (Section 1870(c) of the Act).—If a beneficiary is liable for an incorrect payment, HCFA or SSA may waive recovery if the beneficiary was without fault with respect to the overpayment and recovery would defeat the purposes of title II or title XVIII of the Social Security Act (i.e., cause financial hardship) or would be against equity and good conscience. (Where an overpayment is discovered subsequent to the third calendar year after the year the payment was made, recovery is deemed against equity and good conscience if the beneficiary was without fault.) This section forms the basis for policies and instructions in §§3708.4, 3708.6, 3709.3, and 3709.5.

3707.1 Time Limits on Recovery of Overpayments.—There are two time limitations to consider in deciding whether to recover an overpayment. Do not recover an overpayment not reopened within 4 years (48 months) after the date of payment unless the case involves fraud or similar fault. (See §§3709.2B and 3799ff.) Do not recover an overpayment discovered later than 3 full calendar years after the year of payment unless there is evidence that the provider or beneficiary was at fault with respect to the overpayment. (See §3708.4.)

3708. DETERMINING LIABILITY FOR OVERPAYMENTS ON CLAIMS

Determine whether the provider or beneficiary is liable for the overpayment. Most payments for provider services are made to providers on behalf of the beneficiaries who received the services. In the comparatively few cases where payment is made directly to the beneficiary, liability always lies with the beneficiary. Where the provider has been overpaid, it is liable for the overpayment unless you determine that it was without fault with respect to the overpayment.

If you determine that an overpaid provider was without fault, relieve the provider of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault.

Do not make decisions concerning beneficiary fault except in the case of overpayments arising from medically unnecessary or custodial services. Waive liability if you find both the beneficiary and provider without fault, i.e., take no action to recover the overpayment. (See SS3707(3), 3709.2C, 3709.5A and 3432.) The question of beneficiary fault is considered by HCFA and SSA in deciding whether to waive recovery from the beneficiary in the case of other overpayments. (See S3709.5B.)

3708.1 Provider Liability.-- A provider is liable for overpayments it received unless it is found to be without fault. You make this determination.

Consider a provider without fault, if it exercised reasonable care in billing for, and accepting, the payment; i.e.,

- It made full disclosure of all material facts; and
- On the basis of the information available to it, including, but not limited to, the Medicare instructions and regulations, it had a reasonable basis for assuming that the payment was correct, or, if it had reason to question the payment, it promptly brought the question to your attention.

Normally, it will be clear from the circumstances whether the provider was without fault in causing the overpayment. Where it is not clear, develop the issue. (See S3708.4 for special rule where the overpayment is discovered more than 3 calendar years after the year it was made.)

3708.2 Examples of Situations in Which Provider Is Liable.--In accordance with SS3708 and 3708.1, the following are examples of situations in which the provider is liable for an overpayment it received.

A. The Provider Furnished Erroneous Information or Failed to Disclose Facts That It Knew or Should Have Known, Were Relevant to Payment of the Benefit.--This includes, among others, situations in which a provider failed to request information needed by you to identify cases in which Medicare may be secondary payer, or if it did request such information, it failed to annotate the billing form. (Providers are instructed to ask beneficiaries for, and to annotate the claims form with, information needed to help you identify cases in which Medicare may be secondary payer, e.g., information about the circumstances of the illness or injury and the availability of benefits under an insurance policy or plan.) (See §§3414.3, 3419.3, 3489.3, 3490.15, 3491.5 and 3491.7.)

EXAMPLE 1: A beneficiary was involved in a minor automobile accident shortly before entering a hospital for treatment of back pain. The provider billed an automobile no-fault insurer for the treatment. The automobile insurer refused to pay, claiming that the beneficiary's back pain was due to a pre-existing condition. The provider then billed Medicare but failed to annotate the bill that the beneficiary had been involved in an automobile accident.

Following a beneficiary appeal, the automobile insurer agreed that the treatment of this episode of pain was covered under its policy and paid benefits up to the limits of the insurance coverage for services not covered by Medicare. Later, you learned that the insurer had changed its decision and asked it to reimburse Medicare. The insurer did not pay because the insurance benefits had been exhausted. The provider is liable for the overpayment because it failed to annotate its bill to Medicare with information which would have enabled you to recover Medicare benefits paid for services related to the automobile accident.

EXAMPLE 2: A beneficiary fell in a supermarket, breaking his hip. The provider properly billed Medicare (Medicare pays in potential liability cases subject to recoupment if the beneficiary or provider later receives payment from a liability insurer) but failed to annotate the bill that the beneficiary's injuries occurred as a result of an accident other than an automobile accident. The beneficiary subsequently received a liability settlement from the supermarket's insurer, but did not refund the Medicare payments.

Several months later, you learned of the settlement but were unable to recover the overpayment from the beneficiary because he had died and left no estate. The provider is liable for the overpayment, because, at the time it submitted its bill to Medicare, it failed to furnish information needed by you to conduct the development which might have enabled you to recover the Medicare payment from the liability insurer at the time of settlement.

B. The Provider Improperly Billed Medicare Instead of Another Insurer or Plan for Primary Benefits Where It Knew, or Should Have Known, That The Other Insurer or Plan Was Primary Payer—Providers are instructed to bill other insurers as primary payers where services can be paid for by automobile medical or no fault insurance, workers' compensation, and, an EGHP in the case of working aged beneficiaries. This includes situations where the provider initially could not have known that another insurer or plan was primary payer but, after being so informed, failed to bill the other insurer or plan as the primary payer.

EXAMPLE 1: A beneficiary is referred by an employer to Park Hospital for a fracture received from a fall at work. Park knows that the employer has fewer than 20 employees so the EGHP is not the primary payer. Park checked the work-related box on the billing form affirmatively, but erroneously billed Medicare for the services. You mistakenly paid the bill. Park Hospital is at fault because it failed to bill WC as the primary payer.

EXAMPLE 2: A beneficiary was injured in an automobile accident and was hospitalized for 60 days. The treatment was covered under automobile no-fault insurance. In addition to the hospital care, the beneficiary received extensive private duty nursing care, which is excluded from Medicare coverage. In view of the total expenses incurred for treatment and the dollar limits contained in the automobile policy, it was doubtful if the automobile insurance would be sufficient to pay for all expenses related to the accident. The beneficiary, therefore, requested the hospital to bill Medicare as the primary payer for Medicare covered services.

The hospital billed Medicare as requested, and primary Medicare benefits were incorrectly paid. You later learned that the hospital services could have been paid for by the automobile insurer. The hospital is at fault because it failed to bill the automobile insurer as primary payer.

NOTE: Where there is evidence of a deliberate attempt to obtain Medicare payments to which the provider was not entitled, resolve the fraud issue in accordance with §§3450ff. before attempting recovery. However, retain any unsolicited refund which the responsible party makes.

C. Provider Receives Duplicate Payments from Medicare and Another Insurer or Plan Which Is Primary Payer, i.e., an automobile medical or no-fault insurer, any liability insurer, a WC insurer, or, under certain circumstances, an EGHP. The provider is liable for the portion of the Medicare payment in excess of the amount Medicare is obligated to pay as secondary payer regardless of which payment it received first, even if it refunded the insurance payment to the beneficiary or the insurer.

D. The Overpayment Resulted Through Misapplication of the Deductible or Coinsurance Requirement or Payment After Exhaustion of Benefits and the Provider Could Have Known From Its Own Records the Beneficiary's Utilization Status. Provider is considered liable if it received a remittance record within the 60 days preceeding billing indicating deductible and benefit status. This condition is considered met where, within the 60-day period preceding the admission that gave rise to the overpayment, the beneficiary had been a patient in the same institution or the provider could have known the beneficiary's utilization status from its own records.

The provider is expected to ask the beneficiary, or the person acting on his behalf, at the time of admission if he received inpatient services in a hospital or SNF within the past 60 days, and note the response on its records.

If you refer such an overpayment to HCFA as uncollectible, include this information in Item 11 of the form HCFA-2382. (See §3712.2, Item 11.)

EXAMPLE: John Doe entered University Hospital on January 10, 1985. After using all of his benefit days, including lifetime reserve days, he returned home, but reentered the same hospital in fewer than 60 days and stayed an additional 30 days. University Hospital neglected to check its records and billed you for 30 days of inpatient hospital care. You made payment. Subsequently, the overpayment was discovered. Since the hospital should have known from its own records that John had exhausted his benefit days, seek recovery from the hospital.

If the previous stay had been in a different hospital, or if more than 60 days had elapsed between the end of the first stay and the start of the second stay but the benefit period had remained unbroken because John had been in an SNF or a different hospital, consider University Hospital "without fault." In this latter situation, the hospital would not have been able to ascertain from its own records that benefit days had been exhausted. Seek recovery from the beneficiary.

E. The Overpayment Was Due to a Mathematical or Clerical Error, e.g., an error in calculation by you or the provider, or overlapping or duplicate bills. Mathematical error does not include a failure to assess properly the coinsurance and deductible. Determine the liability for coinsurance and deductible overpayments in accordance with D. above.

F. The Provider Does Not Submit Documentation to Substantiate That Services Billed to the Program Were Covered.

G. The Provider Does Not Submit Documentation to Substantiate That It Performed the Services Billed to the Program Where There Is a Question as to Whether the Services Were Performed. (See §§3450ff. if fraud is suspected.)

H. The Beneficiary Was Not Entitled to Part A Benefits and the Provider Had Reason to Believe That the Beneficiary Was Not Entitled to Such Benefits, e.g., the SSO notified the hospital that the individual was not entitled to hospital insurance benefits.

I. Medicare Paid the Provider for Noncovered Services, and the Provider Should Have Known that the Services Were Noncovered.

1. Services Other Than Medically Unnecessary or Custodial Services, e.g.,skilled physical therapy services furnished by a nonqualified physical therapist, or services rendered pursuant to an authorization from the VA. (See §3153.2.)

In general, the provider should have known a policy or rule, if:

- o The policy or rule is in the provider manual or regulations,
- o You provided general notice to the medical community concerning the policy or rule, or
- o You gave written notice of the policy or rule to the particular provider.

Generally, a provider's allegation that it was not at fault with respect to payment for noncovered services because it was not aware of the Medicare coverage provisions is not a basis for finding it without fault if any of the above conditions is met. However, there may be other circumstances which justify a finding that the provider was not at fault. Consider all of the circumstances, including such factors as whether and to what extent a coverage rule is spelled out in regulations, instructions, or in a HCFA notice, and whether an intermediary misinformed the provider about the rule, in deciding whether a provider acted reasonably in billing for and accepting payment for noncovered services. (See §3709.3D.)

2. Medically Unnecessary or Custodial Services.

Apply the criteria in §§3432ff. in determining whether the provider should have known that the services were not covered.

J. The Overpayment Resulted From Services Rendered in a Nonparticipating Portion of the Facility or in a Bed Certified for a Type of Care Other Than That Furnished.

3708.3 Beneficiary Liability.—A beneficiary is liable for:

Overpayments made to a provider which was without fault with the exception of overpayments for medically unnecessary services or custodial care where the beneficiary, as well as the provider, was without fault. (See §§3432ff.) Included are situations in which Medicare pays a provider, and a WC carrier, automobile medical or no-fault insurer or any liability insurer or EGHP pays primary benefits to the beneficiary for the same services.

Payments made under the "guarantee of payment" (see §§3714ff.),

Overpayments made to the beneficiary.

3708.4 Liability for Overpayments Discovered Subsequent to Third Calender Year After the Year the Payment Was Approved.-- The law prescribes special rules which apply when an overpayment is discovered (i.e., it is determined that a "payment was incorrect") subsequent to the third calendar year after the year in which the claim was approved. Under these rules, deem an overpaid provider without fault without further development, in the absence of evidence to the contrary, i.e., if there is no indication that the provider was at fault. (This provision provides limited relief to providers since, in most cases, the facts that bring to light the overpayment are a sufficient basis for determining whether the provider was at fault.) Where the beneficiary is liable, HCFA will waive recovery if the beneficiary is without fault. A provider is not deemed without fault with respect to overpayments for noncovered services which are part of a pattern of billing for similar services. In such cases, initiate any necessary development to establish whether the provider was without fault.

See §§3709.3A, 3710.3C, 3710.4B, and 3712.4 for the processing of overpayments discovered subsequent to the third calendar year.

If information indicating the provider was at fault comes to your attention without development within 4 years (i.e., 48 months) after the date of the initial determination (the 4-year time limit on reopening described in §§3799ff.) your determination may be revised. After 4 years, your determination may be reopened only in cases involving fraud or similar fault. (See §3709.2B.)

NOTE: Where Medicare makes conditional primary payments and a WC plan, automobile medical or no-fault insurer or any liability insurer or EGHP subsequently pays primary benefits for the same services, HCFA does not waive recovery solely because the other insurer or plan made its payment subsequent to the third calendar year after the year in which the Medicare primary payment was approved.

The statutory language dealing with this waiver provision indicates that it applies only to determinations that a Medicare payment was "incorrect." Since conditional Medicare payments are correct payments, (which are recovered when another insurer reimburses the provider or beneficiary for the same services) they are not subject to this waiver provision.

Similarly, the 4-year limit on reopening does not apply where another insurer makes payment more than 4 years after a Medicare conditional primary payment was made. The 4-year limit on reopening pertains only to the Government's right to change a determination or decision. Since a conditional Medicare primary payment is a correct determination (and remains correct even after the conditional payment is recovered), a Medicare conditional primary payment may be recovered without regard to the 4-year reopening limit when another insurer, primary to Medicare, makes payment.

3708.5 Limitations on Charging Without Fault Beneficiary Where Overpayment for Medically Unnecessary Services or Custodial Care is Discovered Subsequent to the Third Calendar Year.—Where an overpayment to a provider for medically unnecessary services or custodial care is discovered subsequent to the third calendar year after the year in which the payment was approved, the provider is prohibited from charging the beneficiary or any other person for the services notwithstanding the fact that the provider has refunded the overpayment if:

- The provider was at fault with respect to the overpayment; and

- The beneficiary was without fault with respect to the overpayment. (Where the overpayment is discovered in, or before, the third calendar year, an "at fault" provider is not prohibited from charging the beneficiary for if it has refunded the overpayment. However, a without fault beneficiary who pays an at fault provider's bill for medically unnecessary services or custodial care, can be indemnified in accordance with §§3446ff.)

3708.6 How to Determine the Third Calendar Year After the Year the Payment Was Approved. -- Only the year the payment was approved and the year it was found to be an overpayment enter into the determination of the 3-calendar year period. The day and the month are irrelevant. With respect to payments made in 1985, the third calendar year thereafter is 1988. For payments made in 1986, the third calendar year thereafter is 1989, etc. Thus, the rules apply to payments approved in 1985 and discovered to be overpayments after 1988, to payments approved in 1986 and discovered to be overpayments after 1989, etc.

3709. RECOVERY-- GENERAL

After you have established who is liable for an overpayment, undertake recovery action as soon as possible, provided the overpayment is not one of the situations listed in § 3709.2, or 3709.3. See §§ 3710ff. for recovery from providers, and §§ 3711ff. for recovery from beneficiaries.

3709.1 Offset of Overpayments Against Other Benefits Due.--

A. Benefits Payable Under Part B.-- Where you determine that a Part A overpayment has been made to a provider on behalf of a beneficiary, ascertain whether the beneficiary is entitled to any Part B payment for the services in question. (See §3110.) If it appears that Part B benefits are payable, arrange for billings under Part B. Use any Part B benefit as an offset against the Part A overpayment.

B. Use of Lifetime Reserve Days.-- If a Part A overpayment for which a beneficiary is liable was caused by payment for services rendered after exhaustion of benefit period days, reduce the amount of the overpayment by the application of his lifetime reserve days, unless the individual elected not to use them. An individual who has been overpaid for services rendered after exhaustion of benefits can elect not to use reserve days only if he refunds the overpaid amount. (See § 3106.2C.)

3709.2 When You Do Not Attempt Recovery Action and Do Not Refer the Case to HCFA.—

A. Total Overpayment Less Than $50. The cost of recovering such a small amount ordinarily exceeds the amount recovered. However, accept unsolicited overpayment refunds regardless of the amount. If an individual owes several small overpayments, each of which is less than $50, consider the aggregate amount owed for purpose of this tolerance. Thus, if the overpayments total $50 or more, recover the amount even though each individual overpayment is less than $50.

B. You Have Not Taken Action to Reopen the Payment Decision Within Four Years (48 Months) After the Date of the Initial Payment Determination.-- Unless fraud or similar fault is present, a payment determination may not be reopened where you have not taken some action (which can be documented) questioning the correctness of the determination within 4 years (48 months) after the date the initial determination was approved. (See §§ 3799ff. for policies governing the reopening and revision of decisions to allow or disallow a claim.)

C. Payments to Providers for Medically Unnecessary Services or Custodial Care Where Waiver of Liability Applies.—Where both the beneficiary and provider were without fault (see §§3432ff), waive liability for the overpayments.

3709.3 When You Do Not Take Recovery Action In Beneficiary Cases but Refer Cases to HCFA for Waiver of Recovery Consideration.--

Subject to § 3709.2, refer the following overpayment cases to HCFA for consideration of waiver of recovery from the beneficiary following the instructions in § 3712ff. Note especially, the annotation and information required by § 3712.4. These are cases in which the beneficiary is liable and the criteria in §3709.5B for waiver of recovery from the beneficiary are likely to be met, i.e., it appears from the circumstances that the beneficiary was without fault and that recovery is against equity and good conscience or defeats the purpose of the Medicare program (i.e., cause the individual financial hardship). HCFA makes the waiver determination. If HCFA decides that the information available does not justify waiver, it returns the case for normal recovery efforts from the beneficiary.

A. Overpayments Made to Without Fault Provider:--For noncovered services other than medically unnecessary services or custodial care. (See 3709.2C for overpayments to without fault providers for medically unnecessary or custodial care.);

Discovered subsequent to the third calendar year after the year the payment was approved regardless of the cause of the overpayment. (See §3712.4 for special information to include on Form HCFA-2382.)

B. Overpayments to Beneficiaries for Noncovered Services (including overpayments for medically unnecessary services or custodial care).

C. Overpayments to Beneficiaries for Other Than Noncovered Services Discovered Subsequent to the Third Calendar Year After the Year Payment Approved.--(Recovery from a without fault beneficiary is waived if the overpayment was discovered after the third calendar year, per §3708.4.)

D. Overpayments Which Resulted From Misinformation From an Official Source Concerning the Medicare Law or Regulations.--For example, where it is determined that the provider was without fault because it relied on incorrect advice from an intermediary or HCFA concerning the coverage of services.

NOTE: This paragraph does not apply to overpayments resulting from an incorrect query reply concerning a beneficiary's Part A utilization status or Part B deductible status. An incorrect query reply is not considered "misinformation" for this purpose.)

E. Overpayments to Providers or Beneficiaries for Items and Services Rendered During a Period When SSA Records Showed that the Beneficiary Did Not Have Medicare Entitlement.-- See §§ 3711.11A & 3712.4 for processing of overpayments from lack of Medicare entitlement.

F. Effectuation of an Appeal Decision Results in Overpayments for Subsequently Furnished Services.--In some cases, effectuation of a reconsideration, ALJ, AC or Court decision favorable to the beneficiary results in an overpayment to a provider that furnished subsequent services. Such overpayments result, for example, where effectuation causes days previously paid for as full days to become coinsurance days, coinsurance days to become lifetime reserve days, or lifetime reserve days to become "no payment" days. (See § 3787.) In accordance with § 3708.2B, the overpaid provider is not liable since it had no reason to question the beneficiary's entitlement to benefits.

G. Overpayments for Services Which Should Have Been Paid for by Another Insurer or Under Another Government Program, e.g., Medicaid or WC, and the Time Period for Claiming Benefits from the Other Program Has Expired.

H. Overpayments for Which a Medicaid Beneficiary Is Liable and Which the Medicaid Agency Does Not Refund, except where it is apparent from the circumstances that the beneficiary knew or should have known that the payment was incorrect.

3709.4 Recovery Where Fraud Is Suspected.—If there is reason to believe that the overpayment may have been caused by fraud, make no request for refund until the fraud issue is resolved. However, retain any amount voluntarily refunded pending resolution of the fraud issue. (See § 3468.1A.) Also, payments may be suspended with RO concurrence. (See § 3466.)

3709.5 Waiver.--

A. Waiver by You.—Where Medicare has paid a provider for services that are later determined to be not reasonable and necessary or custodial, waive liability if the provider, and the beneficiary, were both without fault, i.e., under the criteria in §3432, the parties did not know, and could not have been expected to know, that the items or services were not covered. Do not take recovery action on these cases and do not refer them to HCFA.

B. HCFA or SSA Waiver of Recovery.—The law provides that if a beneficiary is responsible for an overpayment, recovery may be waived by HCFA or SSA if:

- The beneficiary was without fault, and
- recovery of the overpayment would;
    - (1) defeat the purpose of title II or title XVIII of the Social Security Act by causing financial hardship for the beneficiary; or
    - (2) would be against equity and good conscience.

Consideration of waiver is normally contingent upon the beneficiary's request in response to your refund request or the request of SSA's program service center. However, see §3709.3 for cases which you refer to HCFA for waiver consideration before taking any recovery action.

3709.6 Information and Help Obtainable from the SSO.—Occasionally, it may be possible to get information or help from the local SSO. (See § 3400.) For instance, if the enrollee has moved, the SSO may know the new address; or if he has died, it may know whether the estate will be administered. If the beneficiary takes a check representing an incorrect payment to the SSO, it forwards the check to you. However, do not ask the SSO to collect, or indirectly aid in, the collection of an overpayment.

3710. RECOVERY OF INDIVIDUAL OVERPAYMENT FROM THE PROVIDER

3710.1 Participating Provider.—If you determine that an overpayment on an individual claim should be recovered from a participating provider, notify the provider in writing indicating:

- That an overpayment was made;
- The name and HI number of the beneficiary involved;
- The dates and types of services for which the overpayment was made;
- Why the payment was incorrect;
- How the overpayment was calculated;
- Why it is liable for a refund; i.e., the reasons for finding the provider at fault;
- The proposed method of recovering the overpayment, i.e., by reduction of subsequent Medicare payments due the provider (offset) or by direct refund;
- If it is proposed to recover the overpayment by offset, that the offset will be put into effect 30 days after the date of the notice.
    - If, within 30 days after the date of the notice informing the provider of the intention to offset, the provider submits a request for reconsideration or hearing, or otherwise protests the offset, make an effort to conclude the appeal procedure before the deadline for effectuation of the offset, i.e, the 30th day after the date of notice. However, begin offset 30 days after the initial request for refund, regardless of the status of any appeal request.
- If the overpayment was for medically unnecessary services or for custodial care, and the beneficiary was without fault, and the provider collects the amount of the overpayment from the beneficiary:
    - The beneficiary can be indemnified for this amount by the program and the amount charged to the provider as an overpayment; and
    - The provider has a right to a reconsideration of the decision on coverage of the overpayment, provided it requests it within 60 days of the date of the notice. (See § 3432.2B.)
- If the overpayment was for medically unnecessary services or custodial care and was discovered more than 3 calendar years after the year in which the payment was approved, and the beneficiary was without fault (see §3708.5), the provider is prohibited by law from charging the beneficiary.

3710.2 Provider No Longer Participating.--If the provider is no longer participating in the program (and the provider is not involved in bankruptcy proceedings), recover an overpayment on individual claims in accordance with the following. (See Part II, § 2760, for handling overpayments to providers involved in bankruptcy proceedings.)
If the provider's final cost report has been received, but the final cost settlement has not been completed, adjust the cost report statistics (HI days and HI charges) to properly reflect the amount of the overpayment and notify the provider of the adjustment and the reasons. Include in the notice to the provider appropriate data outlined in § 3710.1

If final cost settlement has been effected and no further funds are due or owing by the provider, send no more than two written requests for refund 30 days apart. They contain appropriate information outlined in §3710.1. In the second refund letter state that if the overpayment is not refunded, HCFA will refer the overpayment to the Dept. of Justice for collection.

If the provider does not make the refund within 30 days after the second request, refer the overpayment to RO for further recovery efforts as required by Part II, § 2227. Referrals to RO consist of a covering letter containing the information and attachments listed below.

Information required:

- An explanation that the letter pertains to an uncollected overpayment due from a provider no longer participating, that the provider's cost report had been received and settled, and that no other monies are due to, or from, the provider;

- The provider's name, address and provider number; and

- The appropriate information outlined in § 3710.1..

Documentary attachments:

- Copies of the original and corrected billing forms;

- Copies of the initial and followup letters sent to the provider; and

- Copies of any other relevant documentation; e.g., the provider's replies to the recovery letters.

If you have completed the final cost settlement of the provider's final cost report (or if the provider has failed to submit its cost report) and have sent the case to the RO for further collection efforts, notify the RO of the overpayment on the individual beneficiary's claim. Identify the adjustment(s) to be made to the cost report statistics in a format which can be used as documentation for the case file.

(If you are preparing to send such a cost overpayment case to the RO, include the individual overpayment in the aggregate overpayment case file.)

Make clear to the RO that it pertains to an uncollected overpayment due from a provider no longer participating, that you have completed the final cost settlement of its final cost report (or that the provider has failed to submit one), and that you have previously sent the case to the RO for further collection efforts. Include the same information required in the notice to HCFA and specify the adjustment(s) to be made in the cost report data.

If you have sent the case to the RO, notify the provider of the overpayment--but only with the approval of the RO since legal action is being taken by the Government. If you have RO approval, your notification to the provider contains appropriate items listed in § 3710.1. Indicate that an upward adjustment will be made to the cost report overpayment which had been referred to the RO for collection.

3710.3 Notification to the Beneficiary When Recovery Is Sought from the Provider.—A notice to the beneficiary is required whenever recovery is sought from the provider.

Include in the notification to the beneficiary a copy of the letter sent to the provider unless the letter to the provider refers to matters which do not concern the particular beneficiary; e.g., where the provider was overpaid on behalf of more than one beneficiary.

Where overpayments to a provider have been determined by means of a sample study, send a notice only to the beneficiaries identified in the overpayment notice sent to the provider as individuals on whose behalf the provider was overpaid a specified amount. Do not send the notice to the beneficiaries until it has been established that recovery action will be taken.

The notice to the beneficiary should contain the following:

- o The name and address of the provider and dates of service for which the overpayment was made.
- o A clear explanation of why the payment was incorrect.
- o A statement that the provider had been requested to refund the overpayment and, if the provider is liable for medically unnecessary services or custodial care, the following additional information, as applicable:
- o If the error is discovered subsequent to the third calendar year after the year the payment was approved, and the other conditions described in § 3708.5 apply, advise the beneficiary that the provider is prohibited, by law, from requesting payment for the services; or

- o If the beneficiary is determined to be without fault state that if the provider collects payment from the beneficiary for such services, the beneficiary has the right to request you to indemnify him for the amount of such payment, less any applicable deductible and coinsurance, and that any indemnification paid the beneficiary will be recovered from the provider. (See §§3446ff.).

- o In all other cases, that the Medicare law does not prohibit the provider from requesting the beneficiary to pay.

An explanation of the beneficiary's appeal rights. (See §3799.15.) Do not mention waiver in the notice of recovery to the beneficiary since there is no provision for waiver when the provider is liable for the overpayment.

3710.4 Sample Letter to Beneficiary Where Recovery Is Sought From Provider.--

Dear _______________:

In (month and year), we made a payment to (provider name and location) on your behalf for services provided you from _______ to _______.

We have reviewed the payment and determined that the services were not covered under the Medicare program. (Explain as clearly as possible the reason why all, or part, of the payment was erroneous. Use the stock paragraphs in §§ 3722ff. where appropriate.)

Use either A, B, or C as appropriate:

A. Provider Liable (In Accordance with §3432.2B) for Medically Unnecessary or Custodial Care Services.-- We have determined that you had no knowledge or any way of knowing that the services you received from _____ to _____ were not covered under the Medicare program. However, the records show that (provider's name) did have knowledge that such services would be considered noncovered. When this situation occurs, the law requires that the liability for these noncovered services be transferred to the provider of services.

We have determined that you are not responsible for the charges billed by the (provider's name) for the period from _____ to _____ except for deductible or coinsurance amounts that apply or any charges for other services or items not covered by Medicare. If the (provider's name) obtains payment from you for the services at issue, reimbursement can be made to you for the amounts paid, less any applicable deductible or coinsurance amounts, and such reimbursement paid to you will be recovered from the provider. To obtain this reimbursement, please advise this office and enclose the following documents:

- o A copy of this notice.

- o The bill you received for the services, and

- o Your receipt for payment to the (provider's name), or any other evidence showing that you have paid the (provider's name) for the services at issue.

B. Provider at Fault and Beneficiary Not at Fault for Medically Unnecessary or Custodial Services and the Overpayment Discovered Subsequent to the Third Calendar Year After Year Payment Was Approved.-- (See NOTE in § 3708.4.) (Provider's name) has been requested to refund this overpayment because it has been found to be at fault in causing it. Under the Medicare law, (provider's name) is prohibited from billing you, or any other source, for these noncovered services. If (provider's name) sends you a bill for these services, send it to us with a copy of this letter.

C. All Other Cases.-- (Provider's name) has been requested to refund the overpayment because it has been found to be at fault in causing it. Since the above services are not covered by Medicare, (provider's name) may ask you to pay for them. However, if you are billed, this is a matter between you and (provider's name) and will not affect your entitlement to future Medicare benefits in any way.

The notification of appeal rights should be in accordance with the reopening rules in §3799.15.

3711. RECOVERY WHERE THE BENEFICIARY IS LIABLE FOR THE OVERPAYMENT

When you have determined the beneficiary to be liable for the overpayment, initiate recovery efforts in accordance with the following sections, as appropriate.

3711.1 Recovery Where Beneficiary Covered Under Medicaid or Another Health Insurance Plan, Private or Governmental.—When the beneficiary carries supplemental health insurance or is covered by another Government health benefits program such as Medicaid, CHAMPUS, CHAMPVA, or the Federal Employees Health Benefits Program, it may be possible to recover the overpayment from the other plan or program. Payments of deductible or coinsurance amounts and payment for services rendered persons who are not entitled to Medicare are the payments most likely to be recoverable.

If, based on the circumstances of the overpayment and your knowledge of the other plan or program, you believe there is a possibility that it will refund the overpayment, attempt to recover from the other plan or program. In this connection, it may be necessary to ask the beneficiary for his policy number or other information concerning his non-Medicare coverage. (See §3416.1 for procedures to follow where the overpayment is for services that should have been paid for by a WC carrier.)

To facilitate recovery of the Medicare overpayments to the extent possible, attempt to work out mutually satisfactory arrangements with the other carrier(s). The methods listed below have been used successfully. Use any one or a combination, as you find appropriate. The most desirable method in a given situation depends upon the particular circumstances, and the provisions of the other plan or program.

- Arrange with the other plan or program for direct refund of overpayments to you. If you are the carrier under the other plan or program, a transfer of funds is the most convenient method of recovering. If another carrier is involved, send it a letter requesting refund of the overpayment. Explain how the overpayment occurred and how it was calculated. Follow up in 30 days by with another letter or a phone call if payment or a letter of explanation has not been received. If this does not bring a meaningful response, write to the President or Chief Administrative Officer of the other carrier.

- If you do not use the above method, arrange with the other plan or program to make payment to overpaid providers upon your request, (even though the provider has not billed the other plan or program) and to notify you of the payment. Upon receiving such a notice, recover the Medicare overpayment from the provider.

- Where neither of the above methods is possible, ask the provider if it would be willing to refund the overpayment and to bill the other plan or program, with the understanding that if it is unable to obtain payment the amount recovered will be refunded to the provider. If the provider does not agree to refund the overpayment before collecting from the other plan or program, ask it to bill the other plan or program and to use the payment to refund the overpayment. If you receive notice that a provider or a beneficiary plans to file a claim with another plan or program, suspend recovery efforts for a reasonable period.

best copy available

If you have questions concerning the proper approach in recovering from a welfare agency, or another insurance plan, contact your RO.

If efforts to recover the overpayment are not successful, or if you are certain that the other plan or program will not refund a particular overpayment, seek recovery from the beneficiary in accordance with § 3711.2. Explain in the notice to the beneficiary that the other plan or program will not make payment directly to you. However, if the beneficiary is a Medicaid recipient, do not attempt recovery from the beneficiary. Instead refer the overpayment to HCFA in accordance with §§3712ff. and 3709.3.

3711.2 Recovery From the Beneficiary.—Initiate recovery from the beneficiary by sending a letter containing the information in §3711.5 if the overpayment is $50 or more. (See model language in §§3711.6 and 3711.7.)

If the refund letter does not result in a refund, send a followup letter unless one of the conditions in § 3711.3 is met. If the beneficiary does not respond to the followup letter within 30 days, refer the overpayment to HCFA as uncollectable.

If the beneficiary protests following the receipt of a notification of overpayment, handle the protest in accordance with §3711.11.

Do not initiate further recovery action after referring a beneficiary overpayment to HCFA since, in most cases, the overpayment will be deducted from the individual's monthly social security or railroad retirement benefits or recovery of the overpayment will be waived. However, if payment is offered after referral to HCFA, accept the payment. Notify HCFA immediately to avoid duplicate collection efforts.

If full or partial refund is made, report the refund on the HCFA-1522, Monthly Intermediary Financial Report, Section D, Line 16b. (See Part I §1414.3e.) If the entire overpayment is not refunded, refer the uncollected portion to HCFA.

3711.3 When to Suspend Efforts to Recover From the Beneficiary Following Initial Letter.—Suspend your efforts to recover from the beneficiary if:

A. The Beneficiary Asks for a Reconsideration or Questions the Overpayment Decision.—Make no further recovery efforts until you dispose of the request for reconsideration. (See §3711.11.)

B. The Beneficiary Requests That Recovery be Waived or States Conditions that Might Qualify Him for Waiver of Recovery.—(See §3709.5 for the qualifying conditions for waiver of recovery.) If the overpayment was for reasons other than services found to be not reasonable and necessary or custodial care, refer the case to HCFA in accordance with §§3712ff. unless recovery of the overpayment is still pending with a State welfare department or other third party. If the overpayment was for services found to be not reasonable and necessary or custodial care, determine whether the beneficiary's liability can be waived in accordance with §§3430ff. and notify the beneficiary of your finding. If you determine that the conditions for waiver of liability under this provision are not met, refer the case to HCFA.

C. The Beneficiary Is Receiving Welfare Benefits.—If the beneficiary is receiving welfare benefits, i.e., cash benefits or Medicaid, ascertain whether the welfare agency will reimburse Medicare for all, or part of, the overpayment. (See §3711.1.) If it does not refund the overpayment in full, do not attempt recovery from the beneficiary. (See §3709.3F.)

D. It May Be Possible To Recover From Another Health Insurance Plan or Governmental Program.—If, after initiating recovery efforts from the beneficiary, you learn that the beneficiary is covered by other health insurance or another governmental program, ascertain whether the other plan or program will reimburse Medicare for all, or part of, the overpayment. Do not send a followup letter to the beneficiary until your efforts to recover from the other plan have been completed. (See §3711.1.)

3711.4 Computation of Overpayment When Recovery Is From Beneficiary.—Subject to the recovery limitations in §§3709.2 and 3709.3, the amount to be recovered from a beneficiary who is liable for a provider overpayment under §3708.3 is calculated as follows:

A. Providers Reimbursed on the Basis of Reasonable Cost.

1. Overpayments Due to Erroneous Payment of Cash Deductibles and/or Coinsurance Amounts.—Where the overpayment resulted because you erroneously reimbursed the provider for some or all of the beneficiary's inpatient deductible, SMI deductible, or coinsurance obligation, the beneficiary is requested to refund the amount of the actual erroneous payment. (See paragraph C, Example 1, below.)

Where the overpayment resulted from erroneous payment for unreplaced deductible blood under Part A or Part B, the beneficiary is requested to refund the amount the provider would have charged for the blood in question if it had not been paid for under Medicare. This conforms with the manner in which reimbursement is made for unreplaced blood. (See §3670, Items 40 through 43.)

2. General Rule for Other Overpayment Cases.—Where the overpayment was caused by reasons other than those specified in 1. above, the amount the beneficiary is asked to refund will be determined as follows. (See 3. below for exception.)

- Where interim reimbursement to the provider is determined on the basis of a percentage of billed charges, request the beneficiary to refund the amount of interim reimbursement incorrectly paid the provider;

- Where interim reimbursement to the provider is determined on some basis other than a percentage of charges, determine the product of the charges that were initially billed by the provider but subsequently determined to be noncovered, by the ratio which the provider's total Medicare reimbursable costs for covered services bears to the provider's total Medicare charges for covered services as reflected in the provider's cost report for the fiscal year in which the beneficiary's stay began. The beneficiary is requested to refund this amount less any applicable deductible or coinsurance amount. If the ratio for the appropriate fiscal year is unobtainable, use the ratio from the most recent cost report available. (See paragraph C, Example 1, below.)

3. Exception to the General Rule Where Medicare Payment Exceeds Provider's Customary Charges.—The beneficiary will be requested to refund the provider's customary charges for the erroneously reimbursed services (less any applicable deductible or coinsurance) in any situation where this amount is less than the amount determined under 2 above (e.g., where the provider is a public provider and is reimbursed on the basis of fair compensation because its charges to the public are nominal). This is because a beneficiary is liable for the Medicare overpayment only to the extent that he benefited from that payment.

B. Providers Reimbursed Under Prospective Payment System.

1. Overpayments Due to Erroneous Payment of Inpatient Deductible and/or Coinsurance Amounts.—Where the overpayment resulted because you erroneously reimbursed the provider for some or all of the beneficiary's inpatient deductible or coinsurance obligation, the beneficiary is requested to refund the amount of the actual erroneous payment. (See paragraph C, Example 2, below.)

Where the overpayment resulted from erroneous payment for unreplaced deductible blood under Part A, the beneficiary is requested to refund the amount the provider would have charged for the blood in question if it had not been paid for under Medicare.

2. General Rule for Other Overpayment Cases.—The beneficiary will be requested to refund the lower of the PPS payment (determined in accordance with §§2405ff of the Provider Reimbursement Manual) or the provider's customary charges less any applicable deductible or coinsurance. (See paragraph C, Example 3, below.)

C. Examples of How Much to Recover from Beneficiary.—Example 1 illustrates a case in which an overpayment was based in part on misapplication of the deductible and coinsurance amounts (§3711.4A1) and in part on payment for services after benefits were exhausted (§3711.4A2b) where the hospital is reimbursed on the basis of reasonable cost; Example 2 illustrates a case in which an overpayment is based on misapplication of the inpatient coinsurance amount where a hospital is reimbursed under PPS (§3711.4B1); Example 3 illustrates a case in which an overpayment is based on nonentitlement where the hospital is reimbursed under PPS (§3711.4B2).

EXAMPLE 1 Provider Reimbursed on Basis of Reasonable Cost:

A beneficiary is hospitalized for 20 days during 1986. The total covered charges are $7,000.

The intermediary receives and approves the bill. The query response indicates that the stay is the beginning of a spell of illness. Since the provider's interim reimbursement formula is $300 per diem, the intermediary made payment of $5,508 (20 days X $300 per day minus $492 deductible).

Subsequently, the intermediary learns that the original query response was incorrect and at the time of admission the beneficiary had only 8 lifetime reserve days available. Consequently, the provider submits a corrected bill showing $3,050 in covered charges and $3,950 in noncovered charges.

The amount which the beneficiary will be requested to refund will be calculated as follows:

1. The beneficiary's liability for the first 8 days of the stay, i.e., the period for which payment was based on misapplication of the deductible and coinsurance, is calculated as follows:

a.	amount of coinsurance which should have been applied (8 lifetime reserve days at $246 per day):	$1968
b.	amount of deductible actually applied:	-$492
c.	amount for which the beneficiary is liable:	$1476

2. The beneficiary's liability for the last 12 days of the stay, i.e, after benefits were exhausted, is calculated as follows:

a.	charges initially allowed but subsequently determined to be noncovered:	$3950
b.	ratio of provider's total Medicare reimbursable costs for covered services to provider's total Medicare covered charges as reflected on cost report for year of admission:	X 90%
c.	amount for which the beneficiary is liable (product of a and b):	$3555

3. Total amount for which the beneficiary is liable: (sum of amount determined under 1 and 2 above).	$5031

EXAMPLE 2 Provider Reimbursed Under PPS:

A beneficiary is hospitalized for 20 days during 1986. The outlier threshold is day 23. The query reply indicated that 27 days of full benefits were available, and that the deductible had been met previously. On that basis, the intermediary reimbursed the hospital its full Medicare payment rate (determined in accordance with §§2405ff of the Provider Reimbursement Manual). The intermediary subsequently discovered that at the time of admission the beneficiary had only 8 lifetime reserve days available. Therefore, the Medicare payment should have been reduced by 8 days of lifetime reserve coinsurance, or $1968 (8 X $246). That is the amount for which the beneficiary is liable. There is no overpayment due to benefits being exhausted, since an entire stay that is within the day outlier threshold is covered under PPS as long as the beneficiary has at least one benefit day remaining at the time of admission. (See §3637.1.)

EXAMPLE 3 Provider Reimbursed Under PPS:

A hospital is incorrectly paid $9,208 ($9,700 Medicare payment rate (determined in accordance with SS2405ff of the Provider Reimbursement Manual) minus $492 deductible) for services rendered in 1986 to an individual who was not entitled to Medicare. The provider had no basis to question the individual's entitlement. The provider's charges for otherwise covered services are $7,000. The individual is requested to refund $6,508, the lower of the hospital's PPS payment or its charges less the $492 deductible.

3711.5 Content of Request for Refund Letter.—Any correspondence with a beneficiary concerning an overpayment must contain a clear and complete explanation of the overpayment. An overpayment which is not clearly explained is less likely to be refunded. Furthermore, lack of clarity may deprive the individual of sufficient information to decide whether there is a basis for questioning your determination. Clarity is important because the letter may eventually be used by HCFA and SSA for further recovery attempts. Your letter and the referral form (Form HCFA 2382 are usually the only sources available to HCFA and the SSA for information regarding the overpayment.

The following is the minimum information to include in refund letters sent to a beneficiary:

- The name and address of the provider;
- Dates and type of services for which the overpayment was made;
- A clear explanation of why the payment was not correct;
- The amount of the overpayment and how it was calculated;
- A statement that the provider was without fault and that the individual is responsible for refunding overpayments where the provider was without fault;
- The refund should be by check or money order and how it should be made out (enclose preaddressed envelope);
- The refund can be made by installments (see S 3711.9);
- That unless a refund is made, the overpayment will be referred to SSA for further recovery action;
- Possible recovery from other insurance (if applicable),
- An explanation of the beneficiary's right to a reconsideration or hearing as appropriate; and
- An explanation of the HCFA/SSA waiver of recovery provisions. (See S3709.5.)

3711.6 Sample Request for Refund Letter.-- You may use or adapt the following model letter for requesting refunds of overpayments:

"Dear Mr. _________:

A. Opening Paragraph:

"In (month and year) we paid (provider's name and location) (you) $____ as reimbursement for (inpatient) (outpatient) services provided to you (from _________ through _____) (on _________). We have reviewed the payment and determined that it was incorrect. The correct payment should have been $________." Include a clear and complete explanation of how the overpayment arose (see §§ 3711.7 and 3722ff. for some suggested explanations), the amount of the overpayment and how it was calculated.)

Add if applicable: "We have recovered $_____ from (specify source). Thus, the total remaining overpayment is $_____.

B. Liability of Beneficiary.-- "Under the Medicare law, you are responsible for overpayments made on your behalf if the provider of services was not at fault in causing the overpayment. In this case, (provider's name) was not at fault. Therefore, you are liable for the $__________ incorrectly paid for the services you received."

C. Request for Refund.—"Please send us a check or money order for $____, within 30 days. Make the check or money order payable to (your name), and mail it in the enclosed self-addressed envelope. If you do not repay this amount, this overpayment will be referred to the Social Security Administration (or Railroad Retirement Board) for further recovery action which, among other actions, may result in the overpayment being deducted from any monthly social security (or railroad retirement) benefits to which you may be entitled.

D. Installment Payments.—"If you are unable to refund this amount in one payment, you may make regular installments. To refund in installments, you are required to pay a minimum of $_____ each month for ___ months. However, we urge you to pay more each month so that this matter can be settled as soon as possible. If you prefer to repay this overpayment through installments, please notify us promptly how much you are able to pay and how often."

E. Possible Recovery from Other Insurance.—(Do not use where you have determined that the private insurer will not pay.) "If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this overpayment by claiming benefits from the other plan, or (name of provider) may be able to submit such a claim on your behalf. If you plan to file a claim with a supplemental plan and use the proceeds to refund this overpayment, please let us know. If you need help in filing such a claim, please contact any Social Security office."

F. Notification of Appeal Rights.—The notification of appeal rights must be in accordance with the reopening rules in § 3799.15.

NOTE: If the overpayment was for medically unnecessary services or for custodial care, begin the first sentence of the appeals paragraph: "If you believe that this determination is not correct, or if you did not know that Medicare does not pay for these services."

G. Notification of Waiver of Recovery Provision.—"The law requires that you must repay an overpayment of Medicare benefits unless you meet both of the following conditions:

- You were without fault in causing the overpayment in that the information you furnished in connection with the claim was correct and complete to the best of your knowledge, and you had a reasonable basis for believing that the payment was correct, and

- Paying back the overpayment would keep you from meeting your ordinary and necessary living expenses or would be unfair.

If you claim that repayment will cause you serious financial hardship, it will be necessary to submit a statement to the Social Security Administration regarding your income, assets, and expenses.

"If you believe that both conditions for waiver of this overpayment apply in your case, please let us know, giving a brief statement of your reasons. You may contact your Social Security office. You will be notified if recovery of this overpayment is waived. If waiver cannot be granted, you will have the opportunity to present your case at a personal conference. The conference will be conducted by an employee of the Social Security Administration who did not participate in the initial waiver determination."

3711.7 Optional Paragraphs for Inclusion in Refund Letters.--We suggest you use or adapt the following paragraphs in explaining how the overpayment occurred.

A. Inpatient Hospital Deductible or Coinsurance Not Properly Assessed.—

1. General.—Medicare pays all costs of covered services furnished during the first 60 days of hospitalization except for the first $____ (the inpatient deductible). For the 61st through the 90th days Medicare pays all costs except for a coinsurance of $ per day. After 90 days of benefits have been used, an additional 60 lifetime reserve days are available. There is $____ per day coinsurance for each lifetime reserve day used.

2. Deductible Overpayment.—Our records show that the claim for the inpatient services you received at (provider's name) was improperly processed. Benefits were mistakenly paid for _____ days in full. However, since these were the first inpatient hospital services furnished in this benefit period, the $____ inpatient hospital deductible should have been subtracted from the reimbursement paid (provider's name) on your behalf. Thus (provider's name) was overpaid by $____.

3. Coinsurance Overpayment.—Our records show that the claim for the inpatient services you received at (provider's name and address) was improperly processed. Benefits were mistakenly paid for _____ full days (less the $____ deductible). However, since you had previously been hospitalized for ______ days at (name of provider where previously hospitalized) during that benefit period, your claim should have been processed as ____ full days and _____ coinsurance days (and/or lifetime reserve days). Therefore (provider's name) has been overpaid on your behalf for ____ coinsurance days at $____ per day and/or lifetime reserve days at $____ per day) (less $____ for the inpatient hospital deductible which was improperly applied to your claim). The total overpayment is $____.

B. Payment Made Under CW Law.—We paid $ in benefits for services furnished you by (provider's name and location) from_________ to________. However, these payments were in error since these services were covered under the (State) workers' compensation law and Medicare may not pay for services which are covered under workers' compensation. Since (provider's name) was not at fault in causing this overpayment, you are required to refund the $____ Medicare paid on your behalf. You may wish to submit the bill for these services to your employer or his workers' compensation carrier for payment under the State workers' compensation provisions.

C. Beneficiary Not Entitled to Medicare Benefits.—"The Social Security Administration's records show that you were not entitled to (specify Part A hospital insurance and/or Part B medical insurance) benefits when these services (item(s)) were furnished. Your Medicare Handbook explains the difference between Part A (hospital) and Part B (medical) insurance. The decision that you were not entitled to these benefits was made by the Social Security Administration, and not by (your name). Therefore, if you disagree with this decision, or if you have any questions about your entitlement to Medicare benefits, contact your Social Security office. If you go to the Social Security office, take this letter with you.

3711.8 Recovery Where Beneficiary Is Deceased.—Where a beneficiary who is liable for an overpayment dies, attempt to recover from such sources as State welfare agencies, or private insurance plans (see § 3711.1), or withhold the overpayment from any underpayments due the beneficiary's estate or due a surviving relative. (See §§ 3715ff.).

If the entire overpayment cannot be recovered by the above methods, send a letter (see sample below) addressed to the estate of the deceased at the address of the legal representative if known, or to the last known address of the deceased. Include the basic information in § 3711.5, but do not mention the possibility of installment payments or the possibility of offset against monthly benefits.

Do not direct recovery efforts against a person who answered a recovery letter concerning an overpayment unless it is known that the individual represents the beneficiary's estate. Do no recover by offset against underpayments payable to a provider of services or to a person (other than the beneficiary's estate) who paid the bill.

If a refund is not received within 30 days after writing to the estate, refer the case to HCFA in accordance with §§ 3712. Include any information you have about the appointment of a legal representative, copies of any correspondence with survivors or others concerning the overpayment and any instructions received for filing a claim against the estate. Annotate item 13, Remarks, of the referral form (HCFA-2382) as follows: "Expedite. Case involves deceased beneficiary." If the file contains instructions for filing a claim against the estate, mention this also.

When forwarding the overpayment to HCFA, notify any party that responded to your recovery letter that the case is being transferred to the Social Security Administration and that further recovery action will be taken by the agency.

Model Refund Request to Estate of Deceased Beneficiary (Adapt to Fit the Situation)

Estate of (deceased beneficiary) (or, if known, "Representative of the Estate of (deceased beneficiary)).

Dear Sir (or Dear M. ______________ if estate representative's name is known).

On (date) we paid (provider's name and location) $_____ more than was due for inpatient services provided to (deceased beneficiary) from _____ through ______." (Include a clear and complete explanation of how the overpayment arose (see §§ 3711.6 and 3722ff. for some suggested explanations), the amount of the overpayment, how it was calculated, and why the payment was not correct.)

Add if applicable: "We have recovered $______ from (specify source). Thus, the total remaining overpayment is $____."

If other Medicare benefits become payable to the estate and you have not refunded the incorrect payment, we will withhold the amount owed from those benefits."

Under the Medicare law, the beneficiary is responsible for overpayments made on his behalf if the provider was not at fault in causing the overpayment. In this case (provider's name) was not at fault. Therefore, the estate of (deceased beneficiary) is liable for the $___ incorrectly paid to (provider's name) for the services it furnished (deceased beneficiary).

Please send us a check or money order in the amount of $___ payable to (your name) in the enclosed, self-addressed envelope within 30 days."

If we do not hear from you within 30 days, we will be required to refer this matter to the Social Security Administration (or Railroad Retirement Board) for further recovery action.

NOTE: Undertake notification of appeal rights in accordance with the reopening rules in § 3799.15.

If you believe that (deceased beneficiary) was without fault in causing this overpayment and that recovery of the overpayment would be unfair, you may request that recovery of the overpayment be waived. Your request should include a brief statement of your reasons for requesting waiver."

3711.9 Beneficiary Wishes to Refund in Installments.—

A. General.—If an overpaid beneficiary states that he is unable to refund the full amount of an overpayment at one time, regular monthly installment payments are acceptable. The amount and frequency of the installments should be in reasonable relationship to the amount of the overpayment.

Normally, the installments should be large enough to effect recovery within 3 years; however, allow a longer installment period if the beneficiary is willing to refund at least $50 per month. In notifying a beneficiary that he can refund an overpayment by installments, specify the amount (not less than $10) and the number of monthly installments necessary to recovery the overpayment. (See § 3711.6D.)

NOTE: These provisions for repayment in installments do not apply to overpayments for which providers are liable.

Exercise care in distinguishing between a request for repayment in installments, and a request for waiver. Where a beneficiary states that he cannot afford an installment of at least $10 per month, or that he can afford installments of $10 to $50 per month but the overpayment is so large that recovery would take substantially more than 3 years, treat his statement as a request for waiver. Refer it to HCFA. Annotate Item 13, Remarks, of the form HCFA-2382 with the phrase, "FOR CONSIDERATION OF WAIVER - BENEFICIARY ALLEGES HARDSHIP."

Notify the beneficiary that his file has been forwarded to HCFA for further consideration and that he will be notified of the decision. The following paragraph is suggested for use in notifying a beneficiary:

> Because you have stated that you cannot afford to pay the monthly installment amount that we require, we have sent your file to the Health Care Financing Administration for further consideration. The Health Care Financing Administration will contact you if additional information is needed and it will also notify you of the decision made in your case.

B. Notification of Installment Schedule.—When agreement is reached with a beneficiary for refund by installments, notify him of the installment schedule. You may, at your option, ask the beneficiary to sign an installment agreement such as the one in paragraph C below. Give one copy of the agreement to the beneficiary. Retain the other.

C. Suggested Installment Agreement.--

______________________________ ______________________________

Name of Overpaid Beneficiary Health Insurance Claim Number

____

Beneficiary's Address

I hereby agree to repay my Medicare overpayment totalling $_____ to (your name), which will receive the payments on behalf of the Health Care Financing Administration. My payments will be made as follows:

DATE PAYMENT DUE (Month, Day, Year)	Amount of Payment

____

Signature of Beneficiary - Date

D. Beneficiary Fails to Remit Installments.—If the beneficiary fails to remit two installments (not necessarily consecutive), or after remitting the overdue instamments he fails to remit any subsequent installments, ask the beneficiary the reason for the lapse. If you do not receive a response within 30 days, or are informed that the beneficiary is unable to continue paying any installments, refer the case to HCFA. (If the beneficiary states that he can afford a lesser installment amount, see paragraph E below.) If you learn that the beneficiary is deceased, see § 3711.8. When referring defaulted cases, annotate the overpayment referral form (HCFA-2382) to that effect, specifying the amount of the installments which were agreed upon, and the amount refunded by the beneficiary.

E. Beneficiary Can No Longer Afford Installment Amount But Can Afford a Lesser Amount.—If the beneficiary notifies you that he can no longer afford to pay the agreed-upon installments but can afford a lesser amount, set up a new agreement, provided the new installment is at least $10 per month, and large enough to effect recovery of the remainder of the overpayment within approximately 3 years after the date of the new installment agreement. If the beneficiary cannot afford such an amount, refer the case HCFA. Annotate the overpayment referral form (HCFA-2382) as in A above.

3711.10 Recording Overpayment Cases in Which the Provider is Not Liable.—If a provider is relieved of liability for refunding an overpayment, and an adjustment bill is required in accordance with §§ 3816ff., treat the charges involved in the year-end cost report as though they were covered; i.e., make provision to assure that the overpaid amount is not recovered from the provider at the time of final cost settlement. To accomplish this, keep a record of such cases including the forms and documents listed in § 3712.1.

If you have a system capable of preventing year-end recovery from the provider, where it was relieved of liability for refunding an overpayment, an additional record of the case is not necessary.

3711.11 Beneficiary Protests.—A beneficiary's reply to a notification of overpayment or request for refund may constitute a request for reconsideration or hearing, a request for waiver or both.

A. Protests To Treat As Requests for Reconsideration or Hearing.—Consider a beneficiary's reply a request for reconsideration or hearing if the beneficiary protests the existence of an overpayment, the amount of the overpayment, or if the nature of the protest is unclear. (See B below for protests to consider requests for waiver.) Take no further recovery action in such cases until the reconsideration or hearing is completed. (See §§ 3781ff.) Tell the beneficiary that the request is being considered (or has been forwarded to the Office of Hearings and Appeals, if a hearing request) and that no action is necessary until further notice. If the overpayment case has been referred to HCFA, inform HCFA of the appeal so that recovery action by SSA may be suspended pending the results of the appeal.

If the reconsideration or hearing determination is that the beneficiary is liable for an overpayment, send the beneficiary another request for refund of the overpayment (including all information in § 3711.5), unless the beneficiary has also requested waiver. In that event, see B below. If the beneficiary does not reply within 30 days, forward the case to HCFA.

If a protest involves entitlement, refer the case to:

Health Care Financing Administration
Overpayment Section
P. O. Box 120
Baltimore, MD 21203

Annotate Item 13, "Remarks" of the HCFA-2382 in red "NONENTITLEMENT CASE - For HCFA Development and/or Waiver Consideration."

An individual may protest a Medicare overpayment determination at a local SSO. That office helps the individual to complete an appeal request. If the overpayment involves an issue other than entitlement to benefits, the SSO forwards the request using form HCFA-2649 (Part A) or form HCFA-1964 (Part B), to you. If the overpayment resulted from a decision that the individual was not entitled to Medicare during the period in which the services were rendered, the SSO uses form HCFA-561 and sends the original to its Program Service Center for a reconsideration. It sends you an informational copy so that can suspend recovery action pending the outcome of the appeal. When the reconsideration is complete, the Program Service Center sends you a copy of its determination. Either resume or terminate recovery action as appropriate. Notify the beneficiary when the recovery is terminated or resumed.

B. Protests To Treat As Requests for Waiver.—If an overpaid beneficiary protests on the grounds of hardship, or that recovery would be inequitable, treat the protest as a request for waiver even if it is filed on a form ordinarily used for requesting reconsiderations. Discontinue collection efforts and refer the case to HCFA for consideration of waiver. If the beneficiary offers evidence about his financial condition, forward it, but do not solicit such evidence. Tell the beneficiary that the overpayment case will be forwarded to the Social Security Administration and that no action is necessary until further notice.

NOTE: If the beneficiary has also requested reconsideration, conduct the reconsideration prior to the referral; and if the original decision is affirmed, advise him that the matter has been referred to SSA for consideration of his claim that refunding the overpayment would be a hardship for him and/or would be unfair.

3712 REFERRAL TO HCFA OF UNRECOVERED OVERPAYMENT CASES (INCLUDING GUARANTEE OF PAYMENT CASES).

When you determine in accordance with §§ 3709.3, 3711ff. or 3714.2 that an overpayment case is to be referred to HCFA as uncollected, address it to:

Health Care Financing Administration
Overpayment Section
P. O. Box 120
Baltimore, MD 21203

(If the Railroad Retirement Board (RRB) has jurisdiction, HCFA forwards the file to the RRB.)

HCFA (or RRB) reviews the case for correct application of program policies and, refers the case to the servicing program center for further recovery efforts or waiver consideration. When referring overpayment cases to HCFA (or RRB) include sufficient information to enable HCFA to determine how the overpayment occurred and whether it was correctly calculated.

No further recovery action is required after referring an uncollected overpayment. However, if the beneficiary refunds all, or part, of the overpayment, or appeals the overpayment decision, or requests waiver, notify HCFA promptly.

3712.1 Use of Form HCFA-2382 to Refer Uncollected Overpayments to HCFA.—Use form HCFA-2382, Intermediary Transmittal of Uncollected Medicare Overpayments, to refer to HCFA, unrecovered overpayments of more than $50 for which beneficiaries are responsible. This form with its attachments, serves a dual purpose.

- It affords a basis for a HCFA review of the overpayment, and
- It provides a summary of how the overpayment arose and was calculated for use by the Social Security Administration, or the HCFA in making further recovery efforts.

3712.2 Instructions for Completion and Distribution of Form HCFA-2382.—Send the original with appropriate attachments to HCFA. Retain a copy for your files. The following are specific instructions for completing certain items on the form.

Item 4. Beneficiary Deceased
You need make no n effort to find out whether the estate of a deceased beneficiary is being administered, but include the information under "Remarks" if it is known.

Item 5. Welfare Number
If the beneficiary is entitled to Medicaid or cash welfare benefits, enter the individual's welfare and/or medical assistance number.

Item 5. Dates of Services
Show the dates of services for which the overpayment was made. Dates are pertinent, for example, to statutory rules on coverage of services, the deductible and coinsurance amounts, and the determination of days covered by the guarantee. In (b) show the number of reserve days used because of the overpayment due to prior utilization or exhaustion of benefits. (See § 3106B.)

Item 9. Cause of Overpayment
Where the checkboxes provided in this item, plus the enclosed correspondence are insufficient to completely describe the cause of the overpayment, furnish additional information under "Remarks". (See § 3712.3.) If the "services not covered" block,explain why the services were not covered in Item 13, "Remarks," and cite the pertinent sections of this manual.

Item 10. Amount of Overpayment
Determine the amount of the overpayment taking into account § 3709.1. Explain the computation of the overpayment in Item 13 "Remarks". The explanation must be sufficient to enable the program service center to explain to the beneficiary how the overpayment was computed.

Item 11. Why Offset Not Made Against Provider
Fully explain why the provider was relieved of liability, in terms of §§ 3808ff. A mere statement that the provider was not at fault or that the overpayment was due to your or HCFA's error is not sufficient.

If the overpayment occurred because of prior utilization; i.e., because of misapplication of the coinsurance or payment for services rendered after benefits were exhausted, list the dates of all prior services rendered by the provider in that benefit period. This information should show that either:

- The beneficiary had not been a patient in this provider during the 60-day period prior to the admission which gave rise to the overpayment or
- If the beneficiary was a patient there during the 60-day period, the provider could not have known from its own records that the payment it received was incorrect. (See § 3708.2B.)

(If in the case of a utilization overpayment, the circumstances do not fit these conditions, recover from the provider.)

Item 12. Efforts to Recover
List the dates of recovery letters and any other efforts (e.g., telephone or personal contacts or offset) undertaken to recover the overpayment. State whether any part of the overpayment has been recovered and from what source. If a beneficiary's response to a notice of overpayment indicates that repayment would cause hardship, note that fact and enclose a copy of his reply.

If the beneficiary was receiving cash welfare benefits or medical assistance or is covered by private health insurance or another government plan, state what efforts you made to recover the overpayment from the welfare agency or insurance plan. If efforts were made, explain why the agency or plan did not refund the overpayment. (Attach a copy of the agency or plan's letter if the refusal was in writing.) If you made no efforts were made to recover from the welfare agency or insurance plan explain why not.

Item 13. Remarks
Use for the following purposes:

- If the beneficiary or survivor requests waiver or indicates that refund would be impossible, would be unfair, or would work a hardship, include a statement to that effect.
- Give further details concerning the information required by any other item, as necessary (particularly items 4, 9 and 10).
- Any pertinent information not provided on the form.
- Include the special annotation and information described in § 3712.4.

3712.3 Attachments to the Form HCFA-2382.—Include the following material:

- Copies of original and corrected billing forms. If the beneficiary filed the claim, include copies of any necessary supporting forms, such as emergency admission information.
- Copies of the initial overpayment letter and any followup letters informing him that he was overpaid.
- Originals of replies from the beneficiary, anyone acting on his behalf, his survivor or estate's representative.
- If the beneficiary or another party questioned the existence of the overpayment, include the disposition of the request for reconsideration and of any subsequent appeal.
- Copies of any letters you sent to insurance companies or welfare agencies requesting reimbursement. Any replies received.
- Any documentation or correspondence bearing on whether the beneficiary was at fault with respect to the incorrect payment, e.g., a letter from the beneficiary.
- Other pertinent correspondence.

3712.4 Special Annotation and Additional Information Required for the Overpayment Situations in § 3709.3.—Section 3709.3 specifies the types of overpayments to referred to HCFA for waiver consideration before undertaking any recovery action.

When referring cases under §3790.3, include (Remarks) the following:

- o The annotation: "For HCFA consideration of waiver per § 3709.3."
- o A recommendation as to whether the beneficiary was without fault with respect to the overpayment and the reason for the recommendation; and
- o If the overpayment was discovered subsequent to the third calendar year after the year of payment:
  - The date the payment in question was approved; and
  - The date the payment was determined to be incorrect. (§3708.6 explains how to determine the third calendar year after the year of payment.)

When referring overpayments caused by lack of Medicare entitlement, annotate (Remarks) in red "Nonentitlement Case - for HCFA development and/or waiver consideration.

3712.5 Refund Offered After Referral to HCFA or RRB.—After an uncollected overpayment for which a beneficiary is liable has been referred to HCFA, do not start any further action to collect the incorrect payment. In most cases either the overpayment can be deducted from the beneficiary's monthly social security or railroad retirement benefit, or recovery may be waived by HCFA or the SSA program service center (or RRB).

In the event that payment is offered after referral, accept it and notify HCFA as soon as possible to avoid duplicate collection.

3712.6. HCFA Processing of Provider Overpayments for Which Beneficiary is Liable.—HCFA refers overpayment cases for which a beneficiary is liable to the appropriate social security program service center and that office either recovers the overpayment or waives recovery. In some cases HCFA may waive recovery. The Medicare law permits waiver of recovery from a beneficiary if :

- o The beneficiary was without fault in causing and accepting the overpayment; and
- o Recovery would either be against equity and good conscience, would defeat the purpose of the Medicare program or would cause economic hardship.

If the program service center is unable to either recover or waive the overpayment, it may report it to the Department of Justice for further recovery action.

3714. GUARANTEE OF PAYMENT PROVISIONS.

A. General.—Under the guarantee of payment provisions, a hospital may be paid, under certain conditions, for inpatient hospital services furnished to a beneficiary whose eligibility for inpatient hospital benefit days has been exhausted. The guarantee provisions also apply to the 190-day lifetime limitation on inpatient psychiatric hospital services.

The guarantee of payment provisions are not applicable until the individual has exhausted his 60-day lifetime reserve days of inpatient hospital services except where the beneficiary is deemed to have elected not to use lifetime reserve days. In these cases, the guarantee of payment provision generally applies since the reserve days cannot be used. (See §§3106B and C and §§3106.2A and 2D(2); but see also §3106.2A for the exception to this rule.)

The guarantee applies only to inpatient hospital services furnished by a participating hospital, whether general or psychiatric. The guarantee does not apply to other benefits provided under the hospital or medical insurance program. The provision assures that payment will be made to a hospital, as limited by the provisions described in §§3714.1 and 3714.2, where it provides services before it becomes aware that the patient's benefits are exhausted.

The guarantee extends only to inpatient services furnished individuals who have exhausted their eligibility for inpatient hospital services as described above, and does not extend to individuals who have no coverage for other reasons, e.g., one who is not entitled under hospital insurance or whose entitlement has been terminated.

A hospital is not required to claim payments under this provision; it may look to the patient for payment. A hospital may not charge a beneficiary for services for which it is paid under the guarantee.

B. Requirements for Payment Under the Guarantee.—A hospital billing involving the guarantee of payment must be accompanied by information sufficient to justify payment under this provision. If such information is not included, request it from the hospital. Evaluate the information on the billing form and the explanation along the following guidelines:

1. Covered Services.—The services shown on the bill must be within the scope of covered services.

2. Reasonable Grounds to Believe Entitlement Existed.—There must have been reasonable grounds for the hospital's assumption that entitlement to benefits existed, e.g., the patient displayed an HI card and was identified as the proper holder of such card or the Social Security Administration office informed the hospital that the patient was insured and had reached age 65. Use the criteria in §3708.1 in deciding whether the hospital acted in good faith in assuming that the individual was entitled to inpatient hospital benefits.

3. Refund Made.—See §3401.1 for requirement that the provider refund payments received from the beneficiary before receiving payment under the guarantee.

C. Attempts to Obtain Payment From Other Third Party Payers.—If the beneficiary has other coverage which pays primary benefits for hospitalization or secondary benefits after Medicare benefits are exhausted, the hospital should seek payment from the other plan before claiming benefits under the guarantee. Every claim under the guarantee should be accompanied by an explanation of why payment for the services could not be obtained from another insurer or Medicaid.

3714.1 Application of the Guarantee When the Hospital Is Reimbursed on a Reasonable Cost Basis.

A. General.—The guarantee includes not only cases in which it is determined that benefits were exhausted prior to admission, but also cases where a beneficiary had some inpatient hospital benefits remaining at the time of admission, e.g., 2 or 3 days of remaining eligibility. Payment under the guarantee for those days after benefits are exhausted, is made at the full rate. The hospital will receive payment on the basis of reasonable cost without reduction for coinsurance.

B. Maximum Number of Days Under Guarantee.—Pay the hospital for inpatient services furnished for up to the 6th elapsed day after the day of admission. Saturdays, Sundays, legal holidays, and the first calendar day of admission are omitted in determining the 6th elapsed day. However, no payment may be made for any day after the day the hospital receives notice from the intermediary, the patient or any other source that the patient's benefits have been exhausted. Note that no payment may be made for any day which is later than the 6th day (as defined) after the admission date. If the notice is given by telephone, the date of confirmation in writing is considered the date of notification.

In determining the days covered by the guarantee, legal Federal holidays are:

New Year's Day
Martin Luther King, Jr.'s Birthday
Washington's Birthday
Memorial (Decoration) Day
Independence Day
Labor Day
Columbus Day
Veterans Day
Thanksgiving Day
Christmas Day

Exclusion of Federal nonwork days prolongs the period covered by the guarantee. When a Federal holiday occurs on Sunday, the day following is observed as a Federal nonworkday and is not counted as an elapsed day. When the holiday falls on Saturday, the previous Friday is not counted as an elapsed day. The hospital is paid for all the days of inpatient services within the guarantee period, i.e., weekends, holidays, and the day of admittance are included in computing the benefit amount due.

C. Recovery from Beneficiary of Funds Advanced Under Guarantee Provision.—Benefits paid to a hospital under the guarantee provision are subject to recovery from the beneficiary and/or third party payers in the same way as other overpayments for which beneficiaries are liable. (See § 3711ff.) The amount for which the beneficiary is liable is the lesser of the customary charges for otherwise covered services furnished during the period encompassed by the guarantee or the Medicare payment. (See §3711.4A3.)

3714.2 Application of the Guarantee When the Hospital Is Reimbursed on Prospective Payment Basis.

A. General.—The hospital receives payment under the guarantee at the full Medicare payment rate (determined in accordance with §2405ff of the Provider Reimbursement Manual) without reduction for coinsurance. The rules for determining when payment can be made under the guarantee depend upon the beneficiary's entitlement status and whether or not outlier days are involved.

B. Determining When Payment Under the Guarantee Provision Can Be Made.—

1. Nonoutlier Days.—If one or more regular benefit days is available, or if regular benefit days are exhausted and one or more lifetime reserve days is available for use under the criteria in §3106.2D(2)(b), payment is made as a regular benefit (not under the guarantee provision). If regular benefit days are exhausted at the time of admission and lifetime reserve days are not available for use under §3106.2D(2)(b) because the beneficiary is deemed to have elected not to use lifetime reserve days, payment is made under the guarantee provision. Pay for the nonoutlier portion of the stay at the full Medicare payment rate, without regard to the period of 6 elapsed days (as defined in §3714.1B).

NOTE: Where the beneficiary has no regular benefit days and no lifetime reserve days available at the time of admission, Medicare pays for the nonoutlier portion of the stay irrespective of when (after admission) the hospital receives information regarding an individual's nonentitlement since all nonoutlier days are included in the prospective payment amount which is paid under the guarantee of payment provision.

2. Outlier Days.—All regular benefit days must be exhausted and all lifetime reserve days must either be exhausted or not available for use under §3106.2D(2) before considering payment under the guarantee provision. Pay for outlier days that fall within the period of 6 elapsed days (as defined in §3714.1B). No payment can be made under the guarantee for any outlier days that fall after the date the hospital receives information regarding the individual's nonentitlement.

3. Examples.--

Example A:

A beneficiary has 12 regular benefit days and no lifetime reserve days available. He is admitted to a hospital on a Friday and is discharged on the 14th calendar day, a Thursday. Days 1 through 8 comprise the nonoutlier portion of the stay; days 9 through 13 comprise the outlier portion. In this instance, "6 elapsed days" encompasses a period of 11 calendar days. Since the beneficiary's regular benefit days do not run out before the end of this period (8 nonoutlier + 3 outlier days = 11 regular benefit days), no payment can be made under the guarantee of payment provision.

Example B:

Same facts as example A except the beneficiary has only 9 regular benefit days remaining. In this instance, days 1 through 8 (nonoutlier days) and day 9 (outlier day) are covered as a regular benefit. Days 10 and 11 (outlier days), furnished after regular benefit days have run out, may be paid for under the guarantee of payment provision since they fall within the period of 6 elapsed days (11 calendar days). No payment can be made for days 12 and 13.

Example C:

A beneficiary has 2 regular benefit days and 7 lifetime reserve days available. He is admitted to a hospital on a Friday and is discharged on the 19th calendar day thereafter. Days 1 through 8 comprise the nonoutlier portion of the stay; days 9 through 18 comprise the outlier portion. In this instance, "6 elapsed days" encompasses a period of 11 calendar days. Lifetime reserve days can be used. Days 1 through 8 (nonoutlier days) are covered by the 2 regular benefit days. Days 9 through 15 (outlier days) are covered by the 7 available lifetime reserve days. No payment can be made under the guarantee provision.

If available lifetime reserve days could not be used because the beneficiary is deemed to have elected not to use lifetime reserve days, payment may be made under the guarantee provision for days 9 through 11, outlier days that fall within the defined period of 6 elapsed days.

Example D:

The beneficiary has two lifetime reserve days available (no regular benefit days). He is admitted to a hospital for a ten day stay. The outlier threshold is day 15. Lifetime reserve days can be used. No payment can be made under the guarantee since the 2 lifetime reserve days are used to cover the entire stay.

Example E:

A beneficiary has 12 lifetime reserve days available (no regular benefit days). He is admitted to a hospital on a Friday and is discharged on the 14th calendar day, a Thursday. Days 1 through 8 comprise the nonoutlier portion of the stay; days 9 through 13 comprise the outlier portion. Lifetime reserve days cannot be used because the beneficiary is deemed to have elected not to use lifetime reserve days. In this instance, "6 elapsed days" encompasses a period of 11 calendar days which can be paid for under the guarantee.

Example F:

Same facts as example E except the beneficiary has only 9 lifetime reserve days available and lifetime reserve days can be used. In this instance, days 1 through 8 (nonoutlier days) and day 9 (outlier day) are covered as a regular benefit (not under the guarantee provision). Days 10 and 11 may be paid for under the guarantee of payment provision since they fall within the period of 6 elapsed days (11 calendar days). No payment can be made for days 12 and 13.

NOTE: No payment will be made for outlier days which fall after the date the hospital receives nonentitlement information. Thus, if the provider receives information regarding the beneficiary's nonentitlement status before the period of 6 days (as defined) elapses, payment for outlier days under the guarantee provision shall be barred. For instance, in examples B and F, if nonentitlement information had been received by the hospital within the first 9 days of the stay, no payment could be made under the guarantee. Medicare would pay for days 1 through 9 (8 nonoutlier, 1 outlier) as a regular benefit (not under the guarantee provision); no payment could be made for days 10 and 11 under the guarantee provision since no payment is permissible for outlier days that fall after the date of receipt of nonentitlement information.

C. Recovery from Beneficiary of Funds Advanced Under Guarantee Provision.—The Medicare payment rate under PPS (determined in accordance with §2405ff of the Provider Reimbursement Manual) paid to a hospital under the guarantee of payment provision is subject to recovery from the beneficiary and/or third party payers in the same way as other overpayments for which beneficiaries are liable. (See §3711ff.)

The beneficiary's liability is limited to the lesser of the Medicare payment rate to the hospital on the basis of the guarantee or the hospital's customary charges for otherwise covered services furnished during the period encompassed by the guarantee. (See §3711.4B2.) If the beneficiary remains in the hospital thereafter, the additional hospital services will not increase his liability for nonoutlier days. Also, the hospital may not charge him for continued care during the nonoutlier phase of the stay.

When a prospective payment hospital learns that a patient's Part A benefits are exhausted, it should advise him of this fact immediately if he is in day outlier status or about to enter day outlier status, since he will be liable to the hospital for his continued stay in outlier status thereafter.

3715. UNDERPAYMENTS

A. General.—The term "underpayment" refers to situations where a beneficiary to whom a Medicare benefit was payable dies before filing a claim or where he filed a claim but died before his claim was settled (e.g., a check was issued but was not negotiated prior to his death).

An underpayment situation includes a situation where the beneficiary dies prior to receiving a refund of overcollected Part B deductible amounts he paid for Part B provider services. (See § 3400B, last sentence.)

It also includes the situation where a Medicare benefit was payable to the beneficiary for covered inpatient hospital services, outpatient hospital services, and Part B services furnished on an inpatient basis by a nonparticipating hospital. These covered services may be classified as follows:

- Emergency and foreign inpatient hospital services provided by a nonparticipating hospital where the hospital has not filed an annual election to bill the program for hospital services;
- Emergency outpatient services provided by a nonparticipating hospital where the hospital has not filed an annual election to bill the program for emergency hospital services; and
- Certain Part B medical and other health services furnished by a nonparticipating hospital.

Where the patient died before the Medicare payment to him for the above services was completed, disposition of the case depends on the type of service rendered the patient and whether or not the hospital services have been paid for.

B. Services Not Paid For.—No health insurance benefits are payable after the death of the beneficiary where Part A inpatient services furnished by a nonparticipating hospital have not been paid for.

Where the case involves outpatient or other Part B services and the hospital has not received payment from the beneficiary or his estate or from another person on his behalf, pay the hospital if it agrees that the reasonable charge, as determined by you, is the full charge. This agreement may be entered in the Remarks section of the HCFA-1450. If the provider does not make this agreement, payment may be made on the basis of an unpaid hospital bill to the legal representative of the beneficiary's estate or other person who assumes the legal obligation to pay the charges. (See § 3715.8.)

An assignment executed by the beneficiary prior to his death continues to be effective after his death. Thus, where the beneficiary has assigned the right to payment for the Part B services prior to his death, you may reimburse the provider.

C. Persons Entitled to Receive Payment on Paid Bills After Patient's Death.--Where the services in subsection A. have been paid for, but the beneficiary died before the Medicare payment to him was completed, the person(s) who paid for the services has the first right to any Medicare payment due. If the services were paid for by the beneficiary or from funds of his estate, pay the legal representative of his estate.

If the person who paid for the services is other than the beneficiary and is deceased or if the deceased beneficiary paid the charges and no legal representative has been appointed, pay certain survivors of the beneficiary in the following order of priority (more detailed definitions of the various degrees of relationship are contained in §3715.6):

1. Surviving spouse who was either living in the same household with the beneficiary at the time of his death or was entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of his death;

2. Child or children of the beneficiary who were entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of his death;

3. Parent or parents of the beneficiary who were entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of his death;

4. Surviving spouse of the beneficiary who was not living in the same household with him at the time of his death, and was not entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of his death;

5. Child or children of the beneficiary who were not entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of his death;

6. Parent or parents of the beneficiary who were not entitled to monthly social security or railroad retirement benefits on the same earnings record for the month of his death.

NOTE: If the charges were paid by someone other than the beneficiary and that person died before the Medicare payment to him was completed, do not pay such person's estate. Nor does the right to payment pass directly to the legal representative of the beneficiary's estate. Pay a surviving relative of the beneficiary in accordance with the six priorities above. If none of the relatives listed survive, pay the legal representative, if any, of the beneficiary's estate.

If no person survives who meets the above requirements, payment may not be made. Furthermore, if a person higher on the priority listing is unavailable or his whereabouts are unknown, do not pay a person in a lower priority. Under this same principle, a person may not waive his right to claim the benefit in favor of a person in a lower priority.

3715.1 Development of Underpayment Claims--

A. Action on Receipt of Notice of Death.--Where notice of the beneficiary's death is received before his claim has been processed to completion (i.e., the claim is still in processing or an unnegotiated check has been returned), check your records and contact the hospital or other sources for information regarding the type of service rendered, whether or not the services have been paid for, and if paid, the name and address of the person who paid.

If the case involves Part B services for which the hospital has not received payment, advise the hospital how to claim the payment. (See § 3715B.) Where the hospital bill has been paid, develop a claim for the underpayment (or request SSO assistance) subject to the tolerance in subsection D. Where the hospital bill remains unpaid, the hospital does not want to file a claim , and someone has assumed or wishes to asume a legal obligation to pay the charges, develop a claim for underpayment (or request SSO assistance) and obtain a statement of assumption of legal obligation in accordance with § 3715.8, subject to the tolerance in subsection D.

B. SSO Development.--Most underpayment claims are developed in an SSO, and as a result, a claim is filed by the qualified person. Thus, if the SSO has assisted in the development of the case, you may assume that the claimant meets the necessary qualifications to receive the underpayment.

C. Requesting SSO Assistance.--Where a claimant contacts you and further information is needed (see also subsection D. below), SSO assistance may be sought. To enable it to obtain sufficient information to determine the proper payee, furnish SSO with all pertinent lead information and specify what is needed to complete the case. For example, indicate the type of service involved, whether the services have been paid for, whether it is known who paid for the services, etc., and what action has already been taken (e.g., a check was issued on a receipted bill and was returned; a widow has submitted a claim on a paid bill but it is not known whether there is a legal representative or whether she was living with the deceased or is entitled to monthly benefits on the same earnings record).

D. Tolerance Rule.--Do not routinely request underpayment development where the amount payable is less than $50. However, where a claim for the underpayment is received, process it regardless of the amount.

E. Returned Check.--If an unnegotiated check is returned by an individual who is also claiming the underpayment or requesting information about how to do so, follow subsection A.

If a check is returned by the Post Office Department marked "Addressee Deceased", etc., and there is no accompanying request for the underpayment, void the check and take no further action if the underpayment is less than $50. If a claim is later filed, process it regardless of the amount. If the underpayment is $50 or more, request SSO assistance.

F. Determination of Relationship.—Although in most cases the person qualified to receive the underpayment is readily apparent, decisions of relationship are governed by the social security law. Refer complex questions to an SSO for development and/or resolution. However, the case need not be routinely referred for verification of the claimant's allegations that he or she is the relative or other person qualified to receive the underpayment and that no one survives in a higher priority are not contradicted by information in file. For example, if the beneficiary had submitted a claim on a paid bill prior to his death, payment may be made to the legal representative without referral to the SSO if the requirements of § 3715.4 are met. Similarly, a claim filed by a widow can be processed without SSO assistance if it is apparent that she lived at the same address with the beneficiary at the time of his death (or is entitled on the same earnings record) if she states in writing that there is no legal representative of the estate and there is no reason to question her statement.

G. SSA Responsibility for Settling Disputes.—In the event of conflict in the evidence, the Social Security Administration has the responsibility for settling a dispute as to whether a claimant meets the qualifications for entitlement to the underpayment. If there is an adverse claimant when you receive the case, or if a decision of entitlement is disputed either before or after payment has been made, refer the case in accordance with § 3715.7.

3715.2 General Provisions Which Pertain to All Underpayment Claims.—

A. Request for Payment.—Aside from the issue concerning the person qualified to receive an underpayment, develop all other aspects of a claim for reimbursement in the same manner as if filed by a living beneficiary. Accordingly, if the beneficiary had not filed a claim prior to his death, a claim is required. The claimant should sign his own name in the space provided. If the beneficiary had filed a claim before he died, it is not necessary for a person claiming the underpayment to file another. In such a situation, any written request for the underpayment suffices.

B. Required Evidence.—Evidence that the services have been paid for and by whom must be submitted in every case. This evidence might be: a receipted bill showing who paid the bill, a cancelled check, or a statement from the provider or other probative evidence.

C. More Than One Person Entitled.—Where more than one person has a right to share in the Medicare underpayment, an application or payment request for the total payable to all is required from only one member of such a group. However, except as specified below, a separate check is issued to each individual entitled. Include with the check to each payee an explanation that a claim for the payment (show amount) has been made by (claimant's name) on behalf of all qualified parties and the enclosed amount represents his share.

D. Total Amounts Payable to Two or More Claimants Do Not Exceed $200.—Where the total program benefit payable to multiple claimants is $200 or less, in the absence of objection by one of the parties, pay the person who files as agent for himself and all others entitled. Obtain an agreement in writing to divide the payment in the proper amounts among the other entitled individuals. If one of the parties objects to this, issue a separate check to each.

E. Partially Paid Bills.—Where only a portion of a medical bill has been paid, payment may be made (or SSO development requested) on the paid portion as on any paid bill. In addition, contact the provider and explain how it may claim the payment on the unpaid portion of the bill. (See §3715B.) If the provider does not wish to claim the payment, you need take no further action. Advise the SSO (which services the claimant on the paid portion of the bill) that the provider has been contacted and does not wish to claim the payment. This notification will aid it in responding to inquiries regarding the case.

3715.3 Special Provisions Regarding Payment to Person Who Paid for the Services.—

A. Identifying Person Who Paid for Services.—A person who paid part or all of a bill may apply for the underpayment. He should furnish the identity and address of any other person who paid any part of the charges.

B. Payment From Own Funds.—The health insurance payment or refund on a receipted bill may be paid to a person who paid part or all of the charges with his own funds. Consider that the charges were paid from funds of the decedent's estate, and a "payer" will not qualify to receive a health insurance payment or refund if:

- He paid the charges in settlement of a debt or obligation to the decedent or his estate,

- He paid the charges from funds of an insurance policy of which the decedent or his estate is the beneficiary, or

- He paid the charges as an employer under a plan or contract of employment. However, there are some employer, union, insurance, or welfare plans that are liable only for deductibles and coinsurance but pay the enrollee's entire medical bill with the understanding that they will receive the Part B reimbursement. Where the medical bill is paid under such a plan, it is not considered paid by the patient's estate. Where the organization claims the payment on such basis, request the RO to verify the organizations qualifying for payment.

In the absence of some indication that these conditions exists, you need not develop further the basis upon which the bill was paid.

C. Charges Paid By More Than One Person.—If the charges have been paid by more than one person, each person who paid is entitled only to his proportionate share of the reimbursement. Where one (or more) of the group has died, his share of the payment is settled under the NOTE in § 3715C.

3715.4 Special Provisions Regarding Payment to Legal Representatives.--

A. Definition of Legal Representative.-- "Legal Representative" of a deceased individual means the executor or administrator of his estate, and includes the survivors designated to receive the assets of the deceased under the small estate statutes of the State in which the deceased resided at the time of his death.

Refer questions concerning the small estate laws and other questions relating to the appointment and authority of a legal representative to the SSO.

B. Order of Appointment.--Obtain a copy of the order of appointment with the request for payment filed by the legal representative unless this proof has already been submitted in connection with another claim. If this proof has been submitted to an SSO, a statement to this effect over the signature of a staff member of the SSO may be accepted as proof of appointment in lieu of a copy of the appointment papers.

3715.5 Special Provision Regarding Payment to Survivors.--

A. Obtaining an HCFA-1660 or Equivalent Information.--The relative(s) highest on the list of priorities in § 3715C must provide information in writing regarding:

- His relationship to the deceased patient;
- His status with respect to entitlement to monthly social security or railroad retirement benefits on the same earnings record as the deceased patient; and
- Whether or not there is a person higher in priority. The HCFA-1660 (Request for Information - Medicare Payment for Services to a Patient Now Deceased) was developed to serve this purpose.

If you secure the necessary information in writing by some means other than an HCFA-1660, do not obtain a completed form.

The questions in item 1 of the HCFA-1660 are general in nature and are required for identifying the type of payee who is eligible. If question 1(a) is answered "yes" and no legal representative is shown in 1(c), or, if question 1(b) indicates that the person who paid the bill is deceased, item 2 is completed. The person who completes item 2 fills in only one block, i.e., the name and address of the living survivor(s) who is a relative in the highest category as listed on the form.

When you send an HCFA-1660 directly to a claimant for completion, enter the deceased patient's name and HICN in the blocks provided. This information is necessary for later association of the completed form with the patient's file. Enclose an addressed return envelope.

Also complete the first part of item 1 to identify the medical bill(s) involved.

B. Evidence to the Contrary of Claimant's Statement.—In the absence of evidence to the contrary, accept a written and signed allegation of the claimant as to his entitlement status and his relationship to the deceased, that there is no relative in a higher priority who qualifies to receive the Medicare payment, and that there is no legal representative of the estate. "Evidence to the contrary" includes situations where there is an indication that a person in a higher priority exists, the claimant does not meet the relationship requirements, etc.

C. Payment to More Than One Child.—Where there is more than one child of the decedent, divide the Medicare payment equally, subject to the $200 rule in §3715.2D. If, however, one or more children has died (either before or after the beneficiary's death) divide the entire amount among the surviving children.

D. Payment to More Than One Surviving Parent.—Where there is more than one surviving parent and they are living together, the payment may be combined and a joint check issued. If the surviving parents are not living together, divide the payment equally between them subject to the $200 rule in §3715.2D.

E. Incompetent Payee.—If a relative who qualifies for payment is incompetent, or where such relative is a minor, the claim may be made on such person's behalf by his legal guardian or other person who has assumed responsibility for him. In the absence of evidence to the contrary, accept the claimant's statement that he has authority to act for the qualified individual.

F. On the Same Earnings Record.—The phrase "on the same earnings record" does not necessarily mean the earnings record of the beneficiary. For example, a female beneficiary may not have an earnings record, but is entitled to monthly benefits on her husband's account. Thus, both parties are entitled on the same earnings record. If she is the deceased beneficiary, her husband qualifies in priority number 1 of §3715C.

3715.6 Definitions of Relationship and Related Principles Governing Eligibility of Survivors.—

A. General.—A decision as to whether an individual meets the requirements of relationship is governed by the social security law. Accordingly, a survivor who has been awarded monthly social security or railroad retirement benefits as the spouse, child, or parent of the deceased is deemed to have this status for Medicare purposes.

However, where a claimant's allegation of relationship is challenged because of evidence to the contrary, be aware of the definitions of relationship which have been established by SSA. Although you are not required to make complex findings of fact, be familiar with the principles which are summarized in the following paragraphs.

Each degree of relationship—spouse, child, parent—appears twice in the priority listing in §3715C. Therefore, the individual who meets the definition may be either high or low on the list. The factor which controls his position in the priorities, in most instances, is whether he is entitled to monthly benefits on the same earnings record as the deceased beneficiary.

B. Surviving Spouse.—Aside from the question of entitlement to monthly benefits, a person who was living with the husband or wife in the month of his or her death is presumed to be the spouse of the deceased in the absence of clear and strong evidence to the contrary and qualifies in the 1st priority in § 3715C. Where the marital relationship is questioned, a person who was living with the beneficiary qualifies as a surviving spouse in priority number 1 if he or she was validly married to the beneficiary at the time of his death, or would have the status of widow or widower with respect to the taking of intestate personal property by the courts of the State in which the deceased lived at the time of his death.

A person also qualifies in the first priority as a surviving spouse if he or she married the beneficiary in good faith but the marriage was invalid because of a legal impediment not known to the claimant at the time of the marriage, provided the claimant was living with the beneficiary at the time of the beneficiary's death.

A couple is considered to be living together as husband and wife in the month of the beneficiary's death even though they were actually separated at the time of death if the separation was caused solely by the illness of either or other circumstances beyond their control. The SSO has been instructed to record the length of, and reason for, the separation. If the separation lasted more than 6 months, the SSO obtains sufficient information about the circumstances to make a determination as to whether there was an intent to resume living together in the same household. If such intent can reasonably be found, payment may be made to the surviving spouse.

An individual who was neither living with the decedent at the time of death, nor entitled to monthly benefits on the same earnings record, qualifies as a surviving spouse in priority number 4 if he or she meets the requirements in the first paragraph of this section.

C. Child.—The term "child" generally means:

- A person who would have the right under applicable State law to inherit intestate personal property from the beneficiary as his natural legitimate child;
- A person who was legally adopted by the beneficiary; or
- The beneficiary's stepchild.

In addition to the above, the Social Security Act recognizes the following individuals as "children" of a beneficiary:

- A child of an invalid ceremonial marriage which would have been a valid marriage except for a legal impediment;

- An illegitimate child who, prior to the beneficiary's death, was acknowledged in writing by the beneficiary to be his son or daughter; who was decreed by a court to be the beneficiary's child; where the beneficiary was ordered by a court to contribute to the child's support; or where the deceased is shown to be the father by other evidence and was living with the child or contributing to the child's support; or

- A child who retains inheritance rights in the beneficiary's estate even though adopted by another person during the beneficiary's lifetime.

D. Parent.—A person qualifies as a parent of the deceased beneficiary if he or she would have the status of parent with respect to the taking of intestate personal property under the law of the State in which the beneficiary lived at the time of his death; is a stepparent of the beneficiary; is an adoptive parent.

3715.7 Adverse Claims Based on Paid Bills.—The law delegates to SSA the responsibility of settling disputes involving the initial determination of relationship. Therefore, where an individual questions a denial or files a claim based on a bill on which reimbursement has already been made, or where an adverse claimant appears before payment has been made, refer the case to HCFA.

Where payment was properly made to a relative because there was no administrator at the time the claim was settled, the subsequent appointment of an administrator does not render the payment erroneous.

3715.8 Assumption of Legal Obligation to Pay Bill.—If a hospital does not want to file a Part B claim on an unpaid bill for services to a deceased beneficiary, the Part B payment may be made to the legal representative of the beneficiary's estate or to some other person who assumes a legal obligation to pay the charges.

If the legal representative seeks payment on that basis, he must submit a signed statement substantially as follows:

> "I am the legal representative of the deceased beneficiary's estate. The estate has assumed the legal obligation to pay charges of (amount of charges) by (name of hospital) for services to ________________, the deceased beneficiary, on (dates of services)."

The legal representative must also submit a copy of his order of appointment as legal representative.

If someone other than the legal representative of the estate seeks payment on that basis, he must submit a statement substantially as follows:

> "I have assumed a legal obligation to pay, from my own personal funds, the charges of (amount of charges) by (name of hospital) for services to ________________, the deceased beneficiary, on (dates of services)."

3716. ALIEN NONPAYMENT CASES

An alien is not eligible for social security monthly benefits and health insurance benefits in certain cases after he has been outside the United States for 6 full consecutive calendar months. (A period of absence from the United States is broken for an alien who has been outside the United States for 30 full consecutive days, if the alien spends a period of 30 full consecutive days in the United States before the expiration of a 6 full consecutive calendar month period. A new period of absence begins as of the first day of the month after the month he again leaves the United States.) If he returns to the United States, benefits become payable beginning with the first full calendar month of presence in the United States. SSA will determine when this susension applies.

You know this provision may apply when you receive a reply to a query showing disposition code 26. See §§ 3512 and 3531.

When you receive this reply, contact the local SSO. Indicate an alien nonpayment case and furnish at least the following information: name, HICN, address, and inclusive dates of hospital and/or medical services. The SSO investigates to determine whether payment may be made. It furnishes a written statement stating whether any or all of the medical services are reimbursable.

The statement shows months for which payment may be made. Future months may be shown. Pay the claim based upon this statement. Subsequent claims where expenses are incurred within this period may be processed based on this report even though you receive another reply showing disposition code 26.

For expenses incurred after the period covered by the report, ask the beneficiary whether he or she was out of the United States after the last month shown on the report. The beneficiary's signed statement that he/she was not, is sufficient to pay the claim. If the beneficiary was out of the United Sttes, refer the case to the SSO for another investigation. Include the beneficiary's statement.

When these cases are referred to the SSO, tell the provider that payment may be barred and that a definitive reply will follow. The follow denial notice to the provider and, where appropriate, to the beneficiary includes a paragraph similar to the following:

> In certain cases, an alien who has been outside of the United States for 6 full consecutive calendar months is not eligible for health insurance benefits. Payment can only be made to, or for, such an alien for the first full calendar month of presence in the United States. It has been determined that payment cannot be made in this case for (months(s).)

Medicare Benefit Notices

3717. MEDICARE NOTICES SENT TO THE BENEFICIARY

Notify Medicare beneficiaries of the disposition of health insurance claims that they have filed, or that providers have filed on their behalf, to advise them about their Part A and B benefits used, Part A and B deductible status, lifetime reserve status, appeal rights, and to assist them in applying for complementary insurance benefits.

Beneficiary notices are prepared and sent by you, by the carrier, and by the Health Maintenance Organization (HMO) contractually obligated to make payment on Medicare claims. The notices prepared and sent to the beneficiary by you (see §§3718ff.) are explained below.

3718. INTERMEDIARY PREPARATION OF THE MEDICARE BENEFIT NOTICE

Furnish a Medicare Benefit Notice, Form HCFA-1533, to each beneficiary for whom you process a hospital or SNF inpatient bill, (except for hospital bills denied partially or completely by a PRO). The PRO sends the denial notices for bills it denies. You send the Medicare Benefit Notice explaining the portion of partially paid bills for which you make the decision (Benefits exhausted, MSP, etc.).

Prepare this notice within 5 working days of the day you prepare the related UNIBILL, and mail it immediately. Use the HCFA supplied Form HCFA-1533, or a facsimile.

In the following instances, prepare a Medicare Benefit Notice only upon the request of the beneficiary or the beneficiary's representative:

o Outpatient services;

o No covered days;

o "R" coded bill. This means that no program payment was made, but utilization is chargeable;

o Home health bill;

o Emergency inpatient hospital services (facility does NOT participate, and the patient elected to file the bill directly instead of via the hospital. (Since payment is made to the patient, there is no need of a notice.);

o Deceased beneficiary with service dates preceding your processing date by 12 or more months; or

o Service dates precede your processing date by 4 or more years.

3718.1 Completing Form HCFA-1533, Medicare Benefit Notice.—This notice primarily reflects the benefits used and any applicable remarks about deductibles, coinsurance, and/or lifetime limits on days. Do not show remaining days for a benefit period. Make entries within the prescribed blocks on the front of the form as shown below.

A. Identification Information.--

1. Name and Address.--Show the name and address of the beneficiary or representative payee in the address block. When your record shows that the beneficiary is deceased, add "THE ESTATE OF" as the first line of the address unless the beneficiary had a representative payee. If there is a representative payee and the payee's name is John Smith and the patient's is George Brown, the legend reads: "John Smith for George Brown."

2. Date and HICN.--Show the date the form is prepared and the HICN.

B. Medicare Benefits (Item 1).--

1. SERVICES FURNISHED BY.--The name and address of the facility that furnished the services.

2. DATE(S).--The FROM and THRU dates covered by the bill.

3. BENEFITS USED.--Show the entries (XX) INPATIENT HOSPITAL DAYS, and/or (XX) HOSPITAL RESERVE DAYS or (XX) SKILLED NURSING FACILITY DAYS as applicable.

C. Payment Status (Item 2).--

Medicare is Primary Payer

Medicare makes either an unconditional or a conditional payment.

If service(s) are all or partially covered (no noncovered days) and no secondary payer involvement, the message(s) are:

MEDICARE PAID ALL COVERED SERVICES, or MEDICARE PAID COVERED SERVICES EXCEPT: (Use one or more of the indented messages)

($AMOUNT) FOR THE INPATIENT DEDUCTIBLE.
($AMOUNT) FOR (XX) DAYS OF HOSPITAL CARE AFTER FIRST 60 DAYS.
($AMOUNT) FOR THE COST OF (XX) PINTS OF UNREPLACED BLOOD.
($AMOUNT) FOR (XX) DAYS OF SKILLED NURSING FACILITY CARE AFTER FIRST 20 DAYS.
($AMOUNT) FOR PHYSICIAN CHARGES BILLED SEPARATELY TO THE MEDICARE CARRIER.

Medicare is Secondary Payer

Primary payer is EGHP for an employed beneficiary and spouse or for a beneficiary entitled to Medicare on basis of ESRD within a prescribed 12 month coordination period, or for a beneficiary entitled to Medicare as a disabled beneficiary.--If services(s) are all or partially covered (no noncovered days), the message is:

MEDICARE PAID ALL COVERED SERVICES NOT PAID BY OTHER INSURER, or MEDICARE PAID ALL COVERED SERVICES NOT PAID BY OTHER INSURER EXCEPT:

($AMOUNT) FOR THE INPATIENT DEDUCTIBLE.
($AMOUNT) FOR (XX) DAYS OF HOSPITAL CARE AFTER FIRST 60 DAYS.
($AMOUNT) FOR THE COST OF (XX) PINTS OF UNREPLACED BLOOD.
($AMOUNT) FOR (XX) DAYS OF SKILLED NURSING FACILITY CARE AFTER FIRST 20 DAYS.
($AMOUNT) FOR PHYSICIAN CHARGES BILLED SEPARATELY TO THE MEDICARE CARRIER.

Primary payer is automobile no-fault or liability insurance, WC, BL, VA, PHS, or other Federal agency.—If service(s) are all or partially covered (no noncovered days), the message is:

MEDICARE PAID ALL COVERED SERVICES NOT PAID BY OTHER INSURER, or MEDICARE PAID ALL COVERED SERVICES NOT PAID BY OTHER INSURER EXCEPT:

($AMOUNT) FOR THE INPATIENT DEDUCTIBLE.
($AMOUNT) FOR (XX) DAYS OF HOSPITAL CARE AFTER FIRST 60 DAYS.
($AMOUNT) FOR THE COST OF (XX) PINTS OF UNREPLACED BLOOD.
($AMOUNT) FOR (XX) DAYS OF SKILLED NURSING FACILITY CARE AFTER FIRST 20 DAYS.
($AMOUNT) FOR PHYSICIAN CHARGES BILLED SEPARATELY TO THE MEDICARE CARRIER.

Primary Payer other Than Medicare Pays For All Services That Medicare Would Have Covered.—If service(s) that Medicare would have covered are all paid by a payer primary to Medicare, the message is:

OTHER INSURER PAID ALL COVERED SERVICES AS PRIMARY PAYER.

Medicare is Primary or Secondary Payer

If the bill includes both covered and noncovered days of service, enter the applicable remarks above as well as:

(XX) DAYS WERE NOT PAID FOR BY MEDICARE. PLEASE REFER TO THE LETTER WE SENT YOU EXPLAINING THE NONCOVERED PORTION.

If the billing data is from an Indian Health Service Hospital, include the following message:

MEDICARE PAYMENT LIMITS DO NOT AFFECT AN INDIAN'S RIGHT TO FREE CARE AT INDIAN HEALTH SERVICE INSTITUTIONS.

If the billing data is for inpatient psychiatric services and no additional psychiatric lifetime days are available, include the following message:

YOU HAVE USED YOUR LIMIT OF 190 DAYS OF PSYCHIATRIC HOSPITAL SERVICES.

If the billing data is for inpatient psychiatric services and days are still available, include the following message:

YOU HAVE (XXX) DAYS REMAINING TOWARD YOUR LIMIT OF 190 DAYS OF PSYCHIATRIC HOSPITAL SERVICES.

If the billing data is for inpatient hospital services and includes lifetime reserve days and days are still available, include the following message:

YOU HAVE (XX) DAYS REMAINING TOWARD YOUR LIMIT OF 60 HOSPITAL RESERVE DAYS.

If the billing data is for inpatient hospital services and includes lifetime reserve days and no additional days are available, include the following message:

YOU HAVE USED YOUR LIMIT OF 60 LIFETIME RESERVE DAYS.

Since potential exists for another insurer to pay for the same services already paid for by Medicare, include the following message (set off from other messages in the notice) on all notices showing Medicare as primary payer:

IF AUTOMOBILE OR LIABILITY INSURANCE, WORKERS' COMPENSATION OR, IN SOME CASES, A HEALTH PLAN FOR EMPLOYEES ALSO PAYS FOR THESE SERVICES, A REFUND MAY BE DUE THE MEDICARE PROGRAM. PLEASE CONTACT US IF YOU HAVE HEALTH INSURANCE COVERAGE FROM ONE OF THESE SOURCES. IF YOU DO NOT HAVE HEALTH INSURANCE COVERAGE FROM ONE OF THESE SOURCES YOU NEED NOT CONTACT US.

If there are admissions of record for earlier dates than the one for which a bill is accepted, include the following message:

YOU WILL BE NOTIFIED OF BENEFITS USED DURING ADMISSION(S) OF XX/XX/XX, WHEN THE BILL(S) FOR THE ADMISSION(S) ARE PROCESSED.

If the beneficiary received a covered organ transplant, include the following message:

> IMMUNOSUPPRESSIVE DRUGS MAY BE COVERED UNDER MEDICARE IF PURCHASED WITHIN ONE YEAR FOLLOWING MMDDYY. THIS IS THE DATE YOU WERE DISCHARGED FROM THE HOSPITAL AFTER YOUR ORGAN TRANSPLANT.

Enter your name, address, and telephone number below Item 2.

3718.2 Amended Medicare Benefit Notices, HCFA-1533.—When you process an adjustment bill (other than in response to a PRO denial) which affects a beneficiary's utilization, deductible or coinsurance data, prepare a HCFA-1533 with the remark "THIS IS AN AMENDED NOTICE" printed across the upper margin on the notice. Use appropriate remarks to explain why the data shown on the beneficiary's original notice have been revised. Base the remarks and data on either the "cancel only" bill of a cancel only adjustment or the "debit" bill of a credit/debit adjustment.

Do not prepare an amended notice for a deceased beneficiary if the service dates on the adjustment bill percede HCFA's processing date by 12 or more months. Upon request, however, prepare a notice for any adjustment bill which is processed after the 12-month limit.

A. Cancel Only Adjustment.—Prepare an amended notice with remarks describing the reason for the cancellation. Some of the remarks and the particular situations which would cause an amended notice to be prepared are:

1. Situation.—Plan transfer, i.e., transfer from Part B to Part A or vice versa.

REMARK: THE SERVICES ABOVE HAVE BEEN REMOVED FROM YOUR RECORD AS THEY WERE PROCESSED INCORRECTLY. YOU WILL RECEIVE A CORRECTED NOTICE LATER.

2. Situation.—Same bill posted to your records more than once.

REMARK: THE SERVICES ABOVE HAVE BEEN REMOVED FROM YOUR RECORD. THEY WERE POSTED TO YOUR RECORD TWICE.

3. Situation.—Bill posted to the wrong individual's record.

REMARK: THE SERVICES ABOVE HAVE BEEN REMOVED FROM YOUR RECORD. THEY WERE RECEIVED BY ANOTHER PERSON.

4. Situation.—Coverage transfer (covered to noncovered); i.e., a previously covered bill is replaced with a noncovered bill; for example, when workers' compensation will pay for the services.

REMARK: THE SERVICES WERE POSTED TO YOUR RECORD IN ERROR. THEY HAVE BEEN REMOVED.

5. Situation.—Cancellation for reason other than described above.

REMARK: THE SERVICES ABOVE HAVE BEEN REMOVED FROM YOUR RECORD AS THEY WERE POSTED INCORRECTLY.

B. Credit/Debit Adjustment.—Send a notice for credit/debit adjustments only if utilization or deductible is affected. Since the debit bill is the basis for an amended notice, enter the same remarks you entered on the original notice, preceded by the statement, "THIS RECORD REPLACES THE PREVIOUS RECORD YOU RECEIVED FOR THE SERVICES ABOVE."

Other Notices

3719 OTHER MEDICARE NOTICES

3719.1 Notices for Part A Bills.—You are responsible for sending the beneficiary and provider Medicare notices in the following situations:

- Totally or partially denied Part A bills other than PRO denials.
- Special spell of illness notices
  - Send a special notice of presumed skilled care relating to the SNF stay immediately prior to the present hospital or SNF inpatient stay sent when presumption 5, §3035 is applicable, the present hospital or SNF bill is totally paid, and the prior SNF stay was at least 60 days, or if less than 60 days, the SNF stay in conjunction with nonhospital and non-SNF days equaled 60 or more consecutive days. Include the following notice language on a special notice.

Medicare has determined that your stay in (name of facility) from (date) to (date) is part of your current benefit period, rather than the beginning of a new one. To make this determination Medicare found that during your prior nursing home stay in (name of facility) from (date) to (date), you received services at the skilled level of care because: (insert reason here)

Although your claim for nursing home benefits in that prior nursing home stay was denied by Medicare and/or Medicaid, it was not denied because the services provided failed to meet skilled level of care requirements.

You may appeal the above determination if you believe that you received services which were not at the skilled care level during your prior nursing home stay. This appeal may be filed now, but in any case it must be filed no later than 60 days after you receive an additional notice (HCFA-1533), which reflects the benefits used during your (SNF or hospital) stay. If you appeal and Medicare agrees that these services were below the skilled level, your stay in (name of facility) from (date) to (date) will begin a new benefit period and if your recent care was in a hospital you will be required to pay a new deductible. Please contact our office or your Social Security Office for assistance in deciding if it is in your best interest to appeal this determination.

- Send a special notice of presumed nonskilled SNF care when presumption 6 or 7, §3035 is applicable and where prior SNF stay was at least 60 days, or if less than 60 days, the SNF stay in conjunction with nonhospital and non-SNF days equaled 60 or more consecutive days. Include the following notice language on a special notice.

Medicare has determined that your stay in (name of facility) from (date) to (date) began a new benefit period, which requires the payment of a new deductible. To make this determination Medicare found that during your prior nursing home stay in (name of facility) from (date) to (date), you did not receive skilled level services because:

- o No Medicare or Medicaid claim was submitted for that prior stay, or
- o A Medicare claim was submitted but the claim was denied because the services were not at the required skilled care level.

You may appeal the above determination if you believe that you received services at the skilled care level during your prior nursing home stay. This appeal may be filed now, but in any case, it must be filed no later than 60 days after you receive an additional notice (HCFA-1533), which reflects the benefits used during your (SNF or hospital) stay. If you appeal and Medicare agrees that these services were provided at a skilled level of care, your stay in (name of facility) from (date) to (date) will not begin a new benefit period. Therefore, you will avoid payment of a new deductible (where the current claim is for inpatient hospital services), but you may become liable for other items, such as coinsurance or lifetime reserve day payments. Please contact our office or your SSO for assistance in deciding if it is in your best interest to appeal this determination.

NOTE: To avoid the impression that the beneficiary is personally liable for his stay at a free, State financed, no charge structure hospital, do not send denial letters to patients whose only stay was in such a hospital.

For HMOs which do not pay claims, you will continue to send the above notices.

Send total denial notices (HCFA-1954) and partial denial notices (HCFA-1955) at the earliest date you can make a noneligibility decision. You may base the decision on one or more eligibility factors such as:

- o Lack of Entitlement to Medicare Benefits;
- o Spell of Illness Requirements;
- o The 3-day Stay Requirements;
- o For SNF stays, the 30-day Transfer Requirements; and
- o Psychiatric Lifetime Limitation Used.

Where you make an advance denial decision, provide an oral denial notification to the provider at once. Follow this immediately by a formal notification (HCFA-1954 or HCFA-1955). Where you give such a decision prior to receipt of the bill and you find that the original notice is incorrect or incomplete, send a corrected notice. Combine the corrected beneficiary notice with any overpayment notice which results, if it will not cause an undue delay in releasing the corrected notice.

In situations involving total denials where no utilization is chargeable, the denial notice (HCFA-1954) is the only official notice the beneficiary will receive, since a HCFA-1533 will not be sent. In situations involving partially denied bills (either initial, interim, or final), in addition to sending the beneficiary the denial notice, also send a HCFA-1533 since you will have posted some utilization and/or deductible to the beneficiary's record. (See §3718 regarding the HCFA-1533.) At your option, you may combine the partial denial message with the Form HCFA-1533.

When an interim bill is fully payable but data included indicates termination or exhaustion of coverage for the remainder of the admission, prepare a partial denial notice. However, you need not repeat the notice on subsequent bills for the same admission.

3719.2 Notices for Part B Bills.—You send beneficiary notices for Part B services you process. In addition, send a Part B notice of denial and partial denial for bills for HHA services including visits. Use the HCFA-1954 and HCFA-1955 form letters. (See §3722.)

3719.3 Notices on Claims Involving Both Part A and Part B Services.—If practical, when you send a denial notice for Part A benefits but pay for some of those services under Part B, send the denial notice and the EOMB together.

3719.4 Notices on Claim Denials Resulting from PRO Determinations.—PROs send denial notices on cases they deny. This applies to both hospital and beneficiary notices. Show on your remittance record to the hospital that the adjustment was a result of PRO review. Do not send a separate written notice to the hospital or beneficiary.

You are responsible for denial notices on cases you deny.

3719.5 Preparation of Medicare Benefit Notices Upon Request.—Medicare beneficiaries or someone acting on their behalf, e.g., SSOs via the HCFA-1938 "SSA Request for Carrier or Intermediary Assistance", may request notice of utilization information from you. Upon receipt of a request, check your records to see if you have received the claim in question. If you have not, advise the SSO accordingly. If you have received the claim, process it, and prepare a HCFA-1533 to forward either to the beneficiary or the inquirer as requested on the HCFA-1938.

3721. DISALLOWANCE FORM LETTERS HCFA-1954 and HCFA-1955.

The HCFA-1954 three-part disallowance letter when you, on behalf of HCFA, are totally disallowing a claim. Use the HCFA-1955 when you or the HMO is partially denying a claim. Since partial denials involve two beneficiary notices for the same bill, the 60-day time period within which a beneficiary may file a reconsideration request must be figured from the final notice sent by HCFA, (one notice from you or a HMO regarding the denied portion of the bill and a subsequent one from HCFA regarding the utilization data.) The only differences in the two letters are that the HCFA-1954 has a sentence in the preprinted closing paragraph covering the 60-day time period for filing a reconsideration request whereas the HCFA-1955 omits this sentence; and the partial denial letter, HCFA-1955, has another preprinted paragraph which mentions the subsequent utilization notice the beneficiary will receive.

Send the original of the HCFA-1954 and the HCFA-1955 to the beneficiary. One copy is retained by you or a HMO and the third copy may be sent to the provider.

NOTE: In addition to sending the HCFA-1954 or HCFA-1955, you or a HMO include a pamphlet, SSA-75-10085, "Your Right to Question the Decision on Your Hospital Insurance Claim" for information regarding the beneficiary's appear rights.

For waiver of liability decisions, in addition to a copy of the HCFA-1954 or HCFA-1955, send the provider a letter explaining its appeal rights under the waiver provision. (See S3722.5C.)

Type the HCFA-1954 and HCFA-1955 to assure ligibility on all copies. Not only is it important that the beneficiary receive a legible copy, but a readable file copy is needed for documentation in any appeals.

Show your return address on the envelope used for mailing the denial notice so that the procedures for handling undeliverable beneficiary notices can be followed. (See S3728.) In addition, the return envelope should have the Medicare identification as required by S3701.

The HCFA-1954 and HCFA-1955 form letters are preprinted by HCFA and may be ordered with your name and address name and address on the form. (See Part 2 S2954B.) Entries to complete on the HCFA-1954 (Total Denials) and HCFA-1955 (Partial Denials) are:

- o Intermediary Number, Name, and Address.—Place your assigned number and name followed by the mailing address.
- o Beneficiary Name and Address.—Show the name and address of the beneficiary or his representative payee in the address block.

- Date.—Date the three copies of the form as if the date is the record used for purposes of establishing the 60-day time limitation for filing a reconsideration request. Use dates, not numbers, i.e., use January 1, 1986, not 1/1/86.

- HICNs.—Place the HICN and alphabetic suffix assigned to the beneficary in the block provided. See §3504 for variations in the HICNs.

- Type of Service Provided.-- Identify the type of service provided, "Hospital," "Skilled Nursing Facility," "Home Health," or "Other," and indicate whether services are for hospital of medical insurance.

- Date of Admission.-- Enter the admission date or the date of first visit on the line provided if the letter is sent based upon an admission notice rather than a bill.

- Services Provided By.--Enter the provider's number followed by its name and address in the space provided.

- Notice Covers Period.-- Show the "from" and "through" date of the billing period.

NOTE: In denial situations where waiver is applicable and a preprinted denial form is used, where necessary, insert the period of time for which waiver applies and check the appropriate box.

Explanation of Denial.-- Enter the appropriate hospital, SNF, HHA, or miscellaneous denial paragraphs located in § 3722ff.

This letter contains an appeals paragraph outlining both Part A and B appeals procedures and directs the beneficiary to contact the local SSO if he questions the decision. (See §§ 3780ff. regarding the reconsideration procedure.)

3722. STOCK DENIAL PARAGRAPHS

The stock paragraphs cover common denial situations to utilize as specified in §3632 or by the HMO in the preparation of denial letters to the beneficiary and providers. The paragraphs may be used on Forms HCFA-1954 and 1955 or in letters which you develop.

The object of denial letters is to explain clearly to the beneficiary or provider, the reason for the denial. Where a denial paragraph is inappropriate, or there is no paragraph which explains the reason, develop or modify the language to fit the situation. Otherwise use the furnished paragraphs.

Forward to the RO for submission to CO any denial language which you develop and which you use frequently. The language will be reviewed and included in the manual as appropriate.

The following sections describe denial conditions and give stock denial paragraphs. An HMO contractually obligated to pay Medicare claims is responsible for appropriate denial notices for claims on which it is unable to make full payment. Although these sections do not specifically mention HMOs, they apply to HMOs responsible for claims payment.

3722.1 SNF Denial Letters.—SNF denial letters consist of:

- o A base paragraph (not required for technical denials (TD));
- o A paragraph giving the specific reason for denial with the applicable regulatory and statutory references;
- o A limitation of liability paragraph (used with denial paragraphs SNF-2A through SNF-4B where the statutory basis for denial is §1862(a)(1) or §1862(a)(9)); and
- o An appeals paragraph (Part A or Part B as applicable).

Use all applicable denial paragraphs for services for which you deny payment.

Where a denial situation is not covered in the following paragraphs, adapt one to fit. If a denial situation appears frequently, submit recommended language to your RO.

On all letters which reference the Act, give the full document name in a footnote; title XVIII of the Act, commonly known as the Medicare Program, 42 U.S.C. §3195 et seq.

SNF-1

Condition.—Definition of skilled nursing benefits - Base paragraph (use with paragraphs SNF-3A-through 4C).

Paragraph.—Skilled nursing facility benefits are paid under Medicare for individuals who need, on a daily basis, skilled nursing care or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis. Skilled care is care which must be furnished by, or under the supervision of, skilled personnel to assure the safety of the patient and to achieve the medically desired result. In addition, skilled nursing or skilled rehabilitation services must be ordered by a physician and be reasonable and necessary for the treatment of a beneficiary's illness or injury.

SNF-2

Condition.--Skilled nursing or skilled rehabilitation - Base paragraph (use with paragraphs SNF-2A-through 2J).

Paragraph.--One of the qualifications for Medicare coverage of skilled nursing facility services is that you must require, on a daily basis, skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.

Skilled nursing or skilled rehabilitation services must be performed by or under the supervision of, a professional nurse, or a physical, speech or occuptional therapist to achieve the medically desired effect.

Skilled services that may be needed in a skilled nursing facility include:

o Skilled management and evaluation by a professional nurse or therapist for medical reasons to promote your recovery and medical safety;

o Skilled observation and assessment when your medical condition is unstable or there is a likelihood of a change requiring a skilled nurse to evaluate the need for changes in your plan of care;

o Teaching and training by skilled personnel necessary to help you manage your plan of care; and

o Certain service(s) recognized by Medicare as always requiring skilled nursing or skilled rehabilitation if it is reasonable and necessary for the treatment of illness or injury, for example, nasogastric tube feeding.

SNF-2A

Condition.--General nonskilled care - full denial.

Paragraph.--The medical information provided us shows that you only needed oral medications, assistance with your daily activities and general supportive services. There is no evidence of medical complications or other medical reasons that required the skills of a professional nurse or therapist to safely and effectively carry our your plan of care. Therefore, Medicare cannot pay for your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-2B

Condition.—Specific nonskilled service provided - no skilled care (full denial).

Paragraph.—The medical information provided us by the skilled nursing facility shows that you only needed (specify service). This does not generally require the skills of a licensed nurse. The information did not show any medical problems which would have required a licensed nurse to perform the service or manage your care. Since you needed neither skilled nursing nor skilled rehabilitation on a daily basis, Medicare cannot pay for your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-2C

Condition.—Specific nonskilled service provided - (partial denial).

Paragraph.—The medical information provided us by the skilled nursing facility shows that you only needed (specify service) after (date). Since you no longer required skilled nursing and did not need skilled rehabilitation on a daily basis, Medicare cannot pay for your stay beginning (date) . (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-2D

Condition.—Observation and management of care plan.

Paragraph.—You needed skilled nursing care beginning (date) to observe and evaluate your condition. The medical information provided us by the skilled nursing facility gives no indication of further likelihood of significant changes in your care plan or of acute changes or complications in your condition. Since you needed neither skilled nursing nor skilled rehabilitation on a daily basis, Medicare cannot pay for your stay after (date). (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

NOTE: If applicable, substitute therapy and type of therapist for skilled nursing and skilled nurse.

Paragraph.—Because of your condition, you needed a skilled nurse from (date) through (date) to evaluate and manage your care plan. Based on the medical information provided, your condition improved so the services you needed could have safely and effectively been given by nonskilled persons. Since you no longer required skilled nursing and did not need skilled rehabilitation on a daily basis, Medicare cannot pay for your stay after (date). (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-2E

Condition.—Teaching and training activities.

Paragraph.—Medicare covers daily skilled care for a reasonable amount of time where progressive learning is demonstrated and, when it is needed to teach you the necessary tasks ordered by your physician.

Subparagraph 1. - However, the nurse or therapist continued to teach you when the medical information showed that you had learned or would not be able, at this time, to learn and perform the tasks. Since you no longer needed skilled nursing and did not need skilled rehabilitation on a daily basis, Medicare cannot pay for your stay after (date) . (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

Subparagraph 2. - The services you received reminded you to follow the physician's instructions. This does not constitute teaching. Since you did not require skilled nursing or skilled rehabilitation on a daily basis, Medicare cannot pay for your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-2F

Condition.—Foley not needed.

Paragraph.—Daily skilled nursing care related to the insertion, sterile irrigation and replacement of a urethral catheter is covered if the use of the catheter is medically necessary. Urethral catheters are not considered medically necessary when used only for mere convenience or the control of incontinence in the absence of special medical needs. Medicare cannot pay for your stay because the medical information shows that the catheter was not medically necessary. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-2G

Condition.—Repetitive exercises.

Paragraph.—The medical information shows that the only therapy services you needed beginning (date) were repetitive exercises and help with walking. These do not generally require the skills or the supervision of a qualified therapist. There was no evidence of medical complications which would have required that the services be performed by a qualified therapist.

Full Denial: Add

Since you did not receive skilled rehabilitation or skilled nursing care on a daily basis, Medicare cannot pay for your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

Partial Denial: Add

Since you no longer needed skilled rehabilitation or skilled nursing care on a daily basis, no further payment can be made for your stay after (date) . (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35)

SNF-2H

Condition.—Therapy services for overall fitness and well-being. (Skilled therapy is physical therapy, occupational therapy, and/or speech-language pathology.)

Paragraph.—The medical information shows that the therapy services you received were for your overall fitness and general well-being. They did not require the skills of a qualified (______________) therapist to perform and/or supervise the services. Since you did not need skilled nursing or skilled rehabilitation services, Medicare cannot pay for your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-2I

Condition.—The services do not constitute covered (________) therapy because they do not require the skills of a (_____) therapist.

Paragraph.—Based on the medical information provided, you did not need skilled rehabilitation or skilled nursing services. The (_____) therapy services you received were only to carry out a maintenance program established to maintain your functional abilities. These services do not require the continued supervision or the skills of a ( ) therapist and, therefore, do not constitute skilled (___) therapy under the Medicare program. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-2J

Condition.—The services do not constitute covered (_____) therapy because they do not require the skills of a (____) therapist (previous (____) therapy services were covered.)

Paragraph.—Medicare cannot cover the services you received beginning (date) because, at that time, based on the medical information provided by the skilled nursing facility, you did not need skilled rehabilitation or skilled nursing care. The (____) therapy services you received after (date), were only to carry out a maintenance program established to maintain your functional abilities. These services do not require the continued supervisor or the skills of a (_____) therapist and, therefore, do not constitute skilled therapy under the Medicare program. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-3A

Condition.—Specific skilled service is not reasonable and necessary (service not specific or effective).

Paragraph.—The (specify service(s)) you received is/are considered a skilled service by Medicare. However, based on the medical information provided, this/these service(s) is/are not considered a specific and/or effective treatment for your condition. Since the services(s) you received was/were not reasonable or necessary for the treatment of your condition, Medicare cannot pay for your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-3B

Condition.—No material improvement in relation to therapy services required.

Paragraph.—The medical information submitted by the skilled nursing facility did not show that the (specify) therapy services provided was/were reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis, the therapy services are not considered reasonable and necessary, Medicare, therefore, cannot pay for your stay after (date). (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

Paragraph.—While you required skilled (specify) therapy from (date) to (date), the medical information shows that the (specify) therapy services after that time is not reasonable in relation to the expected improvement in your condition. In this case, since you do not need skilled nursing on a daily basis and the therapy services are not considered reasonable and necessary, Medicare cannot pay for your stay after (date). (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-3C

Condition.—Frequency not reasonable and necessary.

Paragraph.—Although (specify service) generally requires the skills of a (nurse, physical therapist, speech-language pathologist, occupational therapist), the frequency with which the service is given must be in accordance with accepted standards of medical practice. The service(s) you received is/are not normally needed on a daily basis. The medical information does not show medical complications which require the services to be performed on a daily basis. In this case, the services are not considered reasonable and necessary by the Medicare program. Since you did not need skilled nursing or skilled rehabilitation on a daily basis Medicare cannot cover your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-4

Condition.—Skilled rehabilitation services not received daily - no skilled nursing.

Paragraph.—Although you required skilled (specify) therapy, you did not receive therapy on each day that it was available in the facility. Therefore, you do not meet the requirement for daily skilled rehabilitation services. Since you also did not need daily skilled nursing, Medicare cannot cover your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-4A

Condition.--Skilled services not daily.

Paragraph.--Although you required skilled nursing services, the medical information provided by the skilled nursing facility showed you did not need them on a daily basis. Because you did not need daily skilled nursing or skilled rehabilitation, Medicare cannot cover your stay. (Section 1862(a)(1)(A) of the Social Security Act, 42 CFR 405.310(k), and 42 CFR 409.31-.35.)

SNF-4B

Condition.--SNF or SNF's URC continued stay denied. No independent review performed.

The (name of SNF) (insert if applicable - utilization review committee) has determined that the services you needed beginning (date) did not meet the requirements for payment under Medicare because you did not need skilled nursing or skilled rehabilitation services or did not need them on a daily basis after (above date).

SNF-4C

Condition.--Durable medical equipment not covered in a SNF (Part B only).

Paragraph.--Medicare covers the rental or purchase of durable medical equipment that is reasonable and necessary for use by a patient in his/her home. A skilled nursing facility does not meet Medicare's definition of a home. Therefore, no payment can be made for (specify).

SNF-TD-1

Condition.--Beneficiary does not meet the prior 3-day inpatient hospital stay requirement for SNF services. (For use prior to 1/1/89.)

Paragraph.--Posthospital skilled nursing facility services are covered by Medicare only if a person previously had a medically necessary inpatient stay in a qualified hospital. This stay must have been for a period of at least 3 consecutive days not counting the day of discharge. (Section 1861(i) of the Social Security Act.) Our records show that you do not meet this requirement. Therefore, no Medicare hospital insurance benefits can be paid for your skilled facility stay.

SNF-TD-2

Condition.--Beneficiary neither meets the regular 30-day transfer requirement, nor qualifies for exception to the 30-day requirement. (For use prior to 1/1/89.)

Paragraph.--Posthospital skilled nursing facility services can be paid by Medicare only if you were admitted to a participating skilled nursing facility and received a covered skilled level of care within:

- 30 days after discharge from a qualifying hospital stay; or

- Such time as it was medically appropriate to begin an active course of treatment where your condition was such that skilled nursing facility care would not have been medically appropriate within 30 days after discharge from a qualifying hospital stay. (Section 1861(i) of the Security Act.)

Our records show that you do not meet either requirement. Therefore, no Medicare payment can be made for your stay in the skilled nursing facility.

SNF-TD-3A

Condition.--No benefits are available because the beneficiary has exhausted 100 days of SNF services in the benefit period. (For use prior to 1/1/89.)

Paragraph.--Payment may be made by Medicare for up to 100 days for covered posthospital skilled nursing facility services in each benefit period. (Section 1812(a)(2)(A) and (b)(2) of the Social Security Act.) Our records show that payment had already been made for 100 days during your current benefit period. Therefore, beginning (date) no payment for skilled nursing facility care can be made in this benefit period.

You may be eligible for a new benefit period that would include full hospital insurance skilled nursing facility benefits when, for 60 consecutive days, you are not an inpatient of a hospital or a facility that is primarily engaged in providing skilled nursing or rehabilitation services.

NOTE: Include a notice of presumed skilled SNF care when presumption 5, §3035 is applicable and where the prior SNF was at least 60 days, or if less than 60 days, the SNF stay, in conjunction with nonhospital and non-SNF days, equaled 60 or more consecutive days. Include the following language on the HCFA-1954.

Medicare has determined that your stay in (name of facility) from (date) to (date) is part of your current benefit period, rather than the beginning of a new one. To make this determination, Medicare found that during your prior nursing home stay in (name of facility) from (date) to (date), you received services at the skilled level of care.

Although your claim for nursing home benefits in that prior nursing home stay was denied by Medicare and/or Medicaid, it was not denied because the services provided failed to meet skilled level of care requirements.

You may appeal the above determination if you believe that you received services which were not at the skilled care level during your period of nursing home care. If you appeal and Medicare agrees that these services were below the skilled level, your stay in (name of facility) from (date) to (date) will begin a new benefit period.

SNF-TD-3B

Condition.—No benefits are available because the beneficiary had exhausted 150 days of SNF services in the calendar year. (For admission on or after 1/1/89.)

Paragraph.—Payment may be made by Medicare for up to 150 days for covered skilled nursing facility services per year. Our records show that payment has already been made for 150 days of skilled nursing facility care in calendar year ____. Therefore, beginning (date) no payment for skilled nursing facilitiy care can be made for you. (Section 101(1)(2) of the Medicare Catastrophic Coverage Act, P.L. 100-360.)

3722.3 Home Health Denials, Limitation of Liability and Appeal Paragraphs.—

A. General.—Home health denial letters consist of:

- The base letter (not required for statutory exclusions and miscellaneous paragraphs);
- A base paragraph specific to the reason for denial. (These are identified as base paragraph where applicable);
- The specific denial reason;
- A statement of noncoverage and the statutory and regulatory reference;
- A limitation of liability paragraph where appliable; and
- An appeals paragraph.

Use all paragraphs, specific denial reasons, and statutory references which apply to the services for which payment is denied.

Cite the statutory reference only once when the reference(s) is identified for all services denied. In this case, add all denied services to the no payment statement, e.g., therefore, no skilled nursing or physical therapy can be covered beginning (date).

The no payment statement, statutory reference and appropriate limitation of liability for denial of the qualifying service (SN, PT, SP) also apply to dependent services e.g., home health aide, medical social service, etc., denied solely because there is no need for the qualifying service.

Generally, paragraphs may be used for full or partial denials. Where a particular type, a specific number of visits or visits on specific dates are denied, etc., you may have to substitute a no payment statement for those contained with the statutory/regulatory references. For examples:

- Therefore, no Medicare coverage will be provided for (number and type) visits from date through date .

- Therefore no Medicare payment will be made for type visits made on (dates) .

- Where a denial situation exists that is not covered in the following paragraphs, tailor a paragraph to fit the denial. If a denial situation appears frequently, submit recommended language to the RO for referral to CO.

- On all letters which reference the Act, give the full document name in a footnote; Title XVIII of the Act, commonly known as the Medicare Program, 42 U.S.C. §1395 et seq.

B. Notice of Home Health Determination (Base Letter for Use with HCFA 1954 or Intermediary Letter Format). --The base letter can be manually or computer generated. You have the option to develop complete letters or to use the HCFA - 1954. Use the following letter with all denial paragraphs with the exception of statutory exclusions and the miscellaneous paragraphs. These paragraphs require only the salutation and opening statement.

Dear Medicare Beneficiary:

This is to notify you of the Medicare coverage decision for the services you received from the home health agency during the period (from) (to) . (Show the billing period.)

To qualify for home health benefits under the Medicare program you must be:

- Confined to your home;
- Under the care of a doctor; and
- In need of one or more of the following services:

- Intermittent skilled nursing services;
- Physical therapy;
- Speech therapy; or
- A continuing need for occupational therapy after the need for intermittent skilled nursing care, or physical or speech therapy has ended.

When you meet these requirements Medicare can cover other services such as intermittent or part time home health aide services, medical social services, occupational therapy and medical supplies and durable medical equipment.

The services must be ordered by your doctor on a plan of care which he or she has established and approved and must be considered by Medicare to be reasonable and necessary for the diagnosis or treatment of your illness or injury.

C. Confined to Home.—

1. Base Paragraph.—You are considered to be confined to your home if an illness or injury limits your ability to leave your home or place of residence:

o Except with the aid of a supportive device (such as crutches, a cane, a wheelchair or a walker) or the assistance of another person; or

o Because leaving your home is medically contraindicated.

Your condition should be such that leaving your home requires a considerable and taxing effort, and that absences from home are infrequent or of relatively short duration, or are needed to receive medical treatment.

HB-1

Condition.—Ability to leave home unrestricted.

Paragraph.—Based on the information provided, your ability to leave home was not restricted by an illness or injury nor was leaving your home medically contraindicated.

HB-2

Condition.—Beneficiary leaves home regularly and frequently for nonmedical reasons.

Paragraph.—Based on the information provided, you left your home frequently and for long periods of time for reasons other than to receive medical treatment.

HB-3

Condition.—Beneficiary's residence is primarily engaged in providing medical rehabilitative or skilled nursing care to inpatients.

* Paragraph.--To be paid under the Medicare program, you must be confined to your home except when receiving services provided on an outpatient basis under arrangement by the home health agency. An institution may not be considered your place of residence if it is engaged primarily in providing skilled care to its patients. Based on the information provided, we have determined that you are residing in a facility that does not qualify as your home under Medicare.

2. Homebound Statutory/Regulatory Reference.--For HB-1 and HB-2 add:

Therefore, no services can be covered under Medicare beginning _________. (§1814 (a)(2)(C); §1835 (a)(2)(A) of the Act and 42 CFR 409.42(b)(1).)

For HB-3 add:

Therefore, no services can be covered under Medicare beginning _________. (See §1861(m) and 1814(a)(2)(C) or §1835(a)(2)(A) of the Act and 42 CFR 409.42 (b)(1).)

NOTE: Limitation of liability applies.

D. Skilled Nursing.--

1. Base Paragraph.--(Use with all skilled nursing denials). To be considered reasonable and necessary for the treatment of your illness or injury, the services you require must:

- Be consistent with the nature and severity of your illness or injury;
- Meet your medical needs within accepted standards of medical practice; and
- Require the skills of a licensed nurse.

SN-1

Condition.--Skilled observation.

Paragraph.--Skilled nursing service(s) was required at first to evaluate your medical condition and your response to medication(s) and/or treatment(s). The skills of a nurse are not needed to assess your condition when your medical condition is stable and there are no changes in your condition, medication(s) and/or treatment(s) which require skilled observation.

Paragraph.--Generally, skilled nursing visits are covered when your medical condition is unstable and nursing services are needed to assess your condition and/or your response to medication(s) and treatments.

There must be an indication that a change in your medical condition, treatment, or medication requires observation by the nurse. The information provided did not show any signs of instability or that a likelihood of change existed.

SN-2

Condition.—Teaching.

Paragraph.—Skilled nursing services were required to teach you how to administer medication(s) and/or perform treatment(s) as ordered by your physician. Medicare will cover, for a reasonable amount of time, teaching you or your caregiver the necessary tasks as ordered by your physician. However, the nurse continued to teach when agency records showed that sufficient time had been allowed for you and/or your caregiver(s) to learn and perform the tasks.

SN-3

Condition.—Restorative Nursing

Paragraph.—Medicare will pay for exercises ordered to restore a specific loss of function when they can be performed safely and effectively by a skilled nurse. It is expected that improvement will be achieved in a reasonable amount of time. The records show that you have reached a level of function where you do not need the skills of a nurse to perform such exercises.

Paragraph.—Medicare will pay for exercises ordered to restore a specific loss of function where they can be performed safely and effectively only by a physical therapist or nurse. Repetitive exercises to maintain function generally do not require the skills of a nurse to perform. Your records show that you have reached a level of function where you do not need the skills of a nurse to perform such exercises.

SN-4

Condition.—Procedures which do not require a nurse.

Paragraph.--Medicare covers services that require the skills of a nurse to perform. It generally does not require a nurse to ________________.

Examples for fill in:

- Prepour/place your medication(s) in cups.
- Administer oral/topical medications.

* Paragraph.—Medicare may pay only for the nurse to teach you or your caregiver special procedures and treatments. Medicare generally cannot cover the services of a nurse to __________.

Examples for fill in:

- Perform glucometer testing.
- * Check your pacemaker electronically.
- Prefill your insulin syringes.
- Administer eyedrops.

SN-5

Condition.—Reminding

Paragraph.—Skilled nursing visits made to remind you or a caregiver to follow instructions, do not require the skills of a nurse.

SN-6

Condition.—Venipuncture for Laboratory Tests

Paragraph.--Although the venipuncture for laboratory tests can require the skills of a nurse, the frequency of these venipuncture test(s) must be reasonable and in accordance with accepted standards of medical practice. The frequency of the venipunctures for your laboratory test(s) exceeds that which is considered reasonable under Medicare. Therefore Medicare will not cover the skilled nursing visits on (dates) .

Paragraph.—The collection of venipuncture specimens by a nurse are covered as long as they are needed for your medical condition and ordered by your doctor. However, you have reached a point in your condition where the test(s) are no longer considered by Medicare to be reasonable and necessary.

SN-7

Condition.—Duplication of service(s)

Paragraph.—If the care ordered by your doctor can be given to you during a visit to your doctor's office, a hospital outpatient/clinic, etc., then it would not be necessary to duplicate this service with a home health nursing visit.

SN-8

Condition.—Vitamin B12

Paragraph.--Specific conditions are recognized by Medicare as needing Vitamin B12 injections. You do not have one of the condition(s) for which Medicare considers B12 injection reasonable and necessary.

Paragraph.--The recognized maintenance frequency of Vitamin B12 injection for your condition is one injection per month.

SN-9

Condition.--Medication administration

Paragraph.--Medicare requires that for skilled nursing services to be covered to teach or administer a medication, the medication must be a necessary and an effective treatment for your condition and within accepted standards of medical practice. In accordance with these standards, the medication ordered by your doctor is not considered by Medicare to be reasonable or necessary to the treatment of your condition.

Paragraph.--The medication(s) which was injected by the nurse can be effectively and safely taken by mouth. There was no documentation of reasons which prevented this medication from being taken orally and therefore the injection is not considered to be reasonable and necessary.

SN-10

Condition.--Wound Care

Paragraph.--Wounds usually require the skills of a nurse for observation and/or treatment while they are healing. From the documentation provided, your wound was at a point where it could be cared for by someone other than a nurse.

Paragraph.--Wounds usually require the skills of a nurse for observation and/or treatment while they are healing. Your wounds were at a point where they could be cared for by someone other than a nurse, but Medicare will allow (number and type) visits to monitor the healing process.

SN-11

Condition.--Catheter Care

Paragraph.--The customary medical practice for foley catheter changes is monthly. There may be instances where emergency visits are made for replacement of a catheter, or where your doctor verifies the need for more frequent changes. The documentation provided supports only a need for routine monthly changes during this billing period. Medicare will cover visits made on (dates).

SN-12

Condition.--Psychiatric nursing care.

Paragraph.--Medicare does not consider home health care that is related to the treatment of a psychiatric illness to be reasonable and necessary unless the care is provided by a skilled nurse who has been specifically trained in providing psychiatric nursing care. Based on the information provided, the nurse providing your care has not had this specific training.

SN-13

Condition.--Skilled nursing visits were not intermittent/part time. (Daily skilled nursing service.)

Paragraph.--Intermittent or part time skilled nursing services are usually services for a few hours a day, several times a week. In certain circumstances more frequent services may be provided for a limited period when your doctor documents your need for them and indicates when the need for daily care is expected to end. *

The services you received did not meet the part time or intermittent skilled nursing requirement.

Condition.--Skilled nursing visits were not intermittent. (One nursing visit.)

Paragraph.--Skilled nursing care must be intermittent or part-time for Medicare coverage. A one time skilled nursing visit is usually not intermittent or part-time. The medical information provided showed that you needed only one skilled nursing visit.

E. Skilled Nursing Statutory and Regulatory References.--Add the appropriate statement and statutory/regulatory reference below to skilled nursing denials. See specific references for intermittent skilled nursing denials.

Condition.--If no skilled nursing care was needed at all (from the onset of the care) and the patient also did not need physical or speech therapy, then not only is the skilled nursing care denied, but all other HHA services are denied. Add:

Paragraph.--"Because you did not need skilled nursing care on an intermittent basis, or physical or speech therapy, as the law requires, no home health services can be covered by Medicare. (See §1814(a)(2)(C) or §1835(a)(3)(A) of the Act and 42 CFR 409.42(b)(3).")

Condition.--If skilled nursing care was needed at the onset of the care, but has ceased to be needed and no physical or speech therapy or continued occupational therapy is needed, no further home health care can be covered. Add:

Paragraph.--"Because you have ceased to need skilled nursing care, and do not need physical or speech therapy, no further home health services can be covered by Medicare beginning________. (See §1814(a)(2)(C) or §1835(a)(2)(A) of the Act and 42 CFR 409.42(b)(3).") *

* Condition.--If no skilled nursing was needed (from the onset of care) but physical or speech therapy was needed, then no skilled nursing care may be covered (other home health services may be covered). Add:

Paragraph.—Therefore, no skilled nursing services can be covered by Medicare. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Condition.—If skilled nursing care was needed initially, but ceased to be needed, and the patient needs physical or speech therapy or continues to need occupational therapy, then no further skilled nursing care can be covered but other home health services may continue to be covered. Add:

Paragraph.—Therefore, no further skilled nursing services can be covered by Medicare, beginning ______. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Condition.—If some skilled nursing care is needed, but specific identified skilled nursing services provided from the onset of care were not needed, and were denied, then skilled nursing services of that type may not be covered. Other home health services may be covered. Add:

Paragraph.—Therefore, no (specify type of skilled nursing service) can be covered by Medicare beginning __________. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310 (k)(1).)

Paragraph.—Therefore, Medicare cannot cover (insert more than and/or number) skilled nursing visits from __________ through __________. (Add if applicable) However, * Medicare will pay for (specify number) skilled nursing visits from _______ through ________. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310 (k)(1).)

Condition.—If skilled nursing care is needed, but specific skilled nursing services were needed initially, but have ceased to be needed, and are denied, then skilled nursing services of that type may not be covered. Other home health services may be covered. Add:

Paragraph.—Therefore, no further (specify type of skilled nursing service) can be covered by Medicare beginning __________. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Paragraph.—Therefore, Medicare can no longer cover (insert more than and/or) number skilled nursing visits beginning_________. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

NOTE: Limitation of liability applies.

Condition.—If the services are being denied because they do not meet the intermittent requirement and physical or speech therapy was not required, the statement regarding the lack of coverage reads:

Paragraph.--Therefore no home health services can be covered by Medicare beginning ________. (See S1814(a)(2)(C) or 1835(a)(2)(A) of the Act and 42 CFR 409.42(b)(3).)

NOTE: Limitation of liability applies.

Condition.—If the services are being denied because they do not meet the intermittent requirement and physical or speech therapy is required, the statement regarding the lack of coverage reads:

Paragraph.—Therefore no skilled nursing services can be covered by Medicare beginning ___________. (See S1861(m)(1) of the Act and 42 CFR 409.40(a).)

NOTE: No limitation of liability applies. (Intermittent Denials).

F. Physical-Speech-Occupational Therapy.--Use this denial paragraph for physical, speech, and occupational therapy denial letters.

Base Paragraph.—To be considered covered by Medicare (insert physical therapy, speech therapy, and/or occupational therapy), services must be:

- Reasonable and necessary for the treatment of your illness or injury and at a level of complexity which requires the skills of a therapist;
- The amount, frequency, and duration of the services must be reasonable; and
- The services must be considered under accepted standards of medical practice to be specific and effective treatment for your condition, illness, or injury and provided with the expectation that improvement will occur in a reasonable period of time.

REHAB-1

Paragraph.—The medical information provided did not indicate that the (type(s)) therapy services you received were reasonable and necessary, and at a level of care which requires the skills of a therapist.

REHAB-2

Paragraph.—The medical information provided did not indicate that the amount, frequency, and duration of the (type) therapy services were reasonable and necessary.

REHAB-3

Paragraph.—The medical information provided did not indicate that the (type) therapy services you received were provided with the expectation that your condition would improve within a generally reasonable time.

REHAB-4

Paragraph.—The medical information provided did not support your need for continued therapy. You have reached a level of function where your potential for further improvement will not be materially improved by the amount of therapy requested.

REHAB-5

Paragraph.—The medical information provided indicated that sufficient time had been allowed to establish a maintenance (type) therapy program.

REHAB-6

The medical information provided indicated that the physical therapy services you received were for overall fitness and general motivation. These services generally did not require the skills of the physical therapist.

REHAB-7

Paragraph.—The medical information provided indicated that the (type) therapy is not considered by Medicare as a generally acceptable treatment for your condition.

REHAB-8

The medical information provided indicated that you have received (numbers of visits) more than were considered reasonable and necessary by Medicare for the effective treatment of your condition. However, payment will be made for (number) visits.

- Therapy Statutory and Regulatory References.—Add the appropriate statement and statutory/regulatory reference to therapy denials.

Condition.—If no physical or speech therapy was needed at all (from the onset of the care) and the patient also did not need intermittent skilled nursing, Add:

Paragraph.—"Because you did not need skilled nursing care on an intermittent basis, or physical therapy or speech therapy, as the law requires, no home health services can be covered by Medicare. (See §1814(a)(2)(C) or §1835(a)(2)(A) of the Act and 42 CFR 409.42(b)(3).)

Condition.—If physical or speech therapy was needed at the onset of the care, but has ceased to be needed and no intermittent skilled nursing care or continued occupational therapy is needed, then no further home health care can be covered. Add:

Paragraph.--"Because you have ceased to need ________________ therapy and do not need ______________ therapy, or continued occupational therapy or intermittent skilled nursing, no further home health services can be covered by Medicare beginning ________. (See §1814(a)(2)(C) or §1835(a)(2)(A) of the Act and 42 CFR 409.42(b)(3).)

Condition.--If a qualifying service is still needed (e.g., skilled nursing) but the therapy was denied from the outset. Add:

Paragraph.—Therefore, no _____________therapy can be covered by Medicare. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Condition.—If therapy was needed initially but ceased to be needed, and the patient needs another qualifying service. Add:

Paragraph.—Therefore, no further _____________ therapy can be covered by Medicare, beginning ______. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Condition.—If some therapy visits are needed, but specifically identified therapy visits were not needed and were denied. Add:

Paragraph.—Therefore, no (specify type of therapy service) can be covered by Medicare beginning__________. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310 (k)(1).)

Paragraph.—Therefore, Medicare cannot cover more than (number-type) therapy visits from __________through __________. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310 (k)(1).)

NOTE: Limitation of liability applies to all above.

G. Medical Social Services.—

Base Paragraph.—Medical social services may be covered when they contribute to the treatment of your medical condition and your rate of recovery. If social or emotional problems exist to the degree that they impede the progress or stability of your medical condition, the services of a qualified medical or psychiatric social worker may be required.

MSW-1

Paragraph.—The documentation did not show that social or emotional problems existed to the extent that they impeded the effective treatment of your medical condition or rate of recovery.

MSW-2

* Paragraph.—The medical social service visits which were furnished to counsel family members are not generally covered by the Medicare program.

MSW-3

Paragraph.—Medicare allows medical social services visits to handle problems which impede your medical recovery. It was determined that some of the visits which were made did not relate to your plan of care or assist in your recovery.

MSW-4

Paragraph.—Medical social services were needed at first to resolve the problems which were affecting treatment of your medical condition. The information provided shows that these problems were resolved and that your need for medical social services ceased to be considered by Medicare to be reasonable and necessary.

MSW Statutory/Regulatory References

Condition.—If the beneficiary qualifies for coverage of home health services, and the services being denied are dependent services (e.g., home health aide, medical social worker, supplies, or DME) which were not covered from the start of the care because they were not reasonable and necessary. The statement regarding the lack of coverage reads:

Paragraph.—"Therefore, no (enter the type of dependent service(s)) can be covered by Medicare (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Condition.—If the beneficiary qualifies for coverage of home health services, and the services being denied are dependent services which were covered at the start of the care, but which ceased to be needed at a later point, the statement regarding the lack of coverage reads:

Paragraph.—"Therefore, no further (enter the type of dependent service(s) can be covered by Medicare beginning ________. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Condition.—If some dependent care is needed but specific services/visits were not needed. Add:

Paragraph.—Therefore, Medicare cannot cover (number) of (dependent service) visits from __________ through __________. (See §1862 (a)(1)(A) of the Act and 42 CFR 405.310 (k)(1).) Add if applicable:

- o However Medicare has covered (number of specific visits).

NOTE: Limitation of liability applies to all above.

H. Home Health Aide.--

Base Paragraph.--Home health aide services are primarily for personal care. Personal care duties can include:

- Helping you bathe;
- Helping you get in and out of bed;
- Helping you to care for your hair and teeth, to exercise, to eat and take medications, and/or to retrain you in self-help skills.

When you need personal care the home health aide may also perform household duties which are in accordance with the physicians plan of treatment as long as they do not increase the length of the visit for personal care. Based on information provided, we have determined that the home health aide services you received were not reasonable and necessary because:

Aide-1

Paragraph.--You have a caregiver who is providing services that adequately meet your personal care needs.

Aide-2

Paragraph.--The home health aide services you received were more frequent than were needed to meet your personal care needs.

Aide-3

Paragraph.--Your medical records indicate that you are generally able to perform your own personal care within a reasonable amount of time.

Aide-4

Paragraph.--Based on our review of the information provided, the (number) home health aide visits made during (date(s)) did not include personal care services.

Aide-5

Paragraph.--Although you qualify for coverage of home health care, the home health aide services must be intermittent or part-time for Medicare coverage.

To be considered intermittent or part-time, home health aide services are usually services for a few hours a day, several times a week. In certain circumstances more frequent services may be covered for a limited period, when your doctor documents your need for these services, and indicates when the need for daily care is expected to cease.

The services you received did not meet the part-time or intermittent home health aide requirement.

- Home Health Aide Statutory/Regulatory References

Condition.--If the beneficiary qualifies for coverage of home health services, and the services being denied are dependent services (e.g., home health aide, medical social worker, supplies, or DME), which were not covered from the start of the care because they were not reasonable and necessary add:

Paragraph.—Therefore, no (enter the type of dependent service(s)) can be covered by Medicare. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Condition.—If the beneficiary qualifies for coverage of home health services, and the services being denied are dependent services which were covered at the start of the care, but which ceased to be needed at a later point, add:

Paragraph.--Therefore, no further (enter the type of dependent service(s) beginning___________ can be covered by Medicare. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)

Condition.—If some dependent care is needed but specific services/visits were not needed, add:

Paragraph.—Therefore, Medicare cannot cover (number) of (dependent service) visits from______ through _______.

(See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).) However, Medicare has allowed (number) visits (week/month/other period).

NOTE: Limitation of liability applies.

Condition.—If the services are being denied because they do not meet the intermittent requirement, add:

Paragraph.—Therefore no home health aide services can be covered by Medicare beginning __________. (See §1861(m)(4) of the Act and 42 CFR 409.40 (d).)

* NOTE: No limitation of liability applies.

I. DME.—

Base Paragraph.—Durable Medical Equipment (DME) is used in the home to assist with your treatment and rehabilitation. DME generally is defined as item(s) which:

- Can withstand repeated use;
- Primarily serves a medical purpose; and
- Generally is not useful to a person in the absence of illness or injury.

Based on the information the home health agency provided, we have determined that the equipment you received was not covered because:

DME-1

Paragraph.—The (specify) is not considered by Medicare to be appropriate for home use. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(K)(1).)

DME-2

Paragraph.—The (specify) is not considered to be equipment that is primarily medical in nature. (See §1862(a)(1)(A) of the Act.)

DME-3

Paragraph.—The (specify) is not considered to be primarily medical in nature by Medicare, but is considered to be a comfort or convenience item. (See §1862(a)(1)(A) of the Act.)

DME-4

Paragraph.—The (specify) furnished was not documented as medically necessary for the treatment of your condition. (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(K)(1).)

- DME Statutory/Regulatory References

"Therefore, the (enter the type of equipment) cannot be covered by Medicare beginning (date). (See §1862(a)(1)(A) of the Act and 42 CFR 405.310(k)(1).)"

* NOTE: Limitation of liability applies to DME 1 and 4.

J. Medical Supplies.—

Base Paragraph.—Medical supplies are therapeutic items which are essential to carry out the care ordered by your doctor. Items used by you such as skin conditioners, soaps, and powders, and which serve a routine hygienic purpose are generally not covered by Medicare. Based on the information provided, we have determined that the supplies you received were not medical supplies because:

MS-1

Paragraph.—The supplies were not medically necessary for the treatment of your condition.

MS-2

Paragraph.—The amount of medical supplies furnished was more than was medically reasonable and necessary for the treatment of your condition.

MS-3

Paragraph.—The medical supplies which were furnished to you were not ordered by your physician.

- MS Statutory/Regulatory Reference

"Therefore the (specify) cannot be covered by Medicare beginning __________ (See §1862 (a)(1)(A) and 42 CFR 405.310 (k)(1).)"

NOTE: Limitation of liability applies to MS1 and 2.

K. Statutory Exclusions.—

Stat-1

Condition.—Services covered by another government agency; e.g., CHAMPUS, VA.

Paragraph.—Patients eligible to receive home health benefits from another government agency are not eligible to receive Medicare benefits for the same service. (See §1862(a)(3) of the Act.)

NOTE: No limitation of liability applies.

Stat-2

Condition.—Excluded services.

Paragraph.—Certain services are excluded from coverage under the Medicare law. No Medicare payment can be made for the services you received for (exclusion).

Use the statutory exclusions to fill in the blank:

*

- o Drugs and Biologicals (See S1861(m)(5) of the Act and 42 CFR 409.40(e));
- o Routine Foot Care (See S1862(a)(13)(c) of the Act and 42 CFR 405.310(1);
- o Personal comfort items (specify). (See S1862(a)(6) of the Act and 42 CFR 405.310(j)); or
- o Orthopedic shoes and Appliances (specify). (See S1862(a)(8) of the Act and 42 CFR 405.310(f).)

NOTE: No limitation of liability applies.

Stat-3

Condition.—Prisoners.

Paragraph.—Based on the information provided, we have determined that the services you received are not covered under Medicare.

Payment may not be made for items or services rendered to prisoners, where the State (or other government component which operates the prison) is responsible for your medical needs. (See S1862(a)(2) of the Act.)

NOTE: No limitation of liability applies.

L. Miscellaneous.—

MISC-1

Condition.—Home health administrative visits/evaluation visit.

Paragraph.—In order to participate in the Medicare program, home health agencies are required to make an initial home visit to determine if they can meet your medical needs, and to determine if you qualify for Medicare home health services. Based on the information provided, the visit on (date) was only for this evaluation. The agency may not charge you for the cost of the visit. (See S1866(a)(1)(A) of the Act.)

NOTE: No limitation of liability applies.

MISC-2

Condition.—ESRD.

Paragraph.—Payment may be made for End Stage Renal Disease (ESRD) services only if they are furnished by an ESRD certified facility. (See §1881(b)(1) of the Act.) Medicare covers home health services provided ESRD patients when:

- The care is not associated with the renal disease; or
- The primary reason for the home health visit is not related to renal disease.

Based on the information provided, the home health services you received appear to relate to the services being provided by the dialysis facility. Therefore, based on our review, no additional Medicare payment can be made beginning ________________.

NOTE: No limitation of liability applies.

MISC-3

Condition.—No physician certification.

Paragraph.—Your home health services are not covered because the physician certification required by Medicare law was not obtained. A certification is a signed statement from your doctor which certifies that you were confined to home and in need of skilled nursing care on an intermittent basis or physical or speech therapy. (See §1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR 405.1633 and 42 CFR 489.21(b).) *

NOTE: No limitation of liability applies.

MISC-4

Condition.—Services not provided.

* Paragraph.—The home health agency has billed for visits that were not documented in your medical record. Therefore, no Medicare payment will be made (for number) (type) visits.

The home health agency may not charge you for visits which were provided, but not documented in your record. (See §1866(a)(1)(A) of the Act.)

NOTE: No limitation of liability applies.

MISC-5

Condition.—Services exceeded physician order.

*

Base Paragraph.--An individual is eligible for home health services under the Medicare program when they are ordered by the physician and a plan of treatment for furnishing such services is established.

Paragraph.—The number of visits billed are in excess of those ordered by your doctor on your plan of care. Therefore, no payment can be made under the Medicare program for (number/type of visits) visits. (See §1862(a)(1)(A) of the Act.)

NOTE: No limitation of liability applies.

Paragraph.—The (number, type of visits) were not covered because they were not included in a plan of care established and approved by your physician. The home health agency may not charge you for any items or services that would have been covered by Medicare if they had been included in the plan of care. (See §1814(a)(2)(C), or 1835 (a)(2)(A) 1866(a)(1)(A) and 1861(m) of the Act and 42 CFR 405.1633, 42 CFR 489.21(b) and 42 CFR 409.42(d).)

NOTE: No limitation of liability applies.

MISC-6

Condition.--HHA supervisory visits.

Paragraph.—To participate in the Medicare program, the home health agencies are required to supervise the services provided by home health aides (42 CFR 405.1227). The home health agency cannot charge you for supervisory visit(s) made on (date(s)).

NOTE: No limitation of liability applies.

MISC-7

Condition.—Dependent services billed - no qualifying service ordered.

Paragraph.—Medicare can cover home health services only when intermittent skilled nursing or physical or speech therapy is also rendered. Since you did not receive any of these services, no payment can be made for the (specify dependent service). (See §1814(a)(2)(C) or 1835 (a)(2)(A) of the Act and 42 CFR 409.42(b)(3).)

*

NOTE: Limitation of liability applies.

M. Limitation of Liability.—Use the following paragraphs to explain to the beneficiary and provider their limitation of liability.

L-1

Condition.—Beneficiary liable.

* Paragraph.—Medicare cannot pay the home health agency for the (type of service(s) made on (dates). Based on the information provided, we have determined that you knew that the care would not be covered by Medicare prior to receiving the service(s) because:

o You had been notified of the Medicare denial of these same services under the same circumstances; and/or

o The (agency) notified you in advance of providing the care that Medicare would not pay for the care.

L-2

Condition.—Partial payment under §1879 where the provider is liable.

Paragraph.--Although Medicare cannot cover the (services) that you received, we have paid the agency for the services provided from (date) through (date) because of a special provision of the Medicare law which limits your and/or the agency's liability when certain criteria are met. (See §1879 of the Act.) This permits Medicare payment when neither you nor the agency knew or had reason to know that the services you received were noncovered by Medicare.

For services furnished from (date) through (date) payment was not made because the agency knew that the care would not be covered. However, we believe that you did not know that these services would not be covered by Medicare. Therefore you are responsible only for charges for services not included in the Medicare home health benefit.

If you have paid the agency for the noncovered services prior to the date you received written notification of noncoverage, reimbursement can be made for the amounts paid. Please contact this office or your local Social Security Office (within 6 months of receipt of this letter) and provide:

o A copy of this letter; and

o The bill for services received, receipts, or any other evidence of payment to the agency.

The receipt of this letter is considered notification that you are now aware that the services you received were not covered. Therefore, you will not be protected from liability for the cost of such services in the future if it is determined that they cannot be covered for the same reasons. All subsequent bills for home health services will be subject to review by Medicare.

L-3

Condition.—Provider liable (beneficiary not liable).

Paragraph.--Although Medicare cannot cover the services mentioned above, you are not responsible for paying the home health agency. Medicare has determined from the information provided that you did not know that these services were not covered. Therefore, you are not responsible for charges for these services.

If you have paid the agency for the noncovered services prior to the date you received notification of noncoverage, reimbursement can be made for the amounts charged. Please contact this office or your Social Security Office (within 6 months of receipt of this letter) and provide:

o A copy of this letter; and

o The bill for services received, receipts, or any other evidence of payments to the agency.

L-4

Condition.—Partial provider liability and partial beneficiary liable

Paragraph.--Although Medicare cannot cover the home health care that you received, a provision in Medicare law protects a beneficiary from being responsible for the charges of home health services when the beneficiary neither knew, nor had reason to know, that Medicare would not pay for the charges.

Medicare has determined from the information provided that you did not know that all services you received were not covered until ___(date)___.

Insert Applicable Option

* Option 1.—You had a claim previously denied for the same services under the same circumstances and received notification on (date).

* Option 2.—The home health agency notified you on (date) that your care would not be covered.

Therefore you are responsible only for the charges for services from (date) through (date) which are not included in the Medicare benefit and for all charges for services after (date) .

Please contact this office or your local Social Security Office (within 6 months of receipt of this letter) and provide:

o A copy of this letter; and

o The bill for services received, receipts, or any other evidence of payments to the agency.

* The following information applies to any future claims made for this type of service. The receipt of this letter is considered notification that you are now aware that under the same circumstances the services you received were not covered. Therefore, you will not be protected for the cost of such services in the future if it is determined that they can not be covered for the same reasons. All subsequent bills for services will be subject to review by Medicare.

If you disagree with the determination, you may request a reconsideration as explained in this notice.

L-5

Condition.—Payment made (neither beneficiary nor provider liable).

Paragraph.--Although Medicare cannot cover the home health care that you received, we have paid the agency because of a special provision in the Medicare law. This provision permits Medicare payment for home health services when neither you, nor the agency knew, nor had reason to know that the services would be denied by Medicare. (See §1879 of the Act.)

Since this is the finding in your case, you are responsible only for the coinsurance and any charge for services not included in the Medicare home health benefit. The receipt of this letter is considered notification that you are now aware that services received were not covered. Therefore, in the future you will not be protected from liability for such services if it is determined that they cannot be covered for the same reasons. All subsequent home health bills for services will be subject to review by Medicare.

Even though payment is being made, if you disagree with our determination you may request a reconsideration as explained in this notice.

N. Appeals.--

Condition.--Use the appeals paragraph on all HHA denial letters.

Paragraph.--If you are dissatisfied with this determination, you may make a written request for reconsideration of the determination. For hospital insurance, Medicare Part A, you must file a written request within 60 days from the date of receipt of this notice. For medical insurance (Medicare Part B), you must file your written request for a review within 6 months from the date of this notice. You may file your written request for a review of the determination at your local Social Security Office or by writing directly to (name). You may appoint an attorney or a qualified individual to represent you in your appeal. If you decide you want a representative, you or your respresentative must complete and sign an Appointment of Representative Form SSA-1696-U4 form. This form may be obtained from your local Social Security Office. Forward a copy of this letter with your written request.

- Home health denial determination model letter:

Dear Medicare Beneficiary:

This is to notify you of the Medicare coverage decision for the services you received from the home health agency during the following period (from) (to) .

To qualify for home health benefits under the Medicare program you must be:

- Confined to your home;
- Under the care of a doctor; and
- In need of one or more of the following services:
  - Physical therapy;
  - Speech therapy;
  - Intermittment skilled nursing services; or

* — A continuing need for occupational therapy after the need for intermittent skilled nursing care, or physical or speech therapy has ended.

The services must be ordered by your doctor on a plan of care established and approved by him/her and be considered by Medicare to be reasonable and necessary for the diagnosis or treatment of your illness or injury.

L

To be considered reasonable and necessary for the treatment of your illness or injury, the services you require must:

- Be consistent with the nature and severity of your illness or injury;
- Meet your medical needs within accepted standards of medical practice; and
- Require the skills of a licensed nurse.

Skilled nursing service(s) were required at first to evaluate your medical condition and your response to medication(s) and/or treatment(s). The skills of a nurse are not needed to evaluate your condition when there are no changes in your medication(s) and/or treatment(s) which require skilled observation.

Because you have ceased to need skilled nursing care, and do not need physical therapy or speech therapy, no futher home health services can be covered by Medicare beginning _________. (See §1814(a)(2)(C) or §1835(a)(2)(A) of the Act and 42 CFR 409.42(b)(3).)

Although Medicare cannot cover the home health care that you received, we have paid the agency because of a special provision in the Medicare law. This provision permits Medicare payment for home health services when neither you nor the agency knew or had reason to know that the services would be denied by Medicare. (See §1879 of the Act.)

Since this is the finding in your case, you are responsible only for the coinsurance and any charge for services not included in the Medicare home health benefit. The receipt of this letter is considered notification that you are now aware that services received were not covered. Therefore, in the future you will not be protected from liability for such services if it is determined that they cannot be covered for the same reasons. All subsequent home health bills for services will be subject to review by Medicare.

Even though payment is being made, if you disagree with our determination you may request a reconsideration as explained in this notice.

If you are disatisfied with this determination you may make a written request for reconsideration of that determination. For hospital insurance, Medicare Part A, you must file a written request within 60 days from the date of receipt of this notice. For medical insurance (Medicare Part B), you must file your written request for a review within 6 months from the date of this notice. You may file your written request for a review of the determination at your local Social Security Office, or by writing directly to (name). You may appoint an attorney or a qualified individual to represent you in your appeal. If you decide you want a representative, you or your representative must complete and sign an Appointment of Representative Form SSA-1696-44 form. This form may be obtained from your local Social Security Office. Forward a copy of this letter with your written request.

3722.4 Miscellaneous Situations--All Providers.--

MISC-1

Condition.—The beneficiary has refused to request reimbursement under hospital insurance.

NOTE: When this paragraph is used, omit the appeals paragraph on the HCFA-1954 letter as the appeals procedures are not applicable unless there is a signed claim.

Paragraph.—For Hospital and SNF Show: No benefit can be paid for you under hospital insurance because you did not request payment. Even though no benefits were paid, the days you spent as an inpatient of the institution named above will be subtracted from the total number of days available to you in this benefit period.

If you decide that you want to request payment under Medicare, please get in touch with the institution which provided the services.

Paragraph.—For HHA Visits Show: No benefits can be paid for you because you did not request payment.

If you decide that you want to request payment under Medicare, please get in touch with the HHA which provided the services.

MISC-2

Condition.—Expenses were covered by a WC plan.

Paragraph.—We have been informed that the medical services and supplies you received from the above provider are covered under a WC plan. To the extent that those services are covered by a WC program, payment cannot be made under Medicare. You may resubmit your claim for these benefits if your WC claim is denied.

HHA-2

Condition.—Services did not meet the "intermittent" requirement for skilled nursing care; no physical, speech therapy, furnished. (Applicable to Part A and Part B.)

Paragraph.—An individual is eligible for home health benefits only if he requires skilled nursing care on an intermittent basis or physical or speech therapy. "Intermittent" is defined as the need for a medically predictable skilled nursing service at least once every 60 days except where a condition exists which would clearly establish that the recurring need for skilled nursing services is medically predictable less frequently than once every 60 days.

Since you did not need a skilled nursing service at least once every 60 days and did not have a condition which established a medically predictable recurring need for skilled nursing services less frequently than once every 60 days, you do not meet this requirement. Therefore, no Medicare payment can be made for any of the home health services you received.

HHA-3

Condition.—Services required did not constitute "physical therapy;" no speech therapy, intermittent skilled nursing care furnished. (Applicable to Part A and Part B.)

Paragraph.—An individual is eligible for home health benefits only if he requires skilled nursing care on an intermittent basis or physical, or speech therapy.

Physical therapy has been defined as those services prescribed by a physician which require the skills of a qualified physical therapist and are performed by, or under, the supervision of such a therapist.

Our records show that you do not meet this requirement. Therefore, no Medicare payment can be made for any home health services you received.

HHA-4

Condition.—Beneficiary does not meet requirement of being confined to his home. (Applicable to Part A and Part B.)

Paragraph.—To be eligible for home health benefits under the Medicare program, a beneficiary must be confined to his home. Generally, a beneficiary will be considered to be confined to his home if he has a condition due to an illness or injury which restricts his ability to leave his place of residence except with the aid of crutches, cane, wheelchair, walker, the assistance of another person, or the use of special transportation.

The records show that you did not meet the requirement of being confined to your home. Therefore, no Medicare benefits can be paid for these services.

HHA-5

Condition.--Beneficiary's residence is primarily engaged in providing medical or nursing care to inpatient or rehabilitative services to injured, disabled, or sick. (Applicable to Part A and Part B.)

Paragraph.--To be paid for under the Medicare program, home health services must be furnished in a place of residence used as the beneficiary's home. A beneficiary's home may include an apartment, a relative's home, or a home for the aged. A hospital or a skilled nursing facility may not be considered a place of residence.

The records show that you did not receive home health services in a place that could be considered a place of residence for home health coverage purposes. Therefore, no Medicare benefits can be paid for these services.

HHA-6

Condition.--Nurse's visits not covered since the only services rendered were the administration of vitamin B-12 injections for a condition for which the injections were not a reasonable and necessary treatment. (Applicable to Part A and Part B.)

Paragraph.--An individual is eligible for home health benefits only if he or she receives skilled nursing care on an intermittent basis, or physical, speech therapy. The giving of intravenous and intramuscular injections of medication are considered skilled nursing care. However, in order for the services of the nurse to be covered under Medicare, the injection must be a reasonable and necessary treatment for the condition for which it was given. According to medical advice, vitamin B-12 injections are considered an effective treatment for only certain medical conditions such as pernicious anemia. If the vitamin B-12 injection is not given to treat one of these conditions, the injection is not considered a reasonable and necessary treatment.

The records show that your condition is not one for which vitamin B-12 injections are considered a reasonable and necessary treatment. Therefore, no Medicare payment can be made for the services of the nurse who administered the injection.

B. Partial Denial Paragraphs for HHA Bills (Use with HCFA-1955 Letter).--

HHA-20

Condition.--Services rendered after some initial visits were allowed but did not require the skills of a licensed nurse; no physical or speech, therapy furnished. (Applicable to Part A and Part B).

Paragraph.—An individual is eligible for home health benefits only if he requires skilled nursing care on an intermittent basis or physical or speech therapy. Skilled nursing care is that type of service which must be performed by, or under the supervision of, a licensed nurse to assure the safety of the patient and to achieve the medically desired result.

Beginning with _______ the services you required could have been safely and effectively rendered by a nonmedical person. Thus, they cannot be considered skilled nursing services regardless of who actually performs or supervises the services. Therefore, no further Medicare benefits can be allowed for any home health services furnished you.

NOTE: See S3722.5 for applicable Limitation of Liability paragraph.

HHA-21

Condition.—Nurse's visits not covered for administration of vitamin B-12 injections because the injections were for a condition for which they were not a reasonable and necessary treatment. However, there were covered visits for the other intermittent skilled nursing care provided during the billing period. (Applicable to Part A and Part B.)

Paragraph.—An individual is eligible for home health benefits only if he or she requires skilled nursing care on an intermittent basis, or physical or speech therapy. The giving of intramuscular injections of medication are considered skilled nursing care. However, in order for the services of the nurse to be covered under Medicare, the injections must be a reasonable and necessary treatment for the condition for which it is given. According to medical advise, vitamin B-12 injections are considered an effective treatment for only certain medical conditions such as pernicious anemia. If the vitamin B-12 injection is not given to treat one of these conditions, the injection is not considered a reasonable and necessary treatment.

The records show that your condition is not one for which vitamin B-12 injections are considered a reasonable and necessary treatment. Medicare payment cannot be made for the services of the nurse who administered the injection. Medicare will help pay for the other skilled nursing services that you received during the above billing period even though Medicare cannot pay for the services of the nurse who administered the vitamin B-12 injection. Therefore, Medicare will not pay for (number) visits during this billing period.

HHA-23

Condition.—Some of the visits are reasonable and necesary and others are not. (Applicable to Part A and Part B.)

Paragraph.--The services that you received for your condition during the above billing period would be covered under the home health care provisions of the Medicare law, if they were reasonable and necessary to the treatment of your condition. It has been determined however, that you have received (number) more treatments of (physical therapy or vitamin B-12, etc.) than are necessary and reasonable for effective treatment of your condition. Therefore, Medicare can only pay for the number of visits that are determined to be not excessive.

NOTE: See §3722.5 for applicable Limitation of Liability paragraph.

3722.4 Miscellaneous Situations—All Providers.—

MISC-1

Condition.--The beneficiary has refused to request reimbursement under hospital insurance.

NOTE: When this paragraph is used, omit the appeals paragraph on the HCFA-1954 letter as the appeals procedures are not applicable unless there is a signed claim.

1. Paragraph.—For Hospital and SNF Show: No benefit can be paid for you under hospital insurance because you did not request payment. Even though no benefits were paid, the days you spent as an inpatient of the institution named above will be subtracted from the total number of days available to you in this benefit period.

If you decide that you want to request payment under Medicare, please get in touch with the institution which provided the services.

2. Paragraph.—For HHA Visits Show: No benefits can be paid for you because you did not request payment.

If you decide that you want to request payment under Medicare, please get in touch with the home health agency which provided the services.

MISC-2

Condition.—Expenses were covered by a WC plan.

Paragraph.—We have been informed that the medical services and supplies you received from the above provider are covered under a workers' compensation plan. To the extent that those services are covered by a workers' compensation program, payment cannot be made under Medicare. You may resubmit your claim for these benefits if your workers' compensation claim is denied.

MISC-3

Condition.--VA paid, or or has agreed to pay, the entire bill.

Paragraph.--We have been informed that the Veterans Administration paid for, or has agreed to pay for, the services and supplies you received from the above provider. Under the Medicare law, no payment can be made for these services.

MISC-4

Condition.--A governmental agency paid, or will pay, the entire bill.

Paragraph.--We have been informed that the medical services and supplies you received from the above provider were paid for, or will be paid for, by a governmental agency. Under the Medicare law, no payment can be made for these services.

MISC-5

Condition.--The physician for the beneficiary refuses to certify the hospital or SNF stay or HHA visits for a reason other than lack of medical necessity.

1. Paragraph.--For Hospital and SNF Show: No payment can be made under the Medicare hospital insurance program because your attending physician did not sign the necessary certification, even though your stay may have been medically necessary.

However, the institution may not charge you for any items or services which would have been paid for by the Medicare program had your physician signed the necessary certification.

Although no benefits were paid, the days you spent as an inpatient of the institution shown above will be subtracted from the total number of days available to you in this benefit period.

2. Paragraph.--For HHA Visits Show: No payment can be made under the Medicare hospital insurance program because your attending physician did not sign the necessary certification.

However, the home health agency may not charge you for any items or services which would have been paid for by the Medicare program had your physician signed the necessary certification.

MISC-6

Condition.--Excluded services under Part A and Part B; e.g., noncovered dental care, cosmetic surgery.

Paragraph.--(Describe services) are excluded from coverage under the Medicare law. Therefore, no Medicare payment can be made for these services.

MISC-7

Condition.--Beneficiary is not entitled to Part A.

Paragraph.--The Social Security Administration's records show you are not entitled to hospital insurance benefits under Medicare.

This notice refers only to hospital insurance. Your Medicare Handbook explains the difference between hospital insurance and medical insurance.

MISC-8

Condition.--Beneficiary is not entitled to Part B.

Paragraph.--The Social Security Administration's records show you are not entitled to medical insurance benefits under Medicare. This notice refers only to medical insurance. Your Medicare Handbook explains the difference between medical insurance and hospital insurance.

MISC-9

Condition.--Beneficiary is not entitled to Part A or Part B.

Paragraph.--The Social Security Administration's records show you are not entitled to either hospital or medical insurance benefits under Medicare.

MISC-10

Condition.--Provider fails to submit requested information.

Paragraph.--(Explain the reason for denying the claim in the first part of the fill-in position of the letter. Explain what was needed to complete the bill and why it was not obtainable.)

Add the next paragraph for all types of bills:

"The above facility did not furnish us with the information needed to determine if the services were covered. Therefore, they should not bill you for the services except for the deductible and coinsurance. However, if the institution submits the required information and your claim is reopened, it may be decided that some or all of the services furnished you for the above period were not covered under the Medicare program. In that event, you may have to pay for the noncovered services."

Use the following paragraph for an inpatient hospital on SNF stay:

"Even though no Medicare payment was made on your behalf, the days you spent as an inpatient of the institution named above will be subtracted from the total number of days available to you in this benefit period."

MISC-11

Condition.--Beneficiary (or his representative) is responsible for the failure of the provider to file a timely claim.

Paragraph.--No Medicare payment can be made for the services furnished you for the dates shown above in Notice Covers Period because you did not file a timely request for payment.

The last date you could have filed an effective request for payment was ( ). The records show that your request for payment was filed after this date.

Because you did not file a timely request for payment, the institution may charge you for any items or services furnished during the above period.

NOTE: Where the billing period permits partial payment, appropriately modify the above total denial paragraph.

MISC-12

Condition.--Provider is responsible for failure to file a timely claim.

Paragraph.--No Medicare payment can be made for the services furnished you for the dates shown above in Notice Covers Period because the institution furnishing the services did not file a timely claim. Under the Medicare program, it is necessary for for the institution furnishing the services to file a timely claim for payment.

Although your request for payment was filed timely; the institution did not file its claim within the time limitation.

The institution may not charge you for any items or services which would have been paid for by the Medicare program had the institution filed within the time limitation. The institution can charge you $______ in Medicare deductibles and $______ in coinsurance amounts.

NOTE: Where the billing period permits partial payment, appropriately modify the above total denial paragraph.

MISC-13

Condition.—The services shown did not constitute covered physical therapy, because they did not require the skills of a physical therapist.

Paragraph.—The treatments you received from the provider shown above do not constitute covered physical therapy services for Medicare purposes.

For Medicare purposes, covered physical therapy is defined as those services furnished under a plan of treatment prescribed by a physician, which require the skills of a qualified physical therapist and are performed by, or under, the supervision of such a therapist. The services involved in carrying out an exercise program designed to maintain function do not require the skills of a qualified physical therapist, and, therefore, do constitute physical therapy as defined for Medicare purposes.

MISC-14

Condition.—Beneficiary failed to submit requested information.

Paragraph.—We received a claim for payment for you from the provider stated above but have not been able to verify your entitlement to Medicare hospital insurance. Although we have written you twice requesting verification or correction of your name and/or health insurance number, you have not responded. We are therefore unable to take any further action on your claim.

MISC-15

Condition.—Services may be covered under the BL Program.

Paragraph.—We have determined that the medical services and supplies you received from the above provider may be covered under the Federal Black Lung Benefits Program. To the extent that those services are covered by that program, payment cannot be made under Medicare. Your claim should be submitted to:

Federal Black Lung Program
P.O. Box 34915
West Bethesda, MD 20817

MISC-16

Condition.—Expenses may be covered by automobile medical, or no-fault insurance policy or plan.

Paragraph.—We have been informed that medical services and supplies you received from the above provider may be covered by automobile medical or no-fault insurance policy or plan. To the extent that those services are covered by automobile medical or no-fault insurance, payment cannot be made under Medicare. You may request that the provider resubmit your claim for these benefits if your automobile medical or no fault insurance does not pay your claim in full.

MISC - 17

Condition.--Beneficiary refused to give information concerning other insurance coverage.

Paragraph.--We received a claim for payment for you from the provider stated above, but have not been able to determine if you have other insurance which may be primary to Medicare. Although we have contacted you requesting this information, you have not supplied us with the necessary information. We are, therefore, unable to take any further action on your claim.

MISC - 18

Condition - Expenses covered by EGHP.

Paragraph - We have been informed that the medical services and supplies you received from the above provider are covered by your Employer Group Health Plan. By law the Employer Group Health Plan is primary payer and no Medicare payment can be made for these services unless the Employer Group Health Plan is billed first. Consult your employer and the State Insurance Commissioner or other official having jurisdiction if necessary to receive payment from your Employer Group Health Plan. If the Employer Group Health Plan makes payment but does not pay the full charges, you may request that the provider resubmit your claim for secondary Medicare benefits.

When your Employer Group Health Plan is primary payer under the law, but fails to pay primary benefits or fails to make appropriate reimbursement to the Medicare program, you have the right to take legal action against the Employer Group Health Plan and to collect double damages. This is in accordance with Section 1862(b) (5) of the Social Security Act.

B. Miscellaneous Partial Denial Paragraphs for all Provider Bills (Use with HCFA-1955 Letter).—

MISC-20

Condition.—Part A services and supplies were furnished prior to the beneficiary's entitlement to Part A.

Paragraph.—The Health Care Financing Administration's records show you became entitled to hospital insurance on the first day of (show month and year).

Under the hospital insurance program, we cannot pay for services and supplies furnished you before that date.

MISC-21

Condition.—Part B services and supplies were furnished prior to the beneficiary's entitlement to Part B.

Paragraph.—The Health Care Financing Administration's records show you became entitled to medical insurance on the first day of (show month and year).

Under the medical insurance program, we cannot pay for services and supplies furnished you before that date.

MISC-22

Condition.—Part A services and supplies were furnished after the beneficiary's entitlement to Part A terminated.

Paragraph.—The Health Care Financing Administration's records show your entitlement to hospital insurance ended with the last day of (show month and year).

Under the hospital insurance program, we cannot pay for services and supplies furnished you after that date.

This notice refers only to hospital insurance. Your Medicare Handbook explains the difference between hospital insurance and medical insurance.

MISC-23

Condition.—Part B services and supplies were furnished after the beneficiary's entitlement to Part B terminated.

Paragraph.—The Health Care Financing Administration's records show your entitlement to medical insurance ended with the last day of (show month and year).

Under the medical insurance program, we cannot pay for services and supplies furnished you after that date.

This notice refers only to medical insurance. Your Medicare Handbook explains the differences between medical insurance and hospital insurance.

MISC-24

Condition.--The services do not constitute covered physical therapy because they do not require the skills of a physical therapist; previous physical therapy services were covered.

Paragraph.--For Medicare purposes, covered physical therapy is defined as those services furnished under a plan of treatment prescribed by a physician, which require the skills of a qualified physical therapist and are performed by, or under, the supervision of such a therapist. When a patient reaches the point where the services he requires are designed to maintain his level of function, such services do not constitute physical therapy for Medicare puroses since the carrying out of such services does not require the skills of a physical therapist.

The records show that beginning with __________, the services you required were designed to maintain function and therefore did not require the skills of a qualified physical therapist. Therefore, no further Medicare payment can be made for the services you received.

3722.5 Limitation of Liability Paragraphs--All Providers (Except Inpatient Hospital).--

A. Limitation Provision - Total Denial Paragraphs for all Provider Bills--Except Inpatient Hospital (Use with HCFA-1954 Letter).--

LIMITATION OF LIABILITY-1

Condition.--Beneficiary and provider without fault under the limitation of liability provision of the law.

NOTE: Where applicable, this paragraph is to follow SNF-1, or HHA-1. This paragraph is preprinted on the above forms. If waiver is not applied to total stay, see Limitation-20.

Paragraph.--Despite an adverse determination concerning noncovered services, Medicare payment is being made under the limitation of liability provision. This provision of the law permits payment when it has been determined that neither you, nor the provider, knew or had reason to know that the services received were not covered under Medicare. Since this is the finding in your case, you are liable only for the deductible, coinsurance, and any charges for services or items not covered by Medicare. The receipt of this notice is considered evidence that you are aware that the services you received were not covered. Therefore, you will not be protected from liability for such services in the future if it is determined they involve treatment for the same condition or a similar level of care.

Even though payment is being made, if you disagree with this coverage determination, you may request reconsideration as explained in this notice.

LIMITATION OF LIABILITY-2

Condition.--Beneficiary without fault and provider at fault under the limitation of liability provision of the law.

NOTE: Where applicable, this paragraph is to follow SNF-1, or HHA-1. This paragraph is preprinted on the above forms. If waiver is not applied to total stay, see Limitation of Liability-21, § 3722.5B.

Paragraph.--Despite an adverse determination concerning noncovered services, a provision of the law relieves a beneficiary from liability for payment for such noncovered services when it is determined that the beneficiary neither knew, nor had reason to know, that services received were not covered under Medicare. Thus, you are responsible only for the deductible, coinsurance, and any charges for services or items not covered by Medicare. Also, the number of days and/or visits used during the waived period will be charged against your Medicare utilization record. If you have already paid the provider for the services, please contact this office or your local Social Security office within 6 months of the date of this notice and furnish the following documents: a copy of this notice, the bill received for services, receipts or other evidence of payments to the provider.

The receipt of this notice is considered evidence that you are aware that the services you received were not covered. Therefore, you will not be protected from liability for such services in the future if it is determined they involve treatment for the same condition or a similar level of care. Even though you are not liable for the billed services described above, if you disagree with this coverage determination, you may request a reconsideration as explained in this notice.

LIMITATION OF LIABILITY-3

Condition.--Beneficiary at fault under the limitation of liability provision of the law.

NOTE: Where applicable, this paragraph is to follow SNF-1, or HHA-1.

best copy available

Paragraph.—A provision of the Medicare law could relieve you from liability for charges resulting from certain noncovered services if it is determined that you did not know, and could not reasonably have been expected to know, that the items or services were not covered under Medicare. We have determined that you should have been aware that the services you received were not covered because ___(enter reasons)___.

Therefore, Medicare payment cannot be made for the noncovered services that you received.

If you disagree with either the coverage determination or the decision that you had knowledge that the services you received were not covered, you may request a reconsideration as explained in this notice.

B. Limitation of Liability Provision - Partial Denial Paragraphs for all Provider Bills--Except Inpatient Hospital (Use with HCFA-1955 Letter).--

LIMITATION OF LIABILITY-20

Condition.--Beneficiary and provider without fault under the limitation of liability provision of the law.

NOTE: Where applicable, this paragraph is to follow: SNF-20, and 22A, or HHA-20 and 23. This paragraph is preprinted on above forms. This paragraph may also be used where the total stay is not covered but only a portion of the stay can be waived.

Paragraph.--Despite an adverse determination concerning noncovered services, program payment is being made under the limitation of liability provision for services received after the date given in the above paragraph. This provision of the law permits payment when it has been determined that neither you, nor the provider knew, or had reason to know, that the services received were not covered under Medicare. Therefore, program payment is being made for the services billed by the provider for the period ___(dates)___. The receipt of this notice is considered evidence that you are aware that certain services you received were not covered. Therefore, you will not be protected from liability for such services in the future if it is determined they involve treatment for the same condition or a similar level of care.

If you disagree with this coverage determination, you may request a reconsideration as explained in this notice.

LIMITATION OF LIABILITY-21

Condition.--Beneficiary without fault and provider at fault under the limitation of liability provision of the law.

NOTE: Where applicable, this paragraph follows SNF-20 and 22A, HHA-20 and 22. This paragraph is preprinted on the above forms. It may also be used where the total stay is not covered but only a portion of the stay can be waived.

Paragraph.--Despite an adverse determination concerning noncovered services, a provision of the law relieves a beneficiary from liability for payment for much of the noncovered services when it is determined that the beneficiary neither knew, nor had reason to know, that services received were not covered under Medicare. Therefore, you are not responsible for the charges billed by the provider for the period (dates).

If you have already paid the provider for the services, please contact this office or any SSO (within 6 months of this notice) and furnish the following documents: a copy of this notice, the bill received for services, receipts or other evidence of payments to the provider.

The receipt of this notice is considered evidence that you are aware that certain services you received were not covered. Therefore, you will not be protected from liability for such services in the future if it is determined they involve treatment for the same condition or a similar level of care.

If you disagree with this coverage determination you may request a reconsideration as explained in this notice.

LIMITATION OF LIABILITY-22

Condition.—Beneficiary at fault under the limitation of liability provision of the law.

NOTE: Where applicable, this paragraph follows SNF-20 and 22A, or HHA-20 and 23.

Paragraph.—A provision of the Medicare law could relieve you from liability for charges resulting from certain noncovered services if it is determined that you did not know, or could not reasonably have been expected to know, that the items or services received were not covered under Medicare. We have determined that beginning with (date) you should have been aware that the services you received were not covered because (enter appropriate reason(s) for denial).

Therefore, Medicare payment cannot be made for the noncovered services that you received. If you disagree with either this coverage determination or the decision that you had knowledge that the services you received were not covered, you may request a reconsideration as explained in this notice.

NOTE: For denial situations use: SNF-1, SNF-20, SNF-22A, HHA-1, HHA-20, HHA-23, making sure the beneficiary receives the appropriate waiver paragraphs.

C. Notice to Provider When Either Beneficiary or Provider is at Fault under the Limitation of Liability Provision.—Advise the provider in writing of its rights when services or items are not covered under Medicare. As explained in §3781.4, such rights arise where the ultimate liability rests with the provider or, uder certain circumstances, with the beneficiary.

Where ultimate liability rests with the provider, cover the following:

- Why the services were not covered.
- That the beneficiary was found without fault.
- That no program payment is being made and the provider must bear the cost of the service less any amount collected from the beneficiary attributed to the deductible or coinsurance.
- That the beneficiary will be informed that should the provider obtain payment from him for such services, you will indemnify the beneficiary.
- That the provider has reconsideration rights regarding both the coverage issue and the issue of whether the provider exercised due care.

You may fulfill obligation under this section by sending the provider a copy of the Medicare Notice sent to the beneficiary together with the following statement:

DATE__________

Dear Administrator:

The attached "Medicare Notice" informs the beneficiary that he/she has been relieved of liability for payment of certain items and services under the limitation of liability provision. You, the provider, are ultimately liable for the beneficiary's waived charges since the items or services were not covered because they were not reasonable and necessary or constituted custodial care, and you, the provider, knew or could reasonably have been expected to know, that they were not covered. Specifically, you are ultimately liable because: (give specific reasons why the provider is liable).

You may appeal this determination provided that the beneficiary does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his/her representative has stated in writing that he/she does not intend to request a reconsideration; or the beneficiary's liability was entirely waived in the initial determination, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of receipt of this notice. You may make the request through any social security office or through this office.

____
Signature

Where ultimate liability rests with the beneficiary, cover the following items:

- Why the services were not covered.
- How and why the beneficiary was aware that the care was noncovered.
- How and why the provider was found to have exercised due care.
- That no Medicare payment will be made.
- That the provider has reconsideration rights regarding both the coverage issue and the issue of whether the provider exercised due care.

You may fulfill your obligation under this section by simply sending the provider a copy of the Medicare Notice that was sent to the beneficiary together with the following statement:

DATE______________________

Dear Administrator:

The attached "Medicare Notice" informs the beneficiary that he/she cannot be relieved of liability for payment for certain items and services under the limitation of liability provision.

You may appeal this determination provided that the beneficiary does not exercise his/her appeal rights. If the beneficiary appeals his/her initial determination, you are automatically made a party to the appeals determination. If, however, the beneficiary or his/her representative has stated in writing that he/she does not intend to request a reconsideration, you may initiate an appeal.

You may ask for a reconsideration for hospital insurance (or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 60 days (or 6 months for a medical insurance review) from the date of receipt of this notice. You may make the request through any Social Security office or through this office.

3723. SPECIAL NOTIFICATION LETTERS - REVERSALS OF NONCOVERAGE

Use the following model letter to notify a beneficiary (or representative) when you have reversed a noncoverage decision of the SNF or its URC. (See §3900.1.)

INTERMEDIARY NAME
ADDRESS

DATE

Dear (Beneficiary or Representative):

This is to notify you that we have reviewed medical information submitted by (SNF's Name). We have determined that the medical care and services that you received for your medical condition from (Date) to (Date) are covered under the Medicare program.

You are not responsible for any charges during the period (Date) except for deductible or coinsurance amounts that apply, or charges for services or items not covered by Medicare. If you have been billed by the nursing home and have paid for services during the covered period, you or your representative should request a refund, less the deductible or coinsurance amounts.

This Medicare determination applies only to services you received from (Date) to (Date). No determination has been made for services provided after this time. If you were still in the facility after (Date) you may request that a bill be submitted to Medicare for a coverage decision.

If you have any questions regarding this notice, billing or refund, you may contact any Social Security Office or this office at the above address within 6 months and furnish the following documents: a copy of this notice, the bill(s) received for services, and receipts or other evidence of payments to the provider.

cc: Provider

Use the following model letter to notify the provider of a reversal of its noncoverage decision and to direct the provider to submit a bill for coverage of the determined period. (See §3900.1.)

INTERMEDIARY NAME AND ADDRESS

Provider Name
Address

Date

Re: (Beneficiary Name)

HICN: _____

Dear Administrator:

The attached "Medicare Notice" informs the beneficiary that the medical services provided by your skilled nursing facility from (Date) to (Date) meet the requirements for Medicare coverage based on the medical information which you submitted.

If you have not already submitted a bill for this period, submit it within 30 days of the date of this letter. Reimbursement will be made after you advise us, in writing, that payment has not been made by the beneficiary or other person (e.g., relatives, other insurance carrier or welfare) for covered services, or you submit evidence that a refund has been made.

If the beneficiary remained in the facility after the period described above, you should decide whether to submit a claim for that care. If you have any questions regarding this decision, please contact this office.

Sincerely,

Attachment

3723.1 Letter Requesting SNF to Submit a Bill At Beneficiary's Request.—

INTERMEDIARY NAME
ADDRESS

TO: Name of SNF
Address
Date

RE: Name of Beneficiary
HICN
DATE OF ADMISSION

The beneficiary or person acting on his/her behalf has requested that a determination of Medicare coverage be made for the stay in your facility from (Date) to (Date).

A search of our files indicates that no bill has been submitted for the period in question.

Submit a bill, (specify medical evidence needed) and a copy of the beneficiary denial notice for the period in question within 5 working days of the date of this letter.

Your provider agreement to participate in the Medicare program requires you to submit a bill to Medicare upon the beneficiary's (or his/her representative's) request even though you believe the services to be noncovered. You are prohibited from collecting from the beneficiary or any other person payment for services which could be covered if a bill were submitted to Medicare.

A provider which repeatedly fails to comply with beneficiary's requests to submit bills for Medicare coverage decisions is subject to termination of its participation in the Medicare program.

3724. SPECIAL LETTERS FOR PATIENT-FILED CLAIMS FOR EMERGENCY INPATIENT SERVICES

For emergency admissions to non-participating hospitals where direct payment is made to the patient, prepare and send to the beneficiary one of the letters described below, as appropriate.

The letter explains the Part A payments made and/or the Part B payments made for ancillary services not covered by Part A (see § 3110). This letter also explains the beneficiary's right of appeal.

The emergency services intermediary should retain a duplicate of all notices sent, for documentation in any appeals process. The intermediary should enter the date the notice is released on both copies of all notices.

3724.1 Sample Paragraphs.--

- Enclosed is a check for $____, which is the amount Medicare can pay for the inpatient hospital services you received from (date of admission) to (date of discharge) in (hospital).

- Medicare is able to pay 60 percent of the charges for your room and board plus 80 percent of the charges for all other covered services during the period (date emergency began) to (date payment ended).

- Medicare is able to pay 60 percent of the charges for your room and board, 80 percent of the charges for other separately identified charges, and 66-2/3 percent of the other charges which were not separately identified on the hospital bill.

- Medicare does not pay (the first $__ of charges) (the first three pints of blood) ($ a day after the 60th day) in a benefit period. (Select one or more, if applicable.)

If lifetime reserve days are used, add $__ a day from ____ to ____.

- If you believe your Medicare hospital insurance should have covered all or more, of your expenses, you may get in touch with us at the address shown on this letter or with any social security office.

- If you believe that the determination is not correct, you may request a reconsideration for hospital insurance (or a review for medical insurance). You must file this request within 6 months from the date of this notice. You may make the request through your social security office. If you go in person, please take this notice with you.

- o This check includes a medical insurance payment for 80 percent of the charges for certain nonroutine hospital services which you received from ___ through ___. These services are listed on the enclosed form.
- o If a hospital bill is not itemized, Medicare can pay 66 2/3 percent of the total covered charges. Payment is being made at this rate for charges from (date emergency began) to (date payment ended).
- o We are enclosing a check for $___. This is your payment under medical insurance for 80 percent of the charges for the services which you received from (admission date) through (discharge date) while in (name of hospital). These services are listed on the enclosed form.

When payment cannot be made under hospital insurance, medical insurance covers some, but not all, of the hospital services. Room and board and certain other services are not covered by medical insurance.

3725. SPECIAL LETTERS FOR PARTIALLY OR TOTALLY DENIED (HOSPITAL-FILED) CLAIMS FOR EMERGENCY INPATIENT SERVICES

The patient receives an HCFA-1533 covering the emergency payment of a partially denied claim. A HCFA-1533 is not sent for a wholly denied claim.

Send the patient a letter enclosing model denial letter A or B, as appropriate (see § 3725, Exhibits 1 and 2), and a Part B provider explanation of benefits, prepared by the intermediary. The intermediary's address should be shown on these letters.

EXHIBIT 1

MODEL DENIAL NOTICE A

(Full Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim)

(INTERMEDIARY'S NAME AND ADDRESS)

Date:______________________

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: ______________________ Claim Number: _______________

We are sorry but payment cannot be made for your stay from _______ through ______ at Hospital ____________, ___________. This is because the ____________ Hospital does not participate in Medicare and it has been determined that your treatment there does not qualify as emergency care.

Under the law, payment for services received in a nonparticipating hospital can only be made if you go, or are brought to the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. Care which is necessary to prevent the death or serious impairment of the health of the individual; and

b. which, because of threat to the life or health of the individual, requires the use of the nearest hospital (in miles or travel time) which has a bed available and is equipped to handle the emergency.

The medical facts of your hospital admission and stay have been carefully reviewed by the Health Care Financing Administration. Based upon this review, we have found that, although it was necessary for you to be hospitalized, a medical emergency did not exist. There would have been time for you to have been admitted to a hospital participating in Medicare.

If you have questions about this notice, or if you believe the determination is not correct, you may request a reconsideration for hospital insurance. You must file your request within 6 months from the date of this notice. You may make the request through your Social Security office.

MODEL DENIAL NOTICE B

(Partial Denial - Hospital-Filed or Beneficiary-Filed Emergency Claim)

(INTERMEDIARY NAME AND ADDRESS)

Date:____________________

DETERMINATION ON EMERGENCY HOSPITAL SERVICES

Beneficiary: ____________________ Claim Number: ______________

This refers to your request for reimbursement under Medicare for the services received while a patient at __________ Hospital, _____________, __________, from ______ through ______.

Payment can be made under the hospital insurance part of medicare only for the costs of your hospitalization from ________ to ________.

The ____________ Hospital does not participate in the Medicare program. Under the law, payment for services received in a nonparticipating hospital can only be made if you go, to or are brought to, the hospital to receive emergency care. Emergency care under Medicare is defined as:

a. care which is necessary to prevent the death or serious impairment of the health of the individual, and

b. which, because of threat to life or health of the individual, requires the use of the nearest hospital (in miles or travel time) which has a bed available and is equipped to handle the emergency.

Payment for emergency services stops when the emergency ends and it is permissible, from a medical standpoint, either to transfer the patient to a participating hospital or to discharge him.

The medical facts of your hospital admission and stay have been carefully reviewed by the Health Care Financing Administration. Based upon this review, we have found that an emergency condition existed when you were admitted. However, the medical information indicates that this emergency condition ended on ________. At that time your condition had improved to the extent that you could have been transferred to a hospital participating in the Medicare program.

If you have questions about this notice, or believe the determination is not correct, you may request a reconsideration. You must file your request within 6 months from the date of this notice. You may make the request through your Social Security office.

Part B Notices

3726. PREPARATION OF EOMB

The EOMB is used to notify Medicare beneficiaries of the actions taken on their claims. An important function of the EOMB is to inform beneficiaries of appeal rights if they do not agree with the decision made on their claims.

Furnish an EOMB to beneficiaries in most situations to describe Part B medical and other health services payments made on their behalf to participating hospitals, SNFs, HHAs, outpatient physical therapy providers, CORFs and RHCs. However, do not prepare a beneficiary EOMB for clinical diagnostic lab services reimbursed at 100 percent of the fee schedule where no deductible or coinsurance applies. If other services will appear on the EOMB necessitating its issuance, include the lab services. Appeal rights are not affected by this requirement.

Part B notices are needed where the services are used to satisfy the beneficiary's deductible and coinsurance even when Medicare does not pay for the services because payment was made by an EGHP.

Where total payment is denied, you may use the EOMB format or the HCFA-1954 letter. (See §3721.)

3726.1 EOMB Specifications.—Show the following data:

- Print your name and address across the top of the form in letters no larger than the word "Medicare" in the title of the form;
- Print the notation "This Is Not A Bill" in block letters at least as large as the largest other printing on the form;
- The date of the notice;
- The beneficiary's name and address (for mailing);
- The beneficiary's HICN;
- The provider's name and address;
- The dates of service (from the bill);
- Services paid and related charges;
- Services disallowed, the reason for disallowance or reduction and related charges;
- Deductions made such as the deductible, coinsurance, professional component, or other (primary) insurance payment;

- If blood was furnished, the number of pints or units furnished, the number replaced, and the charges for unreplaced blood;
- Current unmet blood and cash deductible;
- Print the following language on the back of the form.

GENERAL INFORMATION

A. This notice does not include any Hospital Insurance Benefits you may have received. It may not include any Medical Insurance Benefits for services you have received from a physician or supplier.

If you have received services covered by Hospital Insurance, a separate notice will be sent to you.

B. This notice shows the current status of your Medical Insurance cash deductible and the status of your Medical Insurance blood deductible, if you were furnished blood.

When you receive services again from a doctor or institution, show this notice, along with your Medicare card. The doctor or institution will then know how much of your deductibles are met.

You can use this notice to help with your claim for any other health insurance you may have.

C. You are responsible for a cash deductible, in the amount shown in item 2 on the front of this form, for medical insurance services received in a calendar year. In addition, you are responsible for replacing, or paying for, the 1st 3 pints of blood furnished under Medical Insurance. (This is in addition to the 3-pint blood deductible you must meet for blood furnished under Hospital Insurance.) The Medical Insurance program will pay 80% of the remaining covered charges for Medical Insurance services furnished in a calendar year. You are responsible for the other 20% of such charges.

Further information about the Medical Insurance program is given in "Your Medicare Handbook."

D. Hospital outpatient services are covered by the Medical Insurance program. A participating hospital may charge you the full amount of outpatient charges, if they are not more than the total amount of the annual cash deductible and the hospital does not know to what extent you have met your cash deductible and Medical Insurance blood deductible for the year. Where the hospital collected the charges in full and we later find the deductibles were fully or partially met, you will receive payment, along with a notice, for 80% of the paid hospital charges in excess of the cash deductible and any excess charges for the Medical Insurance blood deductible.

E. If you have any questions about the way your claim was handled, or if you believe Medicare should have paid more of the bill, ask us for an explanation. Our address is shown on the other side of this form. If you are not satisfied with the explanation, you may request a formal review of your claim. If you want a review, request it no later than 6 months from the date shown on this notice.

F. Your Social Security office will be glad to help you with any questions you may have about Medicare benefits which are not answered in "Your Medicare Handbook." The people there will be glad to help you in any way possible.

3728. PROCESSING UNDELIVERABLE EOMB's AND NOTICES OF DENIAL AND PARTIAL DENIAL

3728.1 You Receive an Undeliverable Notice.--Medicare Benefit Notices, EOMBs or notices of denial or partial denial may be returned to you when the beneficiary has moved or died.

A. Beneficiary Deceased.--

1. Notice Does Not Include Check.--If the returned notice indicates the beneficiary is deceased and no payment is due, destroy the notice unless it is an EOMB on an assigned claim. These must be retained for investigation per §3728.3.

2. Notice Includes Check.--If the returned notice indicates the beneficiary is deceased and payment is due, void the check and destroy the notice. If the amount due is $50 or more, develop an underpayment claim in accordance with §3715.1.

B. Beneficiary Alive.--

1. Notice Does Not Include Check.--Do not develop for a better address. If the returned notice represents an assigned claim, retain the notice for investigation per §3728.3. If the returned notice is for an unassigned claim, destroy it.

2. Notice Includes Check.--If the returned notice includes a check, review the notice for accuracy of the name and address. If it is clerically correct, i.e., spelling is correct, review the notice for an address change. The Carrier Alphabetic State List (CAST), if available, can be used as a source for address changes. (See §3505.) City and telephone directories can also be checked. Remail the EOMB and check if a new or corrected address is located. Use a new envelope marked "Second Mailing."

If the returned check is $50 or more and a more current address is not available, retain the check and send the notice to the SSO with a request for assistance in accordance with local arrangements. Furnish the SSO the reason(s) the notice and check were not delivered.

If the returned check is for less than $50 and a more current address is not available, void the check and hold the EOMB pending investigation per §3728.3. If a check for less than $50 is returned after a "Second Mailing", void the check and hold the notice pending investigation per §3728.3.

3. SSO Response.--The SSO will repond according to the situation:

- When the address on the notice is incorrect and the correct address is established, the SSO returns the notice to you for remailing with the check.

- If the SSO cannot locate the beneficiary, it returns the notice to you. If it is determined that the beneficiary is deceased, the SSO develops a claim for the underpayment if the amount is $50 or more.

3728.2 Notices Returned Directly to the SSO.--

A. Beneficiary Deceased.--

1. Notice Does Not Include Check.--The SSO destroys notices or EOMBs on unassigned claims without checks. The SSO returns EOMBs on assigned claims to you for investigation per §3728.3.

2. Notice Includes Check.--Attached or accompanying checks are stamped "Not Negotiable" and returned to you with the notice. The SSO gives the person returning the check a receipt and develops an underpayment claim for amounts of $50 or more. The SSO generally takes an underpayment claim regardless of the amount if a check is returned by an individual entitled to the underpayment who wishes to file for it. If a check for less than $50 is returned by a person not entitled to receive it, the SSO explains the underpayment provisions but does not solicit a claim from a qualified person.

B. Beneficiary Alive.--

1. Notice Does Not Include Check.--The SSO destroys undeliverable notices on unassigned claims. The SSO returns notices on assigned claims to you for investigation per §3728.3.

2. Notice Includes Check.--If the SSO can locate the beneficiary, it will send the EOMB and check to the correct address. If the SSO cannot locate the beneficiary, it will return the EOMB and check to you with a statement to that effect. The check is stamped "Nonnegotiable" by the SSO. Void the check and retain the notice for investigation per §3728.3.

3728.3 Use of Undeliverables for Quality Control.--Treat undeliverable notices as a ready source for investigating the quality of your operation. Also, use them as a guide to possible fraud situations. Investigate continued undeliverables involving the same provider.

3730. PROVIDER LETTERS TO ESTABLISH BENEFICIARY NOTICE OF MEDICARE NONCOVERAGE

The following letters must be used by providers and as required by §3440 Establishing When Beneficiary is on Notice of Noncoverage.

3730.1 Completion of SNF Denial Letters (Exhibits 1-5).--The letters serve as notices to the beneficiaries of noncovered SNF services and contain the required noncoverage information. (See §§3421.B.2 and 3439.1.) Where the PRO is not making utilization determinations about SNF care, these letters must be used. The letters notify the beneficiary of noncovered services and contain the required noncoverage information.

NOTE: These letters do not apply to swing-bed determinations.

The provider makes an original and two copies. (If you require a copy, one more copy will be made.) The provider gives or, where this is not possible, mails the original to the beneficiary (or person acting in his behalf); sends the first copy to the patient's attending physician, and keeps the second copy. When a copy is given a beneficiary (or person acting on his behalf) the provider's copy should contain the signature of the beneficiary (or person acting on his behalf) acknowledging the date he received the notice. Where personal delivery is not possible, the provider copy should reflect the date the beneficiary was notified by telephone and the date the notice was mailed.

A. Heading of Letter.—The appropriate letter is selected.

1. Provider Designation.—The SNF's name and address appears at the top.

2. Date Line.—The date the letter is given or mailed to the beneficiary or his representative.

3. Address Line.—The name of the beneficiary (or the person acting on his behalf) and if the letter was mailed, the address of the beneficiary (or the person acting on his behalf) is entered.

4. Re Line.—Where the letter is addressed to a person acting on behalf of the beneficiary, this shows the name of the beneficiary. In all cases, the beneficiary's HICN and the date of admission are shown.

B. Body of Letter.—

1. Dates.—These are inserted following the instructions below.

2. Reason Noncovered.—This may be specific citing the medical facts in the case, or a SNF denial paragraph selected and inserted which best describes the reason the services are noncovered.

3. Notification.—The letters must include all required notifications as stated in the contents of the appropriate letter.

Letter 1. Used where you advised the SNF of the noncoverage of services. The date inserted is the first date you determined that covered care ended.

Letter 2. Used where the SNF is advised by its URC that the stay was not medically necessary upon admission. The date is the first day on which the stay is not medically necessary.

Letter 3. Used where the URC finds and advises the SNF that further stay is not medically necessary. The date is the first day on which the stay is not medically necessary.

NOTE: This notice of noncoverage is not a replacement for, but in addition to required URC notices. It protects the SNF from liability in the event the beneficiary, for some reason, does not receive the URC notice.

Letter 4. Used where the SNF determined prior to, or upon admission, that the services to be furnished the beneficiary are not covered.

Letter 5. Used where the SNF determined that further services to be furnished the beneficiary are not covered. The date inserted is the date of the first day on which the services are not covered, usually the day following the date of the notice.

C. Phone Contact.—Unsuccessful.

An in-person or phone contact could not be made with the beneficiary or the person acting on behalf of the beneficiary. The letter is mailed on the same day that the contact was attempted. (See §3440.1A.)

D. Signature of Administrative Officer.—The SNF's administrative officer or his agent signs.

E. Beneficiary Acknowledgements.—

- Request for Medicare Intermediary Review - The beneficiary or the person acting on the beneficiary's behalf checks one of the boxes indicating whether or not a bill is to be submitted.

- Verification of Receipt - One of the items is completed to verify that the notice of noncoverage was issued to the beneficiary or to the beneficiary's agent. (If the beneficiary or the person acting on the beneficiary's behalf refuses to sign the verification, the provider's copy of the letter is annotated. It indicates the circumstances and persons involved.)

SNF DENIAL LETTER EXHIBIT 1
INTERMEDIARY DETERMINATION OF NONCOVERAGE

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), the Medicare intermediary advised us that the services you receive beginning (Date) will no longer qualify as covered under Medicare.

The Medicare intermediary will send you a formal determination as to the noncoverage of your stay after (Date). If you wish to appeal, the formal notice will contain information about how this can be done. The intermediary will inform you of the reason for denial and your appeal rights.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier, in person or by telephone, were unsuccessful.

Please verify receipt of this notice by signing below.

Sincerely yours,

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 1 (CONT.)
VERIFICATION OF RECEIPT OF NOTICE

A. This acknowledges that I received the attached notice of noncoverage of services under Medicare on (date of receipt).

(Signature of Beneficiary or Person
acting on the Beneficiary's behalf)

B. This confirms that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

(Name of Beneficiary or Representative contacted)

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER EXHIBIT 2
UR COMMITTEE DETERMINATION OF ADMISSION

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), our Utilization Review Committee reviewed your medical information available at the time of, or prior to your admission, and advised us that the services (you or beneficiary's name) needed do not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason the services were determined to be noncovered.)

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request us to submit one. Furthermore, if you want to appeal this decision you must request that a bill be submitted. If you request a bill be submitted, the Medicare intermediary will notify you of its determination. If you disagree with that determination you may file an appeal.

You must also request that a bill be submitted to Medicare if you have questions concerning your liability for payment for the services you received.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 2 (CONT.)
REQUEST FOR MEDICARE INTERMEDIARY REVIEW

☐ A. I do want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

☐ B. I do not want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received the attached notice of noncoverage of services under Medicare on (date of receipt).

(Signature of Beneficiary or Person acting on the Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

(Name of Beneficiary or Representative contacted)

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER EXHIBIT 3
UR COMMITTEE DETERMINATION ON CONTINUED STAY

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date) our Utilization Review Committee reviewed your medical information and found that the services furnished (you or beneficiary's name) no longer qualified for payment by Medicare beginning (Date) .

The reason for this is: (Insert specific reason services were determined to be noncovered).

This decision has not been made by Medicare. It represents the Utilization Review Committee's judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the covered services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services you received after our URC determined them to be noncovered. Medicare will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want the bill for services after (Date) submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

____
Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 3 (CONT.)
REQUEST FOR MEDICARE INTERMEDIARY REVIEW

/ / A. I do want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

/ / B. I do not want my bill for services submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

____
(Signature of Beneficiary or Person acting on the Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

____
(Name of Beneficiary or Representative contacted)

____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER EXHIBIT 4
SNF DETERMINATION ON ADMISSION

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), we reviewed your medical information available at the time of, or prior to your admission, and we believe that the services (you or beneficiary's name) needed did not meet the requirements for coverage under Medicare. The reason is:

(Insert specific reason services are determined to be noncovered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed did not meet Medicare payment requirements. Normally, under this situation, a bill is not submitted to Medicare. A bill will only be submitted to Medicare if you request that a bill be submitted. Furthermore, if you want to appeal this decision, you must request that a bill be submitted. If you request that a bill be submitted, the Medicare intermediary notifies you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

If you have questions concerning your liability for payment for services you received prior to the date of this notice, you must request that a bill be submitted to Medicare.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 4 (CONT.)
REQUEST FOR MEDICARE INTERMEDIARY REVIEW

☐ A. I do want my bill submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

☐ B. I do not want my bill submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if no bill is submitted.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

(Signature of Beneficiary or Person acting on the Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

(Name of Beneficiary or Representative contacted)

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

SNF DENIAL LETTER EXHIBIT 5
SNF DETERMINATION ON CONTINUED STAY

NAME OF SNF
ADDRESS
DATE

TO: NAME
ADDRESS

RE: NAME OF BENEFICIARY
HICN
DATE OF ADMISSION

On (Date), we reviewed your medical information and found that the services furnished (you or beneficiary's name) no longer qualified as covered under Medicare beginning (Date).

The reason is: (Insert specific reason services are considered noncovered.)

This decision has not been made by Medicare. It represents our judgment that the services you needed no longer met Medicare payment requirements. A bill will be sent to Medicare for the services you received before (Date). Normally, the bill submitted to Medicare does not include services provided after this date. If you want to appeal this decision, you must request that the bill submitted to Medicare include the services we determined to be noncovered. Medicare will notify you of its determination. If you disagree with that determination, you may file an appeal.

Under a provision of the Medicare law, you do not have to pay for noncovered services determined to be custodial care or not reasonable or necessary unless you had reason to know the services were noncovered. You are considered to know that these services were noncovered effective with the date of this notice.

We regret that this may be your first notice of the noncoverage of services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

Please check one of the boxes below to indicate whether or not you want your bill submitted to Medicare and sign the notice to verify receipt.

Sincerely yours,

Signature of Administrative Officer

SNF DENIAL LETTER EXHIBIT 5 (CONT.)

REQUEST FOR MEDICARE INTERMEDIARY REVIEW

☐ A. I do want my bill for services I continue to receive to be submitted to the intermediary for a Medicare decision. You will be informed when the bill is submitted.

You are not required to pay for services which could be covered by Medicare until a Medicare decision has been made.

If you do not receive a formal Notice of Medicare Determination within 90 days of this request you should contact: (Name and address of intermediary).

☐ B. I do not want my bill for services I continue to need to be submitted to the intermediary for a Medicare decision.

I understand that I do not have Medicare appeal rights if a bill is not submitted.

VERIFICATION OF RECEIPT OF NOTICE

C. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

(Signature of Beneficiary or Person acting on the Beneficiary's behalf)

D. This is to confirm that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

(Name of Beneficiary or Representative contacted)

(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS

3730.2 Completion of HHA Model Letter (Exhibit 1).--Model letter, Exhibit 1, serves as notice to the beneficiary of noncovered home health services. The provider makes an original and two copies. (If you require a copy, one more will be made.) The provider gives, or where this is not possible, mails the original to the beneficiary (or the person acting on his behalf); sends the first copy to the beneficiary's attending physician, and keeps the second. When a copy is given a beneficiary (or person acting on his behalf) the provider's copy contains the signature of the beneficiary (or person acting on his behalf) acknowledging the date he received the notice. Where personal delivery is not possible, the provider's copy reflects the date the beneficiary was notified by telephone, and the date the notice was mailed.

A. Heading of Letter.—

1. Provider Designation.—The HHAs name and address appears at the top.

2. Date Line.—The date the letter is given or mailed to the beneficiary or his representative is shown.

3. Address Line.—Shows the name of the beneficiary (or the person acting on his behalf) and if the letter was mailed, the address of the beneficiary (or the person acting on his behalf).

MODEL LETTER EXHIBIT 1

NAME OF HHA
ADDRESS
DATE

RE: NAME OF BENEFICIARY
HICN
DATE OF START OF CARE

TO: NAME
ADDRESS

REFERRED TO SERVICES: ______________

The item checked below explains that the above indicated home health services which the Medicare beneficiary received, or was to receive, from this Home Health Agency are not covered by Medicare.

__ 1. The medical information available at the time of, or prior to, the start of care shows that the specific services to be furnished by this agency do not meet the requirements for coverage under Medicare. However, should you request us to file a claim with Medicare, you will receive a formal determination from the Medicare intermediary as to the coverage of the home health services.

__ 2. The specific services furnished you no longer qualify as covered under Medicare, beginning ___________. The Medicare intermediary will send you a formal determination as to the noncoverage of the home health services.

__ 3. The Medicare intermediary advises that the type of services furnished you no longer qualify as covered under Medicare beginning _________. The Medicare intermediary will send you a formal determination as to the noncoverage of the home health services. The Medicare intermediary servicing this agency is (Name and address of Medicare intermediary).

__ 4. We regret that this may be your first notice of the noncoverage of the home health services under Medicare. Our efforts to contact you earlier in person or by telephone were unsuccessful.

____
(Signature of Administrative Officer)

****

VERIFICATION OF RECEIPT OF NOTICE

__ A. This acknowledges that I received this notice of noncoverage of services under Medicare on (date of receipt).

____
(Signature of Beneficiary or Person acting on the Beneficiary's behalf)

__ B. This confirms that you were advised of the noncoverage of the services under Medicare by telephone on (date of telephone contact).

____
(Signature of Administrative Officer)

KEEP A COPY OF THIS FOR YOUR RECORDS
No action on your part is required

4. Re Line.--Where the letter is addressed to a person acting on behalf of the beneficiary, this shows the name of the beneficiary. In all cases, the beneficiary's HICN and the date of start of care appear.

5. Referred to Services.--The type and number of services referred to in the letter is specified. For example, if the beneficiary received 8 nursing visits per month and it was determined that only 2 were medically necessary, this item indicates, "6 nursing visits per month."

If the beneficiary received both nursing services and physical therapy services and the nursing services were not covered, the provider indicates "nursing services only."

If all services were determined not to be medically necessary, "all services" is entered.

B. For Body of Letter.--Appropriate item(s) are checked:

ITEM 1.
Checked where a HHA determined prior to, or at the start of care, that the services to be furnished are not covered.

ITEM 2.
Checked where a HHA determines that further services to be furnished will not be covered. The date inserted is the first day on which the services are no longer covered.

ITEM 3.
Checked where you advised the HHA of the noncoverage of services. The date inserted is the first date you determine that the home health services are no longer covered.

After the above items, your name and address is shown.

ITEM 4.
Checked where an in-person or phone contact could not be made with the beneficiary or the person acting on behalf of the beneficiary. When this item is checked, the model letter is mailed on the same day as the contact was attempted. (See §3440.1A.)

C. Signature of Administrative Officer.—The letter is signed by an administrative officer of the agency or his/her agent.

D. Verification of Receipt.—The appropriate item is checked and completed to verify that notice of noncoverage was issued to the beneficiary or to the person acting on behalf of the beneficiary. Only one item is checked.

ITEM A.
Checked and completed where contact was made in person (i.e., the notice was personally delivered). If the beneficiary or the person acting on behalf of the beneficiary refused to sign the verification, the provider's copy of the model letter is annotated accordingly, indicating the circumstances and persons involved.

ITEM B.
Checked and completed where only telephone contact was made.

Congressional Inquiries

3735. CONGRESSIONAL INQUIRIES CONCERNING RECONSIDERATIONS.

You are responsible for responding to congressional inquiries which constitute requests for reconsideration of Part A claims. Such inquiries may be received directly from congressional staffs, through SSOs, ROs, and the Health Insurance Inquiries Branch (HIIB).

The steps outlined below describe the procedures to follow when processing congressional inquiries. Although these steps relate to HIIB generated inquiries, they apply to all congressional inquiries.

3735.1 Processing Reconsideration Cases Having Congressional Interest.--HIIB notifies you by telephone (followed by Form Letter HI-2 illustrated in Exhibit 1) that it has received a congressional inquiry about a fully or partially denied Part A claim. When you receive the notice:

- Flag the case to identify the source of the referral, i.e., "HIIB Referred Congressional Inquiry--Direct Response Required;"
- Unless a reconsideration is in progress, complete and forward a form HCFA-2649 to the Reconsideration Branch as required per § 3782.1C;
- Expedite the request for reconsideration. If a reconsideration is in progress as a result of a prior request, remove the case from the routine processing cycle and expedite it;

NOTE: If a reconsideration has been completed and a notice released to the beneficiary or a request for reconsideration has been or is being dismissed because it was not timely filed, send the Member of Congress a copy of the determination under a cover letter explaining the situation.

- Send an interim response (Exhibit 2) to the Member of Congress if a final decision has not been reached within 30 days after the receipt of the request;
- Prepare substantive interims (letters which give status information about the case; e.g., Exhibits 3 and 4) at 30 day intervals thereafter until the final response is prepared;
- Ensure that the response conforms with established guidelines as to format, tone, etc.;
- When a final decision is reached, send the Member of Congress a copy under a covering letter 5 days before the release of the notice to the beneficiary or to the person acting as his representative (Exhibits 5, 5A, 6, and 7);

- Forward to the referral source and the appropriate RO a dated copy of the interims and final responses sent to the Member of Congress and a dated copy of the notice sent to the beneficiary. Address the copies for HIIB to:

  Health Care Financing Administration
  Reconsideration Control Supervisor
  HIIB
  East Bldg.
  Baltimore, MD 21235

  File a copy in the case folder.

- Notify the RO of problems which are expected to cause an inordinate delay in completing the reconsideration.

NOTE: Where you have an arrangement with another intermediary to process your reconsiderations, the intermediary writing the reconsideration takes the above steps.

3735.2 RO Responsibilities.—The RO is responsible for monitoring your peformance in preparing congressional replies. This responsibility includes:

- Providing assistance in closing difficult cases;
- Reviewing the final replies prepared to assure that the replies are accurate, responsive, clear, and timely;
- Furnishing recommendations and suggestions concerning your performance with respect to your responses; and
- Acting as liaison between HIIB and you if any problems arise.

LETTER TRANSMITTING REQUEST FOR RECONSIDERATION TO THE INTERMEDIARY

IHI-631
(A)

____(B)________
____
____

Gentlemen:

Re: ____(C)________
____

We consider the enclosed inquiry to be a request for reconsideration. The substance of the inquiry indicates that the issue in question is ____(D)____ stay at __(E)__ from ___(F)___.

Please initiate and expedite a reconsideration action, using §3735. Complete a form HCFA-2649 and send it to the Reconsideration Branch. (See §§ 3782.2 and 3782.3.) If a PRO is involved, process in accordance with §§ 3790ff.

As soon as the reconsideration is completed, please write to ____(C)____. In preparing your reply, be sure to follow the provisions of the Privacy Act.

Forward copies of the interim response(s) and the final response you send to the Member of Congress and to the beneficiary to the Reconsideration Control Supervisor, HIIB, East Building, Baltimore, MD 21235, and to the regional office.

Sincerely yours,

Enclosure

cc:

HIIB Recon. Clerk

Fill-ins:
A. Social Security Number
B. Intermediary's name and address
C. Beneficiary's name and address
D. Beneficiary's surname
E. Name of Facility
F. Period of time in question
G. Name of Member of Congress

INTERIM RESPONSE TO THE MEMBER OF CONGRESS

000-00-0000

Honorable ______________
____
____

Dear

Re: ______________
____
____

We received your letter to the Health Care Financing Administration on behalf of (Mr., Mrs.) (Jones). (He)(She) had written to you about the denial of ______________ claim for services provided by the ______________ during the period ______________ to.

We have been asked to reconsider our initial decision on ______________'s claim and to furnish you a report of our findings. The review is now under way and as soon as a decision is reached, I will be in touch with you.

Sincerely yours,

000-00-0000

Honorable ________________
____
____

Dear

Re: ____________________
____
____

This is to advise you that we are still in the process of completing our reconsideration of ___________________________________'s Medicare claim.

(Brief statement explaining the cause for delay.)

We know of your wish to be of all practicable assistance to ___________, and we assure you that as soon as we have the necessary facts, we will complete our review and send you a copy of the determination.

Sincerely yours,

000-00-0000

Honorable ________________
____
____

Dear

Re: ________________
____
____

We had hoped by this time to be able to furnish a substantive reply to your inquiry on behalf of ________________.

(Explain what development has been made and what remains to be done. See examples below.)

We are doing our best to bring this matter to a proper conclusion and we will be in touch with you again as soon as a decision has been reached.

Sincerely yours,

EXAMPLE 1: To be sure that all pertinent facts will be considered, we have requested the provider to furnish additional information which has not yet been received.

EXAMPLE 2: To be sure that all the pertinent facts will be considered, we have requested the provider to furnish additional information which has just been received. That information and the medical records upon which we based our original decision are being forwarded to our Medical Consultant for evaluation.

AFFIRMATION

Honorable ____________________
____
____

Dear

Re: ____________________
____
____

We have completed our reconsideration of ____________________'s Medicare claim for services furnished by the ________________ during the period __________ to _______. Our findings have resulted in an affirmation of the original decision.

Enclosed is an advance copy of the determination which will be sent to _______. The determination explains in detail the basis for the decision.

________________ will, of course, be advised of __________ right to request a hearing before an Administrative Law Judge of the Office of Hearings and Appeals if __________ disagrees with the decision and the amount of benefits in controversy is $100 or more.

The people in any social security office will be glad to help_________ file for such a hearing should ____________________ decide to do so. We will be glad to answer any questions you may have concerning this matter.

Sincerely yours,

Enclosure

SAMPLE CLOSE-OUT LETTER INCLUDING AN EXPLANATION ABOUT THE WAIVER OF BENEFICIARY LIABILITY

Honorable ____________________
____
____

Dear

Re: ____________________
____
____

We have completed our reconsideration of ____________________'s Medicare claim for services provided by the ____________________ during the period ________________ to. Our findings have resulted in an affirmation of the original decision. However, we are pleased to report that payment can be made for the services furnished from ________ to ________ because the Social Security Act permits reimbursement in those situations where both the provider and beneficiary did not know, and had no reason to know, that noncovered services were involved.

Enclosed is an advance copy of the determination which will be sent to . The determination explains in detail the basis for the decision.

__________________ will, of course, be advised of __________ right to request a hearing before an Administrative Law Judge of the Office of Hearings and Appeals if __________ disagrees with the decision and the amount of benefits in controversy is $100 or more.

The people in any social security office will be glad to help ______________ file for such a hearing should ____________________ decide to do so. We will be glad to answer any qustions you may have concerning this matter.

Sincerely yours,

Enclosure

PARTIAL REVERSAL

Honorable ____________
____
____

Dear

Re: ____________
____
____

We have completed our reconsideration of ____________'s Medicare claim for services furnished by the ____________ during the period ____________ to ____________ .

We are glad to report that we have determined that Medicare benefits can be paid for the services ____________ received during the period to ____________. However, payment cannot be made for the services thereafter because .

Enclosed is an advance copy of the determination which will be sent to. The determination explains in detail the basis for the revised decision.

Of course, ____________ will be advised of ____________ right to ____________ request a hearing before an Administrative Law Judge of the Office of Hearings and Appeals if disagrees with the decision,and the amount of benefits in controversy is $100 or more. The people in any social security office will be glad to help ____________ file for such a hearing should ____________ decide to do so.

We will be glad to answer any questions you may have concerning the matter.

Sincerely yours,

Enclosure

FULL REVERSAL

Honorable ____________________
____
____

Dear

Re: ____________________
____
____

We have completed our reconsideration of ______________'s Medicare claim for services furnished by the ______________ during the period __________ to ___________.

We are glad to report that we have determined that Medicare benefits can be paid for ___________________________'s entire stay at the above facility.

Enclosed is an advance copy of the determination which will be sent to ___________. The determination explains in detail the basis for the revised decision.

____________________ will also be informed of (his/her) appeal rights. If your constituent believes that the reconsideration determination is not correct, and the amount of benefits in controversy is $100 or more, (he/she) may request a hearing before an Administrative Law Judge of the Office of Hearings and Appeals. If (he/she) wants a hearing, (he/she) must request it within 60 days of the date (he/she) receives the notification of the reconsideration determination, which (he/she) will receive shortly. Should (he/she) need assistance in filing the request, the people in the nearest social security office will be glad to help (him/her). We will be glad to answer any questions that you may have concerning the matter.

Sincerely yours,

Enclosure

3736. REPLYING TO CORRESPONDENCE FROM MEMBERS OF CONGRESS.

Follow these instructions when preparing replies to correspondence from Members of Congress.

A. Congress Recessed.—Generally, send the original and the courtesy copy of the reply to the Washington office of the Member of Congress. However, if it is clear that the inquiry was sent from a home office, direct the original and the courtesy copy there.

B. Reply to a Letter Signed by More Than One Member of Congress.—When replying to a letter signed by more than one Member of Congress, prepare a reply for each Member and enclose a courtesy copy with each. State in the opening paragraph that the same reply is being sent to each person who signed the letter. Make an official file copy for each Member of Congress.

C. Replying to More Than One Member of Congress on Same Case.—Release the replies to each Member of Congress at the same time. Indicate that similar information is being sent to the other Member. You may use the following in your final reply: "Similar information is being sent to (Senator or Representative) (name of Member of Congress) who also inquired on behalf of (name of beneficiary)."

D. Reply to a Letter Signed by an Employee in a Congressional Office.—Address replies to the Members of Congress even when the inquiries are signed by staff members.

E. Replying Directly to a Constituent at the Request of a Member of Congress.—When addressing a reply to a constituent, send a tissue letterhead copy to the Member of Congress, along with a copy of the constituent's letter.

F. Replies to Inquiries from Former Members of Congress.—Unless the former Member of Congress requests otherwise, address the reply to the constituent.

G. Replying to Congressional and Noncongressional Inquiries.—Release the congressional reply one working day before the release of the noncongressional reply. Indicate in the reply to the Member of Congress that similar information is being sent to the constituent (or third party, if applicable) in response to an inquiry sent directly to us by that person.

H. Teletyping and Telephoning Award Information.-- As a general rule don't call or write a congressional office about a check which was released more than 1 week previously. Send a letter, instead.

I. Forms of Address.-- When replying to the Washington office, address the letter:

Honorable ____________________
United States Senate
Washington, D.C. 20510

Dear Senator ____________________:

or

Honorable ________________
House of Representatives
Washington, D.C. 20515

Dear Mr. ________________:

Address replies to the home office:

Honorable ____________________
United States Senator
(local address)
City, State, ZIP Code

Dear Senator ____________________:

or

Honorable ________________
Member, United States House
of Representatives
(local address)
City, State, ZIP Code

Dear Mr. ________________:

J. Courtesy Copies.—Prepare a courtesy copy for each congressional response (including those requiring special handling).

K. Constituent's Letter.—Members of Congress frequently forward the constituent's letter for assistance in replying. Return the constituent's letter, if it is an original, with your first written response.

When the constituent's letter is the only enclosure, on the courtesy copy and all other copies of the reply (but NOT ON ORIGINAL), type:

Enclosure:
Constituent's inquiry

When an enclosure in addition to the constituent's letter is forwarded to the Member of Congress:

- On the original only, at the left margin two lines below the signer's title, type:

  Enclosure

- On the copies, beginning at the same place (at the left martin), type:

  Enclosures 2:
  Including constituent's inquiry

Do not mention the constituent's inquiry in the body of your response.

Disclosure of Information

3760. DISCLOSURE OF INFORMATION-- GENERAL.

The following sections contain instructions concerning the confidentiality and disclosure of information acquired and maintained by HCFA, SSA, intermediaries, providers, and State agencies in the administration of the health insurance program. They comply with the statutes and regulations governing disclosure of information, specifically section 1106 of the Social Security Act, the Freedom of Information Act, the Public Information Regulation, and Social Security Regulations Nos. 1 and 22.

3760.1 Procedures for Handling Requests.--The FOI Act requires that within 10 working days of the receipt of a written request for information, a determination must be made as to whether the information will, or will not, be disclosed. Accordingly, inform anyone requesting information in writing within 10 working days of the receipt of the request whether the request will be wholly or partially fulfilled.

You are not permitted to issue a written denial of any request for information under any circumstances.

Determine within 2 days of the receipt of a written request for information whether you are clearly authorized by the guidelines below to disclose the information. If you are not, notify the RO immediately by telephone. If the RO instructs you to refer the request to it for handling, send the request immediately to the RO by telegram, teletype, or special delivery mail (depending upon the distance), or have it delivered by hand if the RO and you are in the same city. Identify the request as a Freedom of Information request.

Acknowledge any request referred to the RO, using the following language:

Dear

We have referred your request for (specify type of information requested) to

(address of HCFA RO)

Any questions you may have relative to your request should be directed to that office.

Sincerely yours,

Send a copy of the acknowledgement with the request to the RO.

Oral requests may be denied orally. If the requester is dissatisfied with the oral denial, advised him of his right to submit a request in writing, to the RO; tell the requester to write "Freedom of Information Request" on the envelope to ensure prompt handling.

You are not required to create records to comply with requests for information. Refer requests which would create records to the RO. (See also § 3775.)

When able to furnish the requested materials under the guidelines below, furnish it whenever possible, within 10 working days of receipt of payment. If it is not possible to furnish the materials within 10 working days, acknowledge the request immediately. Explain the reason for the dealy.

3760.2 Processing Freedom of Information (FOI) Requests.--Form HCFA-3179 serves as a cover sheet for FOI requests. It is designed to expedite the handling of requests, to capture processing and mailing costs, and to provide the information necessary for reporting purposes. For each FOI request complete a form HCFA-3179. Completion instructions are included on the reverse. If it is not practical to furnish actual postage costs, you may furnish estimated costs.

Supplies of form HCFA-3179 are available through the RO.

3760.3 Reporting FOI Activity.—Maintain completed forms HCFA-3179 for the preparation of a summary annual report of FOI activity. Submit the report, with completed forms SSA-3179, to the RO no later than 5 working days after the close of the calendar year.

Include the number of inquiries resulting in the release of information. Show the number inquiries according to the type of information requested and the category of requester (see § 3776, exhibit 2, for sample report).

Blank spaces have been provided for including other specific and miscellaneous types of material. Space is also provided for indicating total amounts of processing and postage costs and the amounts of fees, both collected and not charged (e.g., under the $5 minimum). These costs include total costs incurred during the calendar year in administering the FOI Act. These costs include:

- Direct costs—personnel and non-personnel costs of responding to FOI requests. (See form HCFA-3179 to calculate these costs.)
- Indirect costs—operations management, control, mail, filing, and supervision associated with the direct personnel costs.
- Staff costs—personel costs involved with procdure, systems, and administrative matters directly related to FOI activities.

3761. FEES FOR INFORMATION

Certain fees and charges have been established to recover some of the cost of disclosing information to the public. Providers, contractors, and State agencies are required to pay appropriate fees for copies of reports they request pertaining to other providers, contractors, or State agencies. Such fees are not reimbursable administrative costs under the Medicare program for contractors or State agencies. A provider may claim such fees as allowable costs only if it demonstrates to you that the information is necessary in developing and maintaining the operation of patient care facilities and activities.

Members of Congress, when clearly requesting information on behalf of a constituent or other third party, are subject to the same fees and charges that would apply to the person represented. They are exempt from charges in all other cases.

Charges for disclosing information under the provisions of Regulation No. 1. In general, the fees will be the same as those charged for disclosing information under the FOI Act.

Do not charge the public for inspection of disclosable documents, for normal mailing of requested materials, for time spent in deciding whether to provide information or securing approval, or for requests which result in charges of $5 or less.

3761.1 Fees.—Unless otherwise specified in SS 3761ff., charge the following fees for disclosing information:

A. Photocopying.--Charge 10 cents per page (one side of a sheet) for photocopying documents or records. If the page to be photocopied is too large to be printed on one photocopy, charge 10 cents per photocopy.

B. Searching.—When a request results in searching time in excess of one-half hour, charge $1.50 for each half-hour, excluding the first half-hour. This charge is in addition to any charges for photocopying materials. There is no searching fee for time spent photocopying.

C. HCFA-Printed Material.-- $.01 per printed page.

D. Preparation of Materials from Punchcards, Magnetic Tape, or Microfilm.—Base charges for preparing materials from magnetic tape, microfilm, or punchcards on the actual cost, as determined on a case-by-case basis. Prepare an estimate of such costs and refer requests requiring preparation of materials from machine sources to the RO for determination of the fee. The RO determines the fee based upon the cost information submitted including the following:

1. Personnel Salaries.—Compute the time spent by all staff members (including analysts, supervisors, and clericals) in searching, compiling, and preparing materials. Translate manhours into personnel salary costs using the most current schedule of salary rates. Use the form to aid in this computation.

2. Direct Equipment Costs.—Pro-rate equipment costs with other uses of the equipment.

3. Direct Material Costs.—Estimate costs of all supplies, paper, special holders, etc., used in preparing the materials.

4. Other Direct Costs.—Include any costs not covered in other items listed above.

E. Certification.—Three dollars for each certification or authentication.

F. Special Forwarding Arrangements.—Actual cost. This includes special delivery, airmail, registered mail, etc.

3761.2 Collections and Disposition of Fees and Charges.—You are responsible for billing and accounting for revenues resulting from providing disclosable information. Deposit income from the release of information in the special Medicare bank account (see Part I, § 1404). Give receipts for payments received for material for which fees are collected. Send the receipt and the material within 10 working days of the day payment is received. Show the following information:

- A title indicating that it is a receipt for fees collected in response to requests for specific information (such as provider financial or prevailing charge information).
- Name, address, and, if known, the organization or profession of the requester.
- Date of request and date material is released.
- A description of the material requested, including the number of pages.
- The total charge for copies.
- The total charge for searching fees or other preparation of the materials.
- Your name and address.

Prepare the original and a copy of the receipt. Retain the original, with the incoming request, for 1 year to serve as a record of payment in the event the material is not received. Give the copy to the requester.

3763.3 Requests Received Without Remittance.—Collect fees and charges before furnishing requested material. When requests for information are received without the required fees, notify the requestor of the total charges, using language similar to the following:

> The Health Care Financing Administration regulations require that a charge be made to recover some of the costs incurred in the disclosure of information. This charge covers costs of searching for, preparing, and reproducing the material you have requested. The total (estimated) cost for the material is $ ______. The cost consists of the following charges: (list here breakdown of charges; e.g., "Photocopying: $10; Searching: $450). Please send a check or money order for the total amount made out to the (your name) and mail it to (your address).
>
> For your information, regulations provide that waiver or reduction of fees may be made upon a determination that the waiver or reduction is in the public interest because furnishing the information can be considered as primarily benefiting the general public. Requests for waiver or reduction in fees should be made in writing and addressed to (name and address of RO).
>
> The material will be mailed to you upon receipt of payment.

Forward a fee schedule to the requestor, if appropriate, so that he is aware of the charges for various services. If a check or money order for the wrong amount is received, return it and request a remittance for the correct amount.

3762. DISCLOSURE OF PROGRAM MATERIALS

The FOI Act deals with the right of the public to information about government rules and methods of operating. It requires that every Federal agency make available for inspection and copying:

> "522(a)(2) . . . (B) those statements of policy and interpretations which have been adopted by the agency and are not published in the Federal Register; and (C) administrative staff manual and instructions to staff that affect any member of the public, unless such materials are promptly published and copies offered for sale."

3762.1 Manuals. PMs and Other HCFA Materials.—The information available to the public at your office includes the Intermediary Letters, the Part A Program Memorandums, (Part 1 - Fiscal Administration, Part 2 - Audits-Reimbursement - Program Administration, Part 3 - The Claims Process), Part 4 - Audit Procedures, the provider manuals (Hospital Manual, SNF Manual, HHA Manual, OPT/CORF Manual, RDF Manual, Coverage Issues Manual, and the Provider Reimbursement Manual.)

Do not retain obsolete manual pages and letters to have available to the public.

When an inquirer asks to see manuals and letters that you do not maintain (e.g., the claims manual or Part B Program Memorandums), refer him to the proper entity. Fulfill requests for copies resulting in 50, or fewer, photocopied pages.

Requests to examine manuals or letters usually arise where a beneficiary calls at your office to discuss his claim. In such situations, abstain from engaging in interpretative analysis or discussion of the material.

3762.2 Internal Guidelines.—You must release all interpretive materials, guidelines, and clarification of policies which relate to payment of Medicare benefits.

Upon request, release written guidelines you use to evaluate and make payment decisions on claims subject to MR. You may withhold precise information on the screens, parameters and computer edits used to identify claims for MR.

EXAMPLE: You have a screen which identifies for review any SNF claim with more than 30 covered days. Your written MR policy contains the documentation standards and guidelines which assist the reviewer in the decision to pay or deny the claim.

You are required to release the policy guidelines, but you could withhold the review screen.

You may withhold guidelines that use specific criteria and tolerances intended to identify claims that raise a strong possibility of fraud or abuse because of a pattern of payment requests for excessive or duplicate services, or services not rendered. If, in your judgement, disclosure of such guidelines would adversely affect the program by allowing violators to go undetected, refer the request to the RO with your recommendations.

Acknowledge requests for physicians' prevailing or customary charge screens and refer them to the appropriate carrier.

3763. DISCLOSURE OF INFORMATION ABOUT IDENTIFIABLE BENEFICIARIES

Sections 3764 - 3769 set the guidelines for disclosure of information about a named beneficiary, to whom it may be disclosed, and the purposes for which it may be disclosed. In general, no information may be released except to the beneficiary (or his legal guardian) without the beneficiary's (or legal guardian's) explicit written authorization.

In cases requiring the beneficiary's consent, the authorization may be in any form, but it must:

- Be signed and dated;
- Specify the individual, organizational unit, class of individuals or organizational units that the information may be disclosed;
- Specify the record(s), information, or type(s) of information which may be disclosed; and
- Indicate whether the consent is a one-time or on-going release of records.

Do not honor a blanket consent to disclose all beneficiary records to unspecified individuals or organizational units.

The disclosure of information about beneficiaries is governed by the provisions of S 1106 if the Social Security Act as implemented by Regulation No. 1, the Privacy Act, the FOI Act, and the DHHS Public Information Regulation.

3763.1 Prohibition Against Disclosure.—Section 1106 of the Social Security Act prohibits disclosure of any file, record, report, or other paper, or any information obtained at any time by the Secretary or an officer or employee of HHS in the course of discharging his duties under the Act, except as prescribed by regulations. The same prohibition applies to information received by any person outside HHS from the Secretary or an officer or employee of HHS.

The prohibition applies to any agency, organization (e.g., you), or institution, or any of its officers or employeees, in the fulfillment of a contract or agreement with the Secretary.

A. Disclosure of Provider or Physician Records.—The prohibition also relates to any information received from HHS, you or any person or entity that furnishes services under arrangements with a provider or accepts an assignment under the program. However, patient records in the possession of a provider or physician are not subject to the prohibition against disclosure or to the Departmental rules and regulations concerning confidentiality merely because the patient is entitled to Medicare benefits. Disclosure of provider or physician records not in the possession of HCFA or you may, however, be subject to applicable State or local laws, or to hospital rules governing disclosure.

B. Authority for Refusal to Disclose Information.—When you receive an oral request for information, disclosure of which is prohibited under these guidelines, decline to comply on the basis of the provisions of § 1106(a) of the Social Security Act, as amended, and Regulation No. 1 of the Social Security Administration (20 CFR 401). However, when an oral denial is not acceptable to the requester or a written request is received, follow § 3760.1.

If any officer, employee, agent, or subcontractor is served with a subpoena or other compulsory process requiring the production of records or information, the disclosure of which is prohibited, decline to produce the records or information. The refusal on § 1106 of the Social Security Act and Regulation No. 1 of the Social Security Administration (20 CFR 401). Notify the RO immediately.

C. Penalty for Failure to Comply With the Rules Relating to Disclosure of Information Obtained in the Administration of the Act.--Section 1106(a) of the Act provides that any person who violates the disclosure provisions shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, by imprisonment not exceeding 1 year, or both.

3763.2 The Authority for Disclosure.—Regulation No. 1 defines the basic authorization for disclosure of information obtained in the administration of the program. The general rule is that information about an individual obtained in the administration of the program may not be disclosed without the authorization of that individual. Medical information relating to an individual will generally be disclosed under more restrictive conditions than other information and, where permitted,ususally may be furnished only upon the written authorization of the individual. Specific exceptions to this rule are detailed in the following sections. As far as program operations are concerned, information about an individual may be disclosed without his authorization when the disclosure is necessary in connection with any claim, or other proceeding, under the Social Security Act.

Information will be disclosed for other than program purposes only if the disclosure is authorized by Regulation No. 1 and is consistent with the proper and efficient administration of the program.

3764. DISCLOSURE NECESSARY FOR PROPER ADMINISTRATION OF THE HEALTH INSURANCE PROGRAM.

A. Information About an Individual.—Disclosure of any record, report, or information about an individual is authorized without the individual's authorization connection with any claim, or other proceeding, under the Act when it is necessary for the proper performance of duties of:

- Any officer or employee of the Department; or
- Any officer or employee of a State agency, intermediary, provider of services, or other agency or organization participating in the administration of the program by contract or agreement in carrying out such contract or agreement.

SSOs have a responsibility for public information activities. In their development of a human interest story concerning health insurance, a SSO may, on occasion, request you to provide claims reimbursement information about a specific beneficiary. Honor such a request when it comes from a SSO employee having authority for liaison with you.

Depending upon the agreements made with the parallel SSO, the employee authorized may be the manager, assistant manager, staff assistant, and/or HI coordinator. Do not honor requests by other employeees for beneficiary claims information.

B. Disclosure to Third Parties.-- In the administration of the program, you may want to avail yourself of the services of third parties such as auditors, court reporters, public stenographers, microfilm processors, or companies developing stenographers, microfilm processors, or companies developing equipment for use in the program.

The arrangement between you and such third parties, even where it is of short duration, is in the nature of an agreement supplementing your contract wsith the Secretary. Under such an arrangement, disclosure to these parties of necessary information which relates to, and is used in, the administration of title XVIII of the Social Security Act is permitted as provided by S 1106 of the Social Security Act and Regulation No. 1. However, when you enter into an agreement with these parties, inform them that § 401.1 of Regulation No. 1 precludes the disclosure of any information on identifiable individuals. Call their attention to the penalty clause of § 1106(a). Attention should be called to these provisions by letter (see below), and obtain a written agreement to comply with the disclosure provisions before releasing any information.

Sample Letter to Third Party

Dear

We are prepared to make available to your organization certain social security records so that (state reason).

However, before making these records available, we must point out that by law, all information derived on identifiable individuals in the administration of the Social Security Act is confidential and may be disclosed to others only under very restrictive circumstances. Regulation No. 1 of the Social Security Administration which governs disclosure of official records and information precludes you from disclosing any information on identifiable individuals.

You should also note that section 1106(a) of the Social Security Act imposes criminal penalties for unauthorized disclosure.

Any social security records which do not identify or make identifiable any individuals are not subject to these restrictions, but may be restricted under the provisions of the Freedom of Information Act.

In order to comply with the requirements of the Social Security Act and Freedom of Information Act you must agree to the following conditions before we can make any social security records available to you:

- Any information which is turned over to you will be used only for the specific purpose intended.
- All employees having access to this material will be instructed as to its confidential nature.
- An official of your company will assume the responsibility for ensuring that the information is not revealed to another.
- The material must be returned to us as soon as you have finished the job.
- We must have a letter from a responsible official in your office agreeing to these conditions and assuming responsibility for carrying them out.

Upon receipt of such letter, the social security records will be made available to you.

Sincerely yours,

authorized the provider or supplier to pursue a Medicare claim, the release of information may be treated as a disclosure made with the beneficiary's consent.

3767. DISCLOSURE OF INFORMATION AFTER THE DEATH OF A BENEFICIARY

Information concerning the fact, date, or circumstances of death may be disclosed when efficient administration permits. The request must be in writing and must state why the information is sought. Additional information may be disclosed to a surviving relative or an authorized representative of that relative, the legal representative of the estate, or to a probate court for the purpose of appointing a legal representative of the decedent's estate. Care should be exercised, however, to see that no information which would appear to be detrimental to the individual or his estate is disclosed, i.e., unusual place or manner of death or information which could create a liability to the individual's estate.

Medical information may be disclosed, in form and detail consistent with proper and efficient administration of the program, when reasonably necessary for a title XVIII purpose. (See § 3764 for further information concerning the disclosure of nonmedical and medical information when necessary for a program purpose.)

Medical information obtained in the administration of title XVIII may be disclosed to a surviving relative or legal representative of the estate of the individual or to others for other than a title XVIII purpose, when such information is necessary for a determination as to what supplementary benefits or services such deceased individual was eligible to receive under a private or public hospital or medical insurance program which is consistent with the purposes and objectives of title XVIII. Such information may be disclosed only if the individual has consented to such disclosure or a surviving relative or the legal representative of the estate consents. (See § 3768C "Release of Title XVIII Claims Information for Complementary Insurance Purposes.")

3768. DISCLOSURE TO THIRD PARTIES FOR OTHER THAN PROGRAM PURPOSES

(See § 3767 for disclosure of information after beneficiary's death.)

A. Nonmedical Information.--Nonmedical information about an individual may be disclosed for other than a program purpose, to persons or organizations designated by the individual, if the individual authorizes disclosure, and if disclosure is consistent with the proper and efficient administration of the Act.

B. Disclosure of Medical Information to a Physician, Institution, or Other Supplier of Services.--Medical information may be disclosed to a supplier of medical services solely for purposes of the beneficiary's care or treatment. Such supplier will be informed that the information is being furnished in connection with the treatment of the beneficiary and that its use should be restricted to that purpose.

1. Disclosure to the Source of Medical Evidence.--Occasionally in the course of reviewing medical evidence submitted to substantiate a claim, intermediary medical personel may discover a medical condition

of which the source of the information is unaware. (For purposes of this section, the "source" of the information is the party submitting the evidence.) In cases where a serious or potentially serious condition is found, the intermediary may wish to inform the source of the information. If the source of the information indicates that the beneficiary is not institutionalized and the identity of his current physician is not known, the source should recommend that the beneficiary consult a physician or institution of his choice for further treatment.

2. Disclosure to a Source of Medical Services Other Than the Source of the Information.--Medical information may also be disclosed, upon request, to the beneficiary's physician or to a medical institution at which the beneficiary is or was a patient when such physician or institution is not the source of the information. However, consent for the release must be obtained from the beneficiary.

C. Release of Title XVIII Claims Information for Complementary Insurance Purposes.--Do not release or use information obtained in the administration of the Medicare program for nonprogram activities. However, when the beneficiary has given written authorization you are permitted to release certain information to your complementary insurance program under specific conditions in your capacity as insurance writer or administrator, or to other insurers for complementary health benefits purposes (see § 1601, Part 1). Under no circumstances use the knowledge of an individual's entitlement or benefit utilization information for purposes of dropping an individual from a group health insurance plan.

1. Information Which May be Released.--Subject to necessary authorizations, copies, extracts, or summaries of only the following records may be released:

a. Provider billing forms (e.g., HCFA-1453, HCFA-1487, and HCFA-1483);

b. Explanation of benefits for Part B Provider Services, or denial letters;

c. Information on date of entitlement to Part A or date of enrollment under Part B, or the date Part B coverage began;

However, requests for other information desired for complementary insurance purposes should be referred to the RO.

2. Form of Authorization.--Make certain that information is not released without the required authorization. This authorization may be either indicated on the billing and admission form or on a dated statement from the beneficiary. Where the authorization is on a dated

statement, it must:

a. Authorize release of information about his title XVIII Medicare claim; and

b. Designate to whom the release is authorized; and

c. Show that the release authorized is for complementary insurance purposes (this may be implied by the designation in b above); and

d. Indicate whether the authorization is for a one-time or ongoing release of data (i.e., for the duration of the claims and appeals process, but not to exceed 2 years);

e. Bear the signature of the beneficiary, his legal guardian, or his authorized representative.

Where the bill contains a beneficiary signature or indicates that the beneficiary's signature authorizing release of information is contained in the provider's records, the bill must contain the name of the complementary insurer unless a dated statement as outlined above is already on file.

Where you have a dated statement on file, information may not be released for individual claims when the beneficiary indicated that he does not want disclosure on that claim. This may be indicated on certain claims forms by the beneficiary checking an appropriate block, or by attaching a separate statement.

If someone other than the beneficiary, legal guardian, or authorized representative authorized disclosure to a third party by filling out the appropriate item on the billing form, do not release the information unless an authorization from the beneficiary is on file. Instead, where feasible, you may wish to inform the beneficiary (or legal guardian or authorized representative) that the signature on the claims form does not constitute a proper authorization for disclosure and that, if he desires information to be disclosed to a third party, he should send to either you or the third party a statement authorizing release. (Indicate the necessary contents of a proper authorization or enclose an appropriate form or statement for use by the proper party in authorizing release.)

If invalid authorizations are a frequent problem, advise third party payers to obtain appropriate ongoing consent statements from enrollees.

3. Methods of Handling Requests.--Where the complementary insurers desire title XVIII information for certain claims only, either the complementary insurer or the beneficiary may request its release.

The complementary insurer must furnish the required authorization(s) for release and must pay any charges. (The Medicare program will absorb charges for supplying duplicate EOMB's or billing forms to beneficiaries, their authorized representatives, and to social security offices.) In the absence of a standing arrangement, the mere presence of an "authorization" to release and the identification of a complementary insurer on a title XVIII billing form does not constitute a request for the "release" of information. There must be a specific request for the information.

You may enter into a standing arrangement with a complementary insurer to provide and charge for title XVIII information, such as EOMB or deductible non-met letter, in every case in which you receive a title XVIII claim which contains the necessary authorizations and identifies the complementary insurer.

4. Release of Title XVIII Claims Information for Complementary Insurance Purposes by Providers.--Intemediaries should be aware that, subject to specific written beneficiary authorization, providers are permitted to furnish certain limited information about Medicare eligibility status and related claims information to third party payers for complementary insurance purposes. (See Hospital Manual § 191.3.)

3769. INTEGRATION OF TITLE XVIII CLAIMS PROCESSING WITH COMPLEMENTARY INSURANCE CLAIMS PROCESSING

A. General.--If you wish to merge the processing of title XVIII claims with the processing of complementary claims, obtain HCFA approval of the integrated processing system and of the method of cost allocation. The cost allocation in the integration of a complementary insurance claims process with title XVIII claims requires you to share in the cost of all functions which are determined to be integrated and from which you derive some benefit.

Submit a request for approval if you use as the input to your complementary claims process the claims form submitted under title XVIII, or any by-product of the title XVIII claims process (e.g., a magnetic tape or punchcard; or an EOMB taken directly from the Medicare claims process). (See Part 1 §§ 1600 ff. for fiscal policy requirements for an acceptable integrated system.)

B. Program Identity.--Since title XVIII program identity must be maintained, notices and forms for title XVIII purposes must clearly identify their title XVIII origin. The complementary insurance notices and forms must be free of implication that the coordination of benefits constitutes an official endorsement by HCFA of the complementary insurance plan. Also, they must not imply that title XVIII entitlement or enrollment is dependent upon the individual's retention of his complementary insurance policy.

C. Records and Information.--Records and information obtained in the operation of title XVIII are subject to rules of HCFA and to other Federal rules on maintenance and destruction, availability for inspection, disclosure, etc. This means, for instance, that the complementary insurance record must be separate and distinct from the title XVIII record if disclosure of the complementary insurance record is required or permitted under State or local laws. Furthermore, commingling of records is not permitted if it would prevent conformance with government rules covering the maintenance, transfer, or destruction of records.

Information to which you have access for complementary insurance purposes, except for physician fee profiles, must be disclosed (in accordance with Regulation No. 1) to other complementary insurers, whether or not you use such information to process complementary claims.

D. Matching Complementary Subscriber Files Against Medicare Claims Files.--In using an integrated claims processing system, it is permissible to match a currently updated subscriber file against a run of currently processed Medicare claims to extract information required to pay the complementary claim provided:

1. When routinely securing beneficiary authorization for an ongoing release of information safeguards are maintained to ensure that, where a beneficiary revokes the authorization on the billing form or by a separate statement, there will be no release of information;

2. When a statement is not routinely secured for the ongoing release of information, controls ensure that there is an authorization per § 3768C2 from each Medicare beneficiary with complementary insurance before information is released; and

3. Controls ensure that no information will be released in the matching process for any Medicare beneficiary who does not have complementary insurance.

Update the subscriber file to incorporate all terminations before each match with the Medicare claims file so that information will not be passed to your private business sector for beneficiaries who are not entitled to the complementary insurance plan.

Do not permit your private business sector to have access to the Medicare claims history file and use only information concerning the current claim from the current run of processed claims.

3770. DISCLOSURE TO STATE AGENCIES OR TO INTERMEDIARIES ACTING FOR STATE AGENCIES ADMINISTERING PROGRAMS RECEIVING GRANTS-IN-AID

A. Information That May Be Disclosed and Authorization Required.--Information on such matters as entitlement, benefit payment, or benefit utilization relating to an individual who has applied for benefits administered by the State welfare departments may be disclosed. Such disclosure may be made without the authorization of the individual or his legal representative (i.e., legal guardian appointed by a court or a parent of a minor) to any duly authorized officer or employee of a State agency administration of grants-in-aid programs under titles IV, V, or XIX or in the case of Puerto Rico, Guam, or the Virgin Islands, titles I, X, or XVI of the Social Security Act with the authorization of the individual or his authorized representative. Medical information beyond that shown on billing forms relating to an individual (and obtained in the administration of the Medicare program) may be disclosed to a State agency administering the grants-in-aid program cited above if the State agency shows a special need for the information and the file contains a written authorization by the beneficiary specifically consenting to disclosure of medical information.

Title XVIII billing forms and instructions for their completion provide for authorization by the beneficiary for the release of information to State agencies or their agents. Where you or a third party organization other than you is administering the medical payment program under a contract or underwriting arrangement with the State, release information to yourself or to the third party organization on the same basis as information may be released to a State agency.

B. Procedures for Supplying Title XVIII Information to State Agencies.--The type of billing and payment information concerning individual beneficiaries needed by State agencies depends on the nature of the State program and the extent to which the program provides for the payment of deductibles, coinsurance, and supplementary benefits. Subject to necessary payment of charges by the State in accordance with cost principles set by HCFA (see §1602 in Part I), you may make arrangements to release individual payment data such as copies, extracts, or summaries of Part A and Part B billing forms, explanation of benefits, denial letters, or equivalent special forms.

Because of the variations among State programs, detailed procedures for the release or use of information must be established by arrangements between the State agency and you. Such arrangements may include transfer of information on magnetic tape. For example, you could match the updated State buy-in files or a current Medicaid master file or other file prepared by the State. (See §3769D.) Obtain approval for this procedure with appropriate cost allocation from HCFA RO similarly to the approval required for integrated processing. (See §3769A.)

(See §§1603 and 1604 for instructions about the common provider audit program for titles V, XVIII, and XIX and release of final settlement data.)

C. Electronic Reporting of Crossover Claims.--Provide to State agencies a magnetic tape file of adjudicated claims for which Medicaid has some responsibility. Provide this data in the UNIBILL file and record format in §§3880ff.

If the State agency will accept crossover claims on magnetic tape, but requires additional data, or requires a format other than the UNIBILL format, arrange to report these claims to the State agency, but the State agency is required to absorb additional costs incurred by you for this service. (See Part 1, §1602.1.)

(See Part 1, §§1603 and 1604 for instructions about the common provider audit program for titles V, XVIII, and XIX and release of final settlement data.)

3770.1 Disclosure to Peer Review Organizations (PROs).—Furnish the PRO responsible for MR for the hospital a copy of your UNIBILL record for:

o All inpatient hospital bills, including specialty hospitals and swing-bed claims for SNF level services. (Furnish all Record Identification (RIC) type C and all (RIC) type I with a U in the 3rd position of the provider number, fields 1 and 8 of the UNIBILL.) Include initial bills, adjustments and RTI corrections.

o Any outpatient hospital (RIC) type D record identified as bill type 83x by OCE.

o Any outpatient hospital bill (RIC) type D (bill types 13x) with CPT-4 surgery code in field 33, (CPT-4 codes 10000-69999 and any local codes which are defined); and one or more of the following:

— A revenue code of 360-369 (operating room services) in field 32;

— A revenue code of 49x (ambulatory surgical care) in field 32; and

— A revenue code of 75x (gastrointestinal services) in field 32.

Prepare the PRO copy of the UNIBILL record as a part of your UNIBILL preparation operations. Send it to the PRO within 5 working days of your UNIBILL preparation date.

A. Editing of PRO Data

1. Data Provided by Hospital Requiring Editing.—Your and HCFA's edits specified in §§3825.1 and 3871 are sufficient for most of the information contained in the PRO record. However, the following additional edits are required. They must be accomplished before payment. Correct bill records failing these edits before paying the provider. Be alert to large numbers of errors coming from any hospital, so that you may begin working with it to correct its problems and prevent a substantial reduction in its cash flow.

HCFA permits deviations from specified edit criteria, i.e., the presence of blanks or zeros in fields, without returning a bill to you. The PRO is relying on your adherence to UNIBILL specifications in establishing its electronic system. The PRO will return records that do not meet edit specifications and notify the RO when the appropriate edits have not been performed.

Data Element	Edits
Admission Type (inpatient only)	a. Must be present. b. One position numeric field. c. Valid codes are: 1-Emergency 2-Urgent 3-Elective

Admission Source	a. Must be present. b. One position numeric field. c. Valid codes are: 1-Physician Referral 2-Clinic Referral 3-HMO Referral

4-Transfer from a Hospital
5-Transfer from an SNF
6-Transfer from another Health Care Facility
7-Emergency Room
8-Court/Law Enforcement
9-Information Not Available

Admitting Diagnosis Code

a. Must be present not later than April 1, 1985.
b. Five position alpha/numeric field.
c. Must be valid ICD-9-CM code.

NOTE: The admitting diagnosis must be validated against a complete ICD-9-CM file to insure that the coding represents an acceptable ICD-9-CM code. Use the EBCDIC table "EBCDXTAB" in the Grouper software program or the "DXTAB" in the Medicare code editor to validate this code prior to processing. If the admitting diagnosis cannot be located on this table return the claim and instruct the provider to resubmit the claim with a valid ICD-9-CM admitting diagnosis code.

Attending Physician ID

a. Must be present.
b. Twelve alpha numeric positions.
c. Left justified.

NOTE: Most State Uniform Billing Committees have agreed to identification of physicians by their State license numbers. If this is the convention that has been chosen, the first two positions of this field will be alpha and will contain the post office abbreviation of the State having issued the license. The following ten positions will contain the license number itself, which may be numeric or alpha/numeric depending on the State's numbering system. If you are also capturing physician name for Medicaid cross over claims, you cannot begin entering the name before the 13th position of the field.

If another convention has been chosen, develop appropriate edits for it to assure that the data received from hospitals and transmitted to PROs is valid.

Work with the PRO to develop a file of valid physician ID numbers which should be updated periodically (at least quarterly). Use this file to edit physician numbers received from hospitals. You and the PRO must develop a system of periodically updating the file and also processing records where the ID numbers for new physicians have not been entered on the file. If you and the PRO are unable to develop this file, ask the RO for instructions for editing physician numbers.

Some States have designated a State level condition code for the hospital's use to indicate a newly assigned physician number. The code permits processing of the claim and alerts the PRO to the need to update the master physician file with the new number. This note also applies to operating physician ID below.

Operating Physician ID

a. Must be present if there is a principal surgical procedure also reported.

	b. Twelve position alpha/numeric field. See "Note" under Attending Physician ID above. c. Left justified.
Patient's Zip Code	a. Must be present. b. Nine position numeric field. c. First three positions must be valid in accordance with the table in §3770.1D.
Medical Record Number	a. If provided by the hospital must be captured for the PRO. b. Must be left justified.
Patient Control Number	a. If provided by the hospital must be captured for the PRO. b. Must be left justified.

2. **Data Provided by Your System**

Readmission Indicator	a. One position alpha/numeric field. b. Valid codes in PATBILL format are: 1-Readmitted within 7 days of prior hospital stay. 0-Not a readmit c. Valid codes in UNIBILL are: Y-Readmitted within 7 days of prior hospital stay N-Not a readmit

3. HCFA provides you with HMO data in the R trailer query reply. (See §3512.8 for description of R trailer.) Include this data in UNIBILL for the PRO as reported in the R trailer. The following edits assure that your system has not distorted the data.

HMO Identification	First position is always H; 2nd through 5th position are numeric.
HMO Option Code	Must be 1, 2, A, B, or C.
HMO Election Date (MMYY)	Month must be 01-12. Year must be greater than 75.
HMO Termination Date (MMYY)	Month must be 01-12. Year must be greater than 75. Date must be later than election date.

B. Content of PRO Records.—The physical characteristics (header and trailer labels, density, track size, etc.) for the record you give the PROs are identical to your UNIBILL requirements except that your external label (address) directs the record to the PRO and the first data record contains the acronym PROBILL in the first 7 positions.

The PRO file is limited to inpatient hospital (both acute and long term) records (discharges, no pays, and adjustments). The PRO file includes all swing bed, distinct part psychiatric, rehabilitation, alcohol, and drug units. These bills are identified by an S, T, U, or V in the third positions of the provider number. The PRO file also includes all hospitals exempt from PPS.

The PRO file does not include Christian Science Sanatoria.

See §3635 for content of the return record you receive from the PRO. Return records are furnished to you only where the DRG, or day outlier days or cost outlier charges are changed or where the entire admission is denied. Changes in diagnoses or procedure coding that do not change the DRG will not be furnished. The PRO may want to develop a capability to use your Grouper program. This is encouraged where feasible as otherwise, the PRO would need to obtain and install its own Grouper.

With respect to the data exchange between you and PROs, the tapes on which you furnish data are your property. The PRO, however, may use them for supplying the return record described above. Where the number of tapes forwarded from you to the PRO exceeds the number returned, work out arrangements for their return.

C. Working Relationships with the PRO.—You are responsible for supplying the PRO with the UNIBILL formats. Answer any questions about these formats the PRO may have. Include an explanation of our RTI and adjustment systems so that the PRO will understand the meaning of the data it receives. If any HCFA initiated changes are made in the record format(s), inform the PRO about them on a timely basis and answer any questions it may have regarding accommodation of the new data into its system. You are a technical resource for the PRO with reference to HCFA record specifications. In working with the PRO you will want to assure that the PRO understands:

1. How to recognize adjustment records and RTI corrections so that they can be differentiated from original bill records.
2. When changes require submission of adjustment bills, e.g., change in DRG, utilization, deductibles.
3. How to recognize and determine when interim bills are valid (includes any valid PPS bills with discharge status coded "30").
4. When you have changed the provider's original coding (open biopsies, outliers, etc.).
5. How to recognize an outlier.

6. Limitations in your ability to identify readmissions when bills are submitted out of sequence.

7. The edits you applied to the hospital's data including any over-ride or force codes.

8. Any other areas that you, the RO, or the PRO believe will impact on your exchange of information with the PRO.

D. PRO/Intermediary Agreements

In (re)negotiating agreements with PROs include the following points:

1. Reference the appropriate sections of this and the hospital manual concerning the hospital's reporting the results of PRO review prior to billing. The PRO should also be required to validate this information.

2. The frequency with which the PROBILL file will be furnished.

3. To keep agreements current, reference the appropriate sections in this manual for UNIBILL record specifications rather than spelling them out in the agreement. Thus, as manual requirements change, they are automatically included as requirements in the PRO agreement.

4. Define invalid, erroneous, or incomplete records and reference to the edits in this section for determining valid data.

5. Define adjustments so that the PRO understands when changes will require an adjustment bill (e.g., where DRG is changed).

6. Stipulate what assistance you will provide to the PRO in determining program savings.

7. What access to PRICER and GROUPER will be provided and how.

8. Incorporate data exchange and processing specifications found in §§3634-3635 by reference.

D. Valid Zip Codes

Below is the range of valid zip codes. The numbers shown are the first three positions. They are followed by their respective State or Territory or post office abreviation. The remaining portion of the code (2 or 6 positions) is locally assigned.

006-009	PR & VI	430-458	OH	730-731	OK
010-027	MA	460-479	IN	734-741	OK
028-029	RI	480-499	MI	743-749	OK
030-038	NH	500-508	IA	750-799	TX
039-049	ME	510-516	IA	800-816	CO
050-054	VT	520-528	IA	820-831	WY
056-059	VT	530-532	WI	832-838	ID
060-069	CT	534-535	WI	840-847	UT
070-089	NJ	537-549	WI	850	AZ
090-149	NY	550-551	MN	852-853	AZ
150-196	PA	553-554	MN	855-857	AZ
197-199	DE	556-567	MN	859-860	AZ
200	DC				
202-205	DC	570-577	SD	863-865	AZ
206-212	MD	580-588	ND	870-875	NM
214-219	MD	590-599	MT	877-884	NM
220-246	VA	600-606	IL	890-891	NV
247-268	WV	609-620	IL	893-895	NV
270-289	NC	622-629	IL	897-898	NV
290-299	SC	630-631	MO	900-908	CA
300-310	GA	633-641	MO	910-918	CA
312-319	GA	633-641	MO	910-918	CA
320	FL	644-648	MO	920-928	CA
322-340	FL	650-658	MO	930-937	CA
342	FL	660-662	KS	939-941	CA
350-352	AL	664-679	KS	943-966	CA
354-369	AL	680-681	NE	967-968	HI
370-374	TN	683-693	NE	969	GU
376-385	TN	700-701	LA	970-979	OR
386-397	MS	703-708	LA	980-994	WA
400-418	KY	710-714	LA	995-999	AK
420-427	KY	716-729	AR		

3770.2 Disclosure to Carriers.—Provide the carrier with a copy of all hospital inpatient UNIBILL records, SNF inpatient, and outpatient UNIBILL records that contain value codes 12, 13, 14, 15, or 16. Accumulate SNF denials and send monthly. If agreeable to both you and the carrier, send them electronically. Carriers extract data for Medicare secondary payer development (see §3689) for identification of PRO denials requiring medical review (see §3618.1) and to assure that they do not pay for nonphysician services to inpatients. (See §§3618.2 and 3618.3). Furnish the records within 31 calendar days of preparation of the UNIBILL.

3771. DISCLOSURE TO THE INTERNAL REVENUE SERVICE.

Information may be disclosed to the Internal Revenue Service when requested for investigation of a possible violation of the F.I.C.A., S.E.C.A., F.U.T.A., or any Federal income tax law. Any problem in complying with the IRS request (e.g., machine capability, cost, etc.) should immediately be brought to the attention of the RO.

3772. DISCLOSURE TO THE OFFICE FOR THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS).

A. General.--HCFA may disclose certain information to CHAMPUS for use in administering the CHAMPUS program. The type of information to be made available parallels that made available to noncomplementary title V and XIX State agencies and intermediaries. (See §3770.)

B. Type of Information.--It is expected that most requests from CHAMPUS for information will involve primarily Part B Medicare operations in such areas as identification of physicians and other medical practitioners who may be engaging in providing excess services or fraud. Before this information is released to a requesting CHAMPUS contractor that is not also a Medicare contractor, certain criteria must be met. The information must previously have been released by intermediaries or carriers in the administration of title XVIII to an official of a medical or other applicable professional society or to an official of a State licensing board (§3480) or to any officer, agency, establishment, or department of the Federal Government charged with the duty of conducting an investigation to determine whether there has been a violation of any provision of a Federal law (§3771).

The types of data covered in §3770B may also be disclosed to CHAMPUS upon request when authorized by the beneficiary or his legal representative. In addition, Economic Index Data (as prescribed by §§405.502(a) and 405.504(a) of Regulations No. 5) which might affect the limits on prevailing charge levels will be made available upon request.

C. Procedures for Release.--CHAMPUS fiscal agents desiring Medicare information will usually request it either through the CHAMPUS headquarters in Denver or through the parallel RO. The CHAMPUS headquarters will refer the request to the parallel RO. Should a Medicare contractor receive a request directly, it will refer the request to the RO. The RO will meet with the CHAMPUS fiscal agent and the Medicare intermediary to determine exactly what is needed, impress upon the CHAMPUS carrier that the information cannot be further disclosed, and the cost involved, if any. (See Part A, Part I, §1602; also note that payment may be estimated or waived if collection would interfere with efficient administration.) At the ROs discretion, the Medicare intermediary and the CHAMPUS fiscal agent may meet to discuss data and cost requirements without regional involvement. Upon agreement about data and cost requirements, the RO will authorize release of the information from the Medicare intermediary to the CHAMPUS fiscal agent.

3773. DISCLOSURE OF INFORMATION ABOUT PROVIDERS AND SUPPLIERS.

A. General.--In keeping with the spirit of the Freedom of Information Act and growing consumer interest in health care facilities and suppliers, the Health Care Financing Administration has made available to the public various final reports and other information regarding providers and suppliers. Disclosure to the public by a contractor is limited, but the following guidelines indicate what information is available, to whom it may be released, and the source to which a requestor should be directed for information that the contractor is not authorized to release.

B. Disclosure Necessary for Proper Administration of the Medicare Program.--

1. Disclosure of Survey Information of the Joint Commission on Accreditation for Hospitals (JCAH), American Osteopathic Association (AOA), or any other National Accreditation Organization.--HCFA may not disclose any accreditation survey made and released by the JCAH, AOA or other national accreditation organization except as prescribed by regulations. Accreditation letters and accompanying Recommendations and Comments prepared by the JCAH, AOA or other national accreditation organization for the provider's accreditation survey are confidential and exempted from public disclosure.

A copy of the provider's most recent accreditation survey may be disclosed with the provider's authorization to any authorized representative, employee or agent of HCFA for official use only in connection with the Medicare sample validation or substantial allegation survey program.

2. Information About Hospitals, Skilled Nursing Facilities, Home Health Agencies, and Independent Laboratories.--Information about a hospital, skilled nursing facility, or home health agency, as well as information about independent laboratories, providers of outpatient physical therapy (rehabilitation and public health agencies and clinics) and portable X-ray suppliers, may be disclosed without the authorization of the institution or organization when such disclosure is required for the proper performance of the duties of:

a. An officer or employee of the Department;

b. An officer or employee of an intermediary; or

c. An officer or employee of a State agency when necessary to carry out his duties under State law in the licensing or approving of hospitals, skilled nursing facilities, home health agencies, or independent laboratories, etc.

Information obtained in the provider certification process is not to be disclosed to those not included in the above three categories, except as indicated in C below.

However, information that a particular institution is participating in the program may be released; and information indicating the specialties for which title XVIII payment may be made for services of a particular independent laboratory may be released. This information is usually available from the Directory of Medical Providers and Suppliers of Services published by the Government Printing Office.

3. Intermediaries Disclosure to Third Parties.-- Disclosure to third parties for program purposes of information about identifiable physicians and other suppliers who are natural persons is governed by the same restrictions and procedures as disclosure about named beneficiaries to third parties for program purposes. See § 3764B.

Information about unidentifiable individuals or about providers or corporate entities (e.g., clinics or independent laboratories), is not exempt from disclosure by section 1106 and regulations at 42 CFR, Part 401. However, it is not to be disclosed by third parties to which information is disclosed for program purposes.

If the information the intermediary discloses to third parties for program purpose is solely information which does not identify, or make identifiable, individuals (e.g., aggregate statistics or records on providers and other corporate entities) the following sample letter is to be used instead of the letter in § 3764B.

Sample Letter from Intermediary to Third Party

Dear

We are prepared to make available to your organization certain social security records so that (state reason).

However, before making these records available to you, we must point out that by law all information derived in the administration of the Social Security Act is subject to the provisions of the Freedom of Information Act, which exempts from disclosure certain categories of records. In order to assure that no records held confidential under the Freedom of Information Act are disclosed, you must agree to meet the following conditions before we make any social security records available to you:

1. Any information which turned over to you will be used only for the specific purpose intended and for no other purpose.

2. All employees having access to this material will be instructed as to its confidential nature.

3. An official of your company will assume responsibility for ensuring that the information is not revealed to any other party.

4. The material must be returned to us as soon as you have finished the job and no copies may be retained.

5. We must have a letter from a responsible official in your office agreeing to these conditions and assuming responsibility for carrying them out.

Upon receipt of this letter from your organization, the social security records will be made available to you.

Sincerely yours,

C. Disclosure of Medicare Reports.--

1. Provider Survey Report and Related Information.-- Information concerning survey reports of providers or facilities, as well as statements of deficiencies based on survey reports are available at the local social security office or the public health assistance office in the area where the facility is located. The following data may be released under this provision.

a. The official Medicare survey report;

b. Statement of deficiencies which have been conveyed to the provider following a survey;

c. Plans of correction, and pertinent comments submitted by the provider relating to Medicare deficiencies cited following a survey.

2. Program Validation Review Reports and Other Formal Evaluation.-- Upon request in writing, official reports and other formal evaluations of the performance of providers are made available to the public. After the survey reports and other formal evaluations are prepared by HCFA personnel, the provider evaluated must be given an opportunity (not to exceed 30 days) to review the report and submit comments on the accuracy of the findings and conclusions. The provider's comments must be incorporated in the report if pertinent.

Program validation review reports are generally released from the RO serving the area in which the provider is located. In order that intermediaries will be informed of the findings of the program validation review, the completed survey report and the provider's comments will be made available to the intermediary servicing the provider.

Informal reports and other evaluations of the performance of providers which are prepared by the intermediary may also be available to the public, subject to certain possible exemptions. Requests for these reports are to be referred to the Medicare regional office with a copy of the information requested.

3. Provider Cost Reports.--

a. Requests for Disclosure.--Requests by the public either to inspect or to obtain a copy of a provider cost report must be in writing and must identify the provider or class of providers and specific cost reports requested.

b. 10-Day Notice Requirement.--Intermediaries are required to respond in writing within 10 working days after receipt of the written request, advising the requestor of the date the reports will be available. This date should be no earlier than 10 working days from the date of the intermediary's response. (For exceptions, see c below.) A copy of this response must be sent simultaneously to the provider, thus putting it on notice that its report has been requested and by whom. (For exception, see 4 below.) (The notification and delay in furnishing the data satisfies a court stipulation.) If the request is for a report submitted by a former owner of a participating facility, copies of the intermediary's response should go to both the present and former owners. If the request is for a report submitted by a provider no longer participating in the program, a copy of the intermediary's response should be sent to the former provider. (For both former owners and former providers the copy of the response should be sent to the last known address of the party.)

If the information cannot be made available within a reasonable period of time, the response should include a brief explanation for the delay (e.g., because of the extent of searching, photocopying, or delay in securing reports from records retention centers). In addition to the provider's copy, a copy must also be sent to the Medicare regional office servicing the provider.

If an intermediary receives a request for information concerning providers that it does not service, such request should immediately be forwarded to the Medicare regional office servicing the provider and the requester so informed. The regional office forwards the request to the servicing intermediary.

c. Exceptions to 10-Day Notice Requirement.--No 10-day delay in furnishing cost reports is necessary in the case of requests from:

(1) Federal or State agencies that need cost report information to carry out requirements of the Social Security Act (e.g., a State health planning agency under title XI (§ 1122), or a Medicaid State agency under title XIX).

(2) The Congress. Requests from Congress are limited to those from the Congress as an official body (e.g., the Speaker of the House or the President of the Senate, or from the chairman of a committee or subcommittee of the House or Senate with jurisdiction related to the information requested). Requests from individual members of the House or Senate are considered as requests from the public.

d. Information That Can Be Disclosed.--Disclosure is limited to cost report documents that providers are required by regulations and instructions to submit. In the case of a settled cost report, this includes the intermediary's notice of program reimbursement. Cost report documents include the statistical page, the settlement pages, trial balance of expenses, cost finding schedules, balance sheet, statement of income and expenses, and other schedules or documents required as part of the regular cost report process. (Where a provider, after first obtaining program approval, submits equivalent documents in lieu of official program documents, they are subject to the same disclosure rules as apply to official forms.)

If a provider chooses to submit with its cost report additional information not specifically required by regulations or instructions, the intermediary should not disclose such information unless it is contained within an official document or the equivalent thereof. For example, some providers may submit supplementary analyses of certain expenses, details of the professional component adjustment, financial statements (other than the statement of income and expenses and the balance sheet as required in accordance with cost reporting instructions), or income tax returns that are not required by the program. These would not be disclosable by the intermediary. Except where a provider has not submitted an acceptable cost report and supplements are required to complete the report, any additional documents or schedules that the intermediary requires the provider to submit in support of its cost representations are also not to be disclosed. In addition, do not disclose audits, schedules, letters, notes, and comments; comments on results of desk reviews (including copies of the actual desk review documents); intermediary notes and comments (including transmittal letters); audit adjustment summaries that intermediaries and auditors are required to prepare; and information pertaining to an individual patient. Requests for this type of information are to be acknowledged and referred to the regional office.

> NOTE: Any of the cost report information that the intermediary may not disclose may be disclosed under the Freedom of Information Act by the Medicare regional office, central office or, upon appeal of a denial, by the Administrator, HCFA. Disclosure may also be ordered by a U.S. District Court upon judicial review.

When an intermediary discloses a settled report, it may disclose schedules applicable to the settlement that have been reworked. The general rule is that if the intermediary has reworked any of the schedules that the provider is required to submit with its original submission, these schedules become an integral part of the report for disclosure purposes. However, any details containing intermediary or auditor comments concerning the settlement, details of specific adjustments, or supporting schedules applicable to the settlement of the provider's operation are not to be disclosed by the intermediary.

Prior to the release of cost report information to the requestor, the intermediary servicing the provider must screen each cost report and remove nondisclosable documents and information. If the intermediary is uncertain whether a particular document must be disclosed it should consult the regional office in the region in which the provider is located. Further, if you discover as a result of review that the cost report reflects information which might result in adverse program publicity, alert the RO immediately. However, do not delay disclosure.

The above instructions do not negate in any manner the requirement that you submit cost reports to HCFA that contain full and complete information, including the details of all intermediary and auditor adjustments, comments, and any supporting schedules that may be needed to verify the settlement.

e. Responding to Requests for Inspection of Cost Reports.--Cost reports will be made available for inspection by the requestor at the intermediary's office during regular business hours. In addition, arrangements will be made to make copies available upon specific request at any RO, or at central office. Provide appropriate space for such inspections. Procedures must be established to ensure that all reports inspected are properly accounted for. Under no circumstances should any requester be permitted to remove cost reports from the place of inspection.

If the requester has questions with respect to the interpretation or analysis of cost report information, such requests for more than routine explanations should be submitted by the requester in writing to the regional office.

f. Disclosure of Cost Reports.--If a request is received to inspect or to obtain a copy of a report that has not been settled, i.e., the final settlement notice of program reimbursement has not been sent, disclose a copy of the report as submitted by the provider. If settlement has been made, disclose the settled report. If a requester specifically asks for both the settled and unsettled cost reports of a provider, comply with such request. When a report is made available for inspection or copying, it should be clearly marked with one of the following captions, as applicable (see Part A, Part 2, § 2043).

(1) Cost report as submitted

(2) Settlement subject to audit

(3) Audited settlement

Requests for reproduction of all or part of a provider's cost report may be subject to photocopy fees. If it is determined that a fee must be charged, prepare the written response to the requester in accordance with § 3760.2.

g. Responding to Requests for Information.--A requester may desire only selected cost report information of a provider or several providers. However, the HEW Freedom of Information Regulation specifies that agencies are not required to create a record by compiling selected items from the files; such requests will be met by furnishing copies of specific documents which contain the information requested. In addition when you receive a request that requires selecting documents from various cost reports, the request should be honored. Follow the written response procedure in "b" above even though the entire report is not being disclosed. Advise the requester that a searching fee will be charged and give an approximate date when the documents will be ready.

4. Medicare Payment and Cost Data.--You may release Medicare payment or Medicare cost data concerning a named provider without giving the provider the 10-day notice required in section 3b above. However, do not give the requester enough information to calculate provider non-Medicare data as well. For example, do not tell a requester that Medicare payments to the provider represent 30 percent of its total revenues.

The Medicare payment or Medicare cost data may be extracted from such documents as cost reports or Form HCFA-3286, Monthly Actuarial Sample of Hospital Reimbursement. Any extraction of data is subject to the instructions in 3f above concerning creation of records.

5. Waiver of Liability Status.--The waiver of liability status of a particular provider and the statistics used to determine that status may be disclosed.

D. Disclosure of Information About Named Physicians and Other Suppliers of Services.--Generally, requests for information about a specific physician or other supplier of services, or for information which would identify such a physician or other supplier of services are not to be honored, except as noted in B above. Acknowledge such requests and refer them to the RO for response.

If you receive a written request for a physician's or supplier's customary charges, acknowledge the request and send it to the appropriate carrier, when known. If not known, send the request to the RO.

Requests for information about amounts of program payments made to physicians, whether an individual or a member of groups, or to other suppliers, should also be referred to the appropriate carrier.

E. Disclosure of Names of Providers, Physicians, and Suppliers of Services.--

1. Names of Providers Terminated from Program Participation.--The fact that a provider no longer participates in the program may be disclosed to the public upon request. Inquiries as to why a provider no longer participates in the program are to be referred to the RO.

2. Names of Providers, Suppliers, and Physicians Found Guilty of Fraud.--HCFA publishes the names of providers, physicians, other suppliers of services, or any other persons who have been found by a Federal court to have been guilty of submitting false claims in connection with title XVIII. Refer requests for such names to the RO for response.

3. Names of Physicians on Second Opinion Lists.--The DHEW Second Opinion Campaign has led to requests under the Freedom of Information Act for the lists of physicians who have volunteered to accept referrals for second opinions. If an intermediary has a list, it should disclose it upon request.

3774. DISCLOSURE OF REPORTS ABOUT NAMED CONTRACTORS.

A. Annual Contract Evaluation Reports (ACER's).-- ACER's are available to the public at the RO servicing the contractor. Refer requests for ACER to the RO for response. Refer requests for an ACER of a multi-State contractor to the RO servicing the home office of the contractor.

Refer requests for supporting documentation for the ACER contained in the Contractor Performance and Evaluation Program (CPEP) reports to the RO.

B. Disclosure of Medicare Audit Reports to the Press and Public.-- HHS Audit Agency reports issued to Medicare intermediaries are available if requested, to members of the press and the public. Refer requests for HHS Audit Agency reports directly to the Audit Agency, which is responsible for decisions regarding the release of these reports.

3775. DISCLOSURE OF STATISTICS.

Statistical data and similar information which does not relate to any identifiable person or persons may be disclosed. However, HCFA and its agents are not required to create records for requestors by compiling selected items from the files, nor must records be created to provide such data as ratios, proportions, percentages, per capitas, frequency distributions, trends, correlations or comparisons.

Such records, however, may be created when efficient administration permits. Final authority to determine when "efficient administration permits" rests with HCFA. Refer requests for information which can be created by hand to the RO unless the requestor is willing to accept copies of the pages containing the data needed to compile the requested information (i.e., to do the necessary compilation himself). Refer requests for information which must be created by machine, i.e., information on punchcards, microfilm, or tape, to the RO.

HCFA and the intermediaries have a joint obligation to ensure that the program is clearly and accurately represented and that the public is given a complete picture of program performance.

There are certain problems in accurately representing program performance by means of statistical data alone, since some groupings of statistics are subject to inadvertent inaccuracies or are susceptible to misinterpretation. Careful judgment is, therefore, essential in presenting information on operating and payment activities.

A. Information That the Intermediary May Disclose.-- When you consider it appropriate, you may release operating, payment, and cost data listed below without prior approval of the health insurance regional representative. Forward a copy of information under this guideline promptly to the RO.

In releasing any data under this guideline, the intermediary must insure that the data are related specifically to the geographical area for which the intermediary is responsible. For example, if a press inquiry is clearly for the purpose of presenting program operating data for a geographical area beyond the jurisdiction of the intermediary, and such data have not been made available by HCFA for public release, the requestor should be advised that the intermediary does not have the responsibility for release of information beyond its operational jurisdiction. The request should be referred to the RO (see § 3775B).

In releasing payment data, the intermediary must indicate that the information refers only to the area it services and does not include payments to direct dealing providers, group practice prepayment plans, or railroad beneficiaries.

If it is not clear whether information can be released under this guide, any doubt should be resolved in favor of obtaining prior clearance from the RO.

The data released under this guideline should be based on the figures furnished to HCFA in the monthly financial report and the monthly workload report. The administrative cost information should be the same as in the quarterly Operations Schedule-Cumulative Interim Expenditure Report.

The following data, relating only to your own title XVIII workload, may be released:

1. Benefit amounts paid by the intermediary, including:

a. aggregate amounts, or

b. amounts broken out by category; e.g., inpatient hospital, outpatient hospital, etc., or

c. amounts broken out by provider, including interim rates, and cost reports (see also § 3773Be).

2. Total number of bills or claims paid by the intermediary, either as an aggregate or broken out by category.

3. Total number of bills processed.

4. Admission notices, by category--inpatient hospital, skilled nursing facility, home health agency. (Extreme caution must be exercised to assure that this statistic is properly related to the items shown above.)

5. Claims volume as an aggregate amount, or broken out by category.

6. Median claims processing time, by category. Processing time should be derived by subtracting date of receipt from date of approval for payment using the dates shown on the bills.

7. Any data determined from the data in items 1-6 above and related data available to the public (e.g., average payment per paid claims).

8. Total administrative cost.

9. Average (arithmetic mean) cost per bill or claim processed.

10. Number or percentage of claims requiring contact with providers for further development.

11. Intermediary-completed SSA forms and reports listed chronologically by form number. Refer requests for BHI generated reports to RO.

a(1) Form SSA-1522 (Monthly Intermediary Financial Report)

(2) Form SSA-1523 (Estimate of Administrative Costs and Credits)

(3) Form SSA-1566 (Intermediary Workload Report)

(4) Form SSA-1566 Supplement (1972 Amendment Supplement to Intermediary Workload Report)

(5) Form SSA-1615 (Operations Schedule - Final Administrative Cost Proposal)

(6) Form SSA-1822 (Monthly Provider Audit Activity Report--Schedule I)

(7) Form SSA-1822A (Final Summary of Audits Completed During Quarter--Schedule II)

(8) Form SSA-1822B (Costs Accrued During Quarter, Cumulative Costs by Contract and FY, Schedule III)

(9) Form SSA-2580 (Cost Classification Report)

(10) Form HCFA 2582 (Plan of Expenditures)

(11) Form HCFA 2598 (Budget Distribution)

(12) Form HCFA 3208 (Provider Audit Cost Report)

b Form HCFA 1527 (Operations Schedule - Cumulative Interim Expenditure Report and Budget)

Release of the last form should be accompanied by a qualifying statement such as the following:

> "This report is based on prelimimary data and is subject to adjustment by subsequent cumulative reports and a final cost proposal."

Release only the data listed above without prior clearance. A request for data not included in the above list may, in your judgment, requdre an immediate response. If so, you may furnish general comments but do not provide statistics. You need not take further action on these requests unless the requester asks for additional information. When additional information is requested, the request should be referred to the RO.

B. Information That May Be Released Upon Authorization by the Regional Office.—

1. Total man-years (or man-quarters, etc.) employed per report period.

2. Man-hours per claim or bill processed.

3. Number of weeks' work on hand.

4. Denial rates.

5. Percent of claims or total payments involving reduction in charges.

Data which contrast one intermediary's performance with the performance of any other intermediary, or which compare an intermediary's performance with any set of national, regional, or other combined intermediary performance data, may not be released by the intermediary without prior approval by the RO. Requests for such information must be referred to the RO. Generally, data of this type will be made available in periodic

HCFA releases when sufficient to permit valid statistical inferences. When the release of this kind of information is considered valuable for intermediary or program public relation, telephone request and approval for intermediary release may be appropriate.

This section applies only to data compiled in the administration of the health insurance program; compilations created by BCA or NABSP, for example, may be disclosed by the intermediary without prior RO approval.

Data pertaining to more than one intermediary or which compare intermediary performance may be released only in proper perspective. Essentially, cost information alone is not an accurate indication of an intermediary's performance and, therefore, is not to be publicized without other relevant data accompanying it, e.g., information pertaining to workload volume and processing time. Moreover, release should always be accompanied by an interpretive statement indicating the limitations of the data and the known variables, e.g., wage differentials, etc.

Requests which include a provider population beyond the jurisdiction of the intermediary may involve data which have not been made available by HCFA for public release. Requests for such combined data will be handled by the RO, which, if it approves the release, will furnish the requestor with the appropriate combined data and alert the other intermediaries involved regarding the release.

3776. EXHIBITS

Exhibit 1A.	Form SSA-3179, Freedom of Information Inquiry
Exhibit 1B.	Reverse of Form SSA-3179
Exhibit 2.	Guidelines for Mailing Material in Response to Freedom of Information Requests
Exhibit 3.	Quarterly Report of Freedom of Information Activity (items completed)
Exhibit 4.	Quarterly Report of Freedom of Information Activity
[Exhibit 5.	Collection and Use of Medicare Information

FREEDOM OF INFORMATION INQUIRY

Hand carry - *Do Not* Put in Interoffice Mail

Use Telephone Where Possible

REQUESTOR'S NAME AND ADDRESS

ORGANIZATION OR PROFESSION

The law requires a final decision within 10 working days. Failure to meet the deadline enables the inquirer to take the matter into Federal court. If the court finds that records were improperly withheld, it may order them produced and require HCFA to pay the court costs and the complainant's attorney fees.

If the court orders payment of such fees and costs and finds that records were withheld "arbitrarily and capriciously," the Merit Systems Protection Board (MSPB) will investigate to determine whether disciplinary action is warranted against the officer or employee who was primarily responsible for the withholding. HCFA is then required by the law to take whatever action the MSPB decides is appropriate.

INSTRUCTIONS: Each person who handles this request must fill in the appropriate information below so that the actual cost of processing can be determined.

				PROCESSING COST INFORMATION FILL IN AMOUNT OF TIME EXPENDED IN APPROPRIATE COLUMN			
DATE/TIME RECEIVED	DATE/TIME RELEASED	SIGNATURE AND OFFICE SYMBOL OR CONTRACTOR'S NAME	GS GRADE OR HOURLY SALARY RATE	TIME SPENT SEARCHING FOR DOCUMENTS (HRS & MIN)	OTHER TIME (Reviewing, copying, preparing, and typing reply, etc.) (HRS & MIN)	TOTAL (HRS & MIN)	COST

NUMBER OF PAGES		FEE
COPIED	PRINTED	
☐ SEARCHING ☐ CERTIFYING/AUTHENTICATING		
TOTAL FEE		

FEE WAIVED ☐

DENIAL ☐

AUTHORITY FOR DENIAL

☐ 5 U.S.C. 552(b) ___

☐ Non-possession of records

☐ Inadequate identification

☐ Refusal to pay fee

☐ Other ___

TOTAL COST →

EXTENSION REQUIRED ☐ REASON:

☐ Need to search field facilities or other components

☐ Voluminous records requested

☐ Need for consultation

NUMBER OF DAYS FOR COMPLETION

PAYMENT RECEIVED ☐

Form HCFA 3179 (1-80)

GUIDELINES FOR MAILING MATERIAL IN RESPONSE TO FREEDOM OF INFORMATION REQUESTS

When responding to Freedom of Information (FOI) requests, use the following guidelines to mail material and furnish postage cost information in section 3 of form SSA-3179.

Letters must be mailed first class. It is not economical, however, to mail more than 35 sheets of material at first class rates. For this reason, responses which total more than 35 sheets of material, including the responding letter, will be mailed as follows. The letter will be mailed first class and the remaining material will be mailed under separate cover as third class mail. (Envelopes containing third class mail must be prominently marked "THIRD CLASS" above the addressee information.)

Use letter-size envelopes (normally 4 1/8" x 9 1/8") for items 1 and 2 below; use larger size envelopes (normally 9 1/2" x 12 1/2") for items 3, 4, and 5; and package material described in item 6, as indicated.

When total sheets of material. including the letter, amount to:	Use this class of mail:	Postage Cost:	Total Cost Incl Letter:
1. 1 - 6 sheets	First	$ .13	
2. 7 - 12 sheets	First	.24	
3. 13 - 35 sheets	First	.46	
4. 36 - 60 sheets		.47	
(letter only)	First	(.13)	
(other material)	Third	(.34)	
5. 61 - 125 sheets		.90	
(letter only)	First	(.13)	
(other material)	Third	(.77)	
6. Over 125 sheets			
(letter only)	First	.13	
Packages of 14 lbs. or less	Fourth	(1.83)	$1.96
Packages of 14 - 27 lbs.	Fourth	(3.72)	$3.85
Packages of 27 - 40 lbs.	Fourth	(5.34)	$5.47

QUARTERLY REPORT OF FREEDOM OF INFORMATION ACTIVITY, Blue Shield of W. N.Y.
(Name of Contractor)

FROM 1/76 (mo.,yr.) TO [illegible]76 (mo.,yr.)

REQUESTER CATEGORY ⟶	NUMBER OF INQUIRIES							
TYPE OF MATERIAL FURNISHED	PHYSICIANS	CLINICS, HOSPITALS, LABS, & PHARMACIES	MEDICAL ASSNS & HEALTH SERVICE GROUP	INSURANCE COMPANIES	ATTORNEYS	CIVIC ORGAN. & NEWS MEDIA	OTHER	TOTAL
Customary Charge Profiles Prevailing Charge Screens	35	16	0	0	0	0	52	103
Reports of Provider Audits	0	0	0	0	0	0	0	0
Cost Reports	0	0	0	0	0	0	0	0
Intermediary Letters and Manuals (Instructions)	0	0	0	0	2	0	0	2
Procedure Codes	0	0	0	0	0	0	0	0
Guidelines on Internal Policy, Screen, or Payment	11	2	0	0	4	0	0	17
Utilization Guidelines	0	0	0	0	0	0	0	0
TOTAL	46	18	0	0	6	0	52	122

PROCESSING COSTS: $ 732.
POSTAGE COSTS: $ 15.86
FEES: Collected $ 63.50
No Charge $ 33.80

COMPLETE ONLY IN REPORT FOR OCT - DEC

CALENDAR YEAR COSTS
DIRECT: $
INDIRECT: $
STAFF: $

QUARTERLY REPORT OF FREEDOM OF INFORMATION ACTIVITY, ______________________ FROM ________ TO ________
(Name of Contractor) (mo.,yr.) (mo.,yr.)

NUMBER OF INQUIRIES

REQUESTER CATEGORY ⟶ TYPE OF MATERIAL FURNISHED	PHYSICIANS	CLINICS, HOSPITALS, LABS, & PHARMACIES	MEDICAL ASSNS & HEALTH SERVICE ORGAN	INSURANCE COMPANIES	ATTORNEYS	CIVIC ORGAN. & NEWS MEDIA	OTHER	TOTAL
Customary Charge Profiles								
Prevailing Charge Screens								
Reports of Provider Audits								
Cost Reports								
Intermediary Letters and Manuals (Instructions)								
Procedure Codes								
Guidelines on Internal Policy, Screen, or Payment								
Utilization Guidelines								
TOTAL								

PROCESSING COSTS: $ ______

POSTAGE COSTS: $ ______

FEES: Collected $ ______

No Charge $ ______

COMPLETE ONLY IN REPORT FOR OCT - DEC

CALENDAR YEAR COSTS

DIRECT: $ ______

INDIRECT: $ ______

STAFF: $ ______

3776 Exhibit 5

Collection and Use of Medicare Information

Under the Privacy Act of 1974, individuals being asked to furnish information must be advised of the statutory authority for the request, why the information is needed, whether it is voluntary or mandatory to furnish the information, what the result would be if the requested information were not furnished, and the uses which may be made of the information furnished.

- The statutory authority for requesting information under the Medicare program is Section 1872 of the Social Security Act, as amended, which incorporates by reference the provisions of Section 205(a) and Section 1875 of the Act.

- Information requested under the Medicare program is needed to identify the individual making a claim for benefits, to determine eligibility under the program, to decide if the services or supplies received are covered by Medicare, and to insure proper payment.

- All information requested is voluntary with the one exception described in the next paragraph. Failure to provide information on services received or amounts charged would, however, prevent payment of a claim. Failure to provide other information, such as name or claim number, would delay and could prevent payment of a claim.

(over)

- The one exception to voluntary submittal of information requested is that, under Section 1877 (a) (3) of the Social Security Act, it is a criminal offense to withhold information for the fraudulent purpose of securing benefits or payments in a greater amount or quantity than is due or where no benefit or payment is authorized by law. For example, it is mandatory that you tell us if you are being treated for a work related injury, so that we can determine whether workmen's compensation will pay for your treatment.

- The information we receive may be given to a Professional Standards Review Organization, peer review groups, or State licensing boards if they need to review the medical services you received to determine program coverage. Information about your Medicare status—such as whether you have met the deductible or how many hospital days you have used—may be given to physicians, hospitals and other providers of service, but only to the extent they need to know in order to submit Medicare claims for services rendered to you. Information may also be given to State agencies when necessary to process claims for medical reimbursement if both Medicaid and Medicare are involved.

Health Care Financing Administration
HCFA Pub. No. 031 (8-78)

Appeals

3780. APPEAL PROCESSES--GENERAL

3780.1 Questions Involving Entitlement or Emergency Services or Reasonable Cost Determinations.--

A. Entitlement or Emergency Services in Nonparticipating Hospitals.--Questions and complaints involving the individual's entitlement to hospital or medical insurance benefits and cases in which there is doubt as to jurisdiction must be referred to the social security office for resolution.

Some issues involve the question of whether the beneficiary:

1. Had attained age 65 or is entitled to Medicare benefits under the disability or renal disease provisions of the law;
2. Is entitled to a monthly retirement, survivor, or disability benefit;
3. Was qualified as a railroad beneficiary;
4. Met the deemed insured provisions;
5. Met the eligibility requirements for enrollment under the supplementary medical insurance program or for hospital insurance obtained by premium payment.

Where the issue concerns emergency inpatient hospital services in a nonparticipating hospital, the request for reconsideration should be sent to the Medicare Bureau regional office (RO) for a determination of accessibility. After the RO makes its determination, it routes the request for reconsideration to the Medicare Bureau Reconsideration Branch.

Acknowledge any questions and complaints relating to these issues and inform the individual that due to the nature of the subject, the matter must be handled by the Social Security Administration.

If you receive a Request for Reconsideration filed on Form SSA-2649, Request for Reconsideration of Part A Health Insurance Benefits, which involves either an entitlement issue or emergency services as described above and which was sent to you in error by a social security office, notify the Reconsideration Branch, Medicare Bureau, to cancel their pending controls. Transfer the SSA-2649 to the proper office as specified in § 3782.6.

B. Services in a Participating "Excess Cost" (Section 223) Provider.--

1. Emergency Services.--Under certain circumstances a provider designated as an "excess cost" provider (see the Provider Reimbursement Manual, §§ 2570ff.) may charge beneficiaries for excess costs over Medicare reimbursement. It may not charge, however, where the services were emergency services. A beneficiary may dispute a provider decision to bill for services as nonemergency. (See PRM § 2574.) If you receive a request for reconsideration of an RO determination that services do not constitute emergency services, search your records for any data which might bear upon the matter and forward it to the RO along with the request for reconsideration. If you are currently conducting a reconsideration of the same claim, forward legible copies of any pertinent material. If a PSRO or PSR State Council is currently conducting a reconsideration of the emergency services, forward the request for reconsideration to the RO with a notation that records potentially relevant to the reconsideration have been requested from the PSRO (or Council) and will be forwarded to the RO as soon as they are received. You should then request all pertinent data from the PSRO or Council and forward it. If there has been an appeal beyond the reconsideration stage on a coverage issue, notify the RO that potentially relevant information is in the possession of some other office such as the Reconsideration Branch, Medicare Bureau, or BHA.

2. Beneficiary Complains About Charges.--Where a beneficiary complains that an excess cost provider is charging more than the allowable excess costs, there is no appeal available. However, such complaints should be referred to the RO for investigation and corrective action.

C. Provider Hearing on Reasonable Cost Determination.--Effective with cost reporting periods ending on or after December 31, 1971, a provider has the right to request a hearing on an intermediary's determination of reasonable cost. (See Code of Federal Regulations, Title 20, Chapter III, Part 405, sections 405.1800ff.) Details of the provider appeals procedure are included in Part A, Part 2, Chapter VII.

Part A Appeals

3781. APPEALS OF PART A PAYMENT DETERMINATIONS

3781.1 Steps in the Appeals Process.--Under title XVIII of the Social Security Act and the regulations issued by the Secretary of Health, Education, and Welfare (Code of Federal Regulations, Title 20, Chapter III, Part 405, sections 405.701-405.750), a party who is dissatisfied with an initial determination (see §§ 3781.3 and 3781.4) may appeal the decision. The mandatory first step of the appeals process is the reconsideration. After the reconsideration, if the party is still dissatisfied and the amount in controversy (see § 3785.1) is $100 or more, a hearing before an administrative law judge (ALJ, formerly called hearing examiner) of the Bureau of Hearings and Appeals may be requested.

The cover letter to the reconsideration determination (see exhibit 10) notifies the beneficiary that he has a right to a hearing. If a hearing is desired, it must be requested within 60 days of the date of receipt of the reconsideration notice (see § 3781.7).

At the hearing, oral testimony or other evidence may be presented in person or the party may request that the case be reviewed by the ALJ on the evidence of record. If the dissatisfaction continues after the ALJ's decision, the party may request that the Appeals Council of the Bureau of Hearings and Appeals review the decision. The Appeals Council may on its own motion review an ALJ decision. After Appeals Council review or denial of review, a party who is still dissatisfied may file a civil action in the U.S. District Court for a review of the final administrative decision if the amount in controversy is $1,000 or more.

3781.2 Party Defined.—A party to an initial determination is a beneficiary with regard to issues listed in § 3781.3 below or a provider with regard to issues listed in § 3781.4. (Refer to § 3789, Beneficiary's Right to Representation under Part A.)

3781.3 Initial Determinations with Respect to Beneficiaries.—An initial determination with respect to a beneficiary is any determination concerning a request for payment under Part A relating to:

A. Coverage of furnished items and services;

B. Amount of deductible;

C. Application of the coinsurance provision;

D. The number of inpatient hospital days used during a benefit period towards the 190-day lifetime limitation of inpatient psychiatric hospital covered days;

E. The number of lifetime reserve days utilized;

F. The number of SNF days utilized;

G. The number of home health visits utilized;

H. The physician certification requirement;

I. The request for payment requirement;

J. The beginning and ending of a benefit period;

K. The medical necessity of the services;

L. A determination with respect to the limitation of liability (§1879) provision; or

M. Any other issue(s) affecting the amount of benefits paid (at present or in the future) including whether there has been, and the amount of, an overpayment or an underpayment.

3781.4 Provider's Right to Appeal Initial Determination.--Section 1879(d) of the Act establishes that the provider has a right to challenge through the appeals process and the courts: (1) an intermediary's decision that items or services furnished are not covered because they are not reasonable and necessary or constitute custodial care (§1862(a)(1) or (9)) or (2) coverage denials occurring on or after July 1, 1987 and before November 1, 1990 involving the failure to meet the requirement that a patient be homebound or the requirement that the patient be in need of skilled nursing care on an intermittent basis (§1814(a)(2)(C) and §1835(a)(2)(A)). Such challenge may be made where the ultimate liability rests with the provider or, under certain circumstances, with the beneficiary. The provider may appeal an initial determination as described above when either the beneficiary or the provider knew or could reasonably have been expected to know that such items or services were not covered and the beneficiary does not exercise his appeal rights.

If the beneficiary appeals such initial determinations, then the provider is made a party to the appeal.

3781.5 Situations Where Provider May Initiate Appeal.-- A provider may initiate an appeal only if the ultimate liability rests with the provider or with the beneficiary and it has been determined that the beneficiary will not exercise his appeal rights. A determination will be made that the beneficiary will not exercise his appeal rights if (1) the beneficiary's liability was not waived for a portion of the items or services and the beneficiary or his representative has stated in writing that he does not intend to request a reconsideration; or (2) the beneficiary's liability was entirely waived in the initial determination.

3781.6 Appeals That Involve an Adverse Utilization Review Committee (URC) Decision.-- A decision rendered by a URC is essentially a medical decision made by the provider to assure proper utilization of inpatient facilities. Inherent in such a decision are certain coverage implications for the Part A hospital insurance program, e.g., that the individual requires only a noncovered level of care, or that no further care of any kind is necessary. While the findings of the URC are evidence which must be considered in making a determination, and should be given great weight, they are not determinations made by HCFA or the intermediaries and, therefore, the beneficiary may not appeal the URC's findings per se, nor any provider actions resulting from such findings (e.g., a request by the hospital to the beneficiary to leave).

While the URC has responsibility for making a medical finding, you have the responsibility, under the term of your contract with the Secretary, for determining the coverage of services on a claim. In most cases, through an exchange of information among institutions, physicians, URCs and your medical staff, the medical finding made by the UR committee and your coverage determination will coincide. Regardless of whether your adverse coverage determination is precipitated by a negative finding of a URC, the beneficiary has a right to file a request for reconsideration.

Time limits on Appeals

3781.7 Time Limits for Filing Appeals.-- The time limit for filing a request for reconsideration is 60 days from the date of receipt of the utilization notice or denial letter, whichever is later. (See §3781.8 for clarifications and exceptions to this rule.) The reverse side of all notices of utilization furnishes an explanation of the time limit. In the event no benefits are payable, a disallowance letter is sent which refers to the 60 day time limit. (See §3721.) The time limit for filing a request for hearing is 60 days from the date of receipt of the reconsideration notice. The time limit for filing for a review by the Appeals Council of the decision of the administrative law judge presiding at the hearing is 60 days from the date of the judge's notice of decision. The time for filing for judicial review is 60 days from the date of the Appeals Council's decision. A request filed with you is considered to have been filed with SSA as of the date of filing.

Compute the 60 day limit for requesting a reconsideration and a hearing by allowing 65 days from the date of the previous notice. This allows a 5-day period for mail delivery.

These time limits may be extended if good cause is shown. (See §3781.8.) When a reconsideration request appears to be filed late, make a finding of good cause using the guidelines in § 3781.8 before taking any other action on the reconsideration. (If the request is for a hearing, the administrative law judge will make the good cause determination; if the request is for judicial review, the Appeals Council will make the determination on good cause.)

3781.8 Finding Good Cause for the Late Filing of Reconsideration Requests.--

A. General.--If a reconsideration request is filed late, the issue of whether good cause exists for the delay in filing is to be resolved prior to taking any other action on the reconsideration.

The time limit for filing for reconsideration is 60 days from the date of receipt of a utilization notice or denial letter, whichever is later. Allow 5 days beyond the date of the notice for mail delivery. (See B below.) For example, a beneficiary who received a notice dated June 15, 1976, had through August 19, 1976 (60 days from June 16 through August 14 plus 5 days for mail delivery) to file timely. If, however, the request is filed late and you determine that good cause exists, the reconsideration request is accepted and handled as a regular case throughout the remainder of the reconsideration process.

B. Establishment of Time Limit for Filing.--The end of the 60 day period will be computed as follows:

1. Full Denial.--When the initial determination is a full denial, count the 60 days from the date of receipt by the party of the determination, normally 5 days after the date of the denial notice (SSA-1954). Ordinarily, a copy of the notice will have been attached to the reconsideration request form by the claimant or by social security office personnel. However, since some beneficiaries will not have kept the notice or included it with the reconsideration request, it is essential to have a copy of the SSA-1954 in the intermediary file (see § 3721).

2. Partial Denial.--When an initial determination is a partial denial, count the 60-day period from the date the party receives the utilization notice, normally 5 days after the date of the notice. (Although the beneficiary will also have received an SSA-1955, the time limit is counted from the later utilization notice because this notice contains an appeal paragraph.) Ordinarily, a copy of either the partial denial notice (SSA-1955) or the utilization notice will be furnished by the beneficiary and attached to the reconsideration request form.

If neither notice is attached, the request will be deemed to be filed timely if it is filed within 8 months and 5 days of the date of the partial denial notice (SSA-1955). For this reason, it is essential to have a copy of the SSA-1955 in the intermediary file (see § 3721). When the partial denial notice is used to establish timely filing, 8 months is allowed to assure that the beneficiary is given at least 60 days from the date of the utilization notice. This is necessary because normally the utilization notice is not mailed simultaneously with the SSA-1955, since all processing must be completed before the utilization notice is prepared. (In a rare case, the beneficiary may make attachments indicating the partial denial notice was sent after the date of the utilization notice. If this occurs, count the 65 days from the later date.).

If the request was not filed within 8 months and 5 days of the date of the SSA-1955, make a written request to the Social Security Administration, Part A Systems Branch, BHI, Bay A-5 Gwynn Oak Building, 1710 Gwynn Oak Avenue, Baltimore, Maryland 21235, for the date of the utilization notice (SSA-1533, SSA-1533A, RR-100, and RR-100A).

3. Full Allowance.--If a beneficiary should appeal a full allowance, the 65-day period will be counted from the date of the utilization notice. If a copy is not attached, the request will be deemed to have been filed timely if it was filed within 8 months and 5 days of the date you approved the bill for payment. If the request was not filed within 8 months and 5 days of this date, then you must make a written request to the address in the paragraph above, for the date of the utilization notice (SSA-1533, SSA-1533A, RR-100, and RR-100A).

4. Alternative Method in Full or Partial Allowance Cases.--This method may be applied where the utilization notice is not attached to the request and the request was filed more than 8 months and 5 days after the date of the notice of utilization or SSA-1955. You may develop the case for good cause without requesting the information from BHI as described in 2 and 3 above. If good cause is found to exist, the reconsideration will be processed and the SSA-2649 will be annotated in Item 10, Remarks, of page 4 with the remark "timely filing questionable" and the reason for good cause will be explained. If good cause is not found to exist, this alternative method may not be used and a query on timely filing must be sent to the Social Security Administration.

5. Beneficiary Alleges Later Date of Receipt.--Where the beneficiary establishes that he could not have received the notice advising him of his appeal rights until a date later than the presumed delivery date (e.g., beneficiary was away from home for an extended period), count the 60 days from the earliest date on which receipt could reasonably be established.

C. Conditions Which Establish Good Cause.--Good cause may be found when the record clearly shows, or the claimant alleges and the record does not present any reason to question that the delay was due to one the following conditions:

1. circumstances beyond the individual's control, including mental or physical impairment (e.g., disability, extended illness), or significant communication difficulties;

2. the death of the individual or his advanced age (advanced age will be met automatically if the individual attains age 75 prior to the date services began in the contested claim);

3. incorrect or incomplete information about the subject claim furnished by official sources (SSA, intermediary, or carrier) to the individual, e.g., whenever a beneficiary is not notified of his appeal right or of the time limit for filing, good cause must be found;

4. delay resulting from efforts by the individual to secure supporting evidence, where the individual did not realize that such evidence could be submitted after filing a request;

5. unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or

6. destruction by fire, or other damage, of the individual's records, when such destruction was responsible for the delay in filing.

NOTE: When the beneficiary's claim is being handled by a representative (§ 3789), the above conditions for finding good cause should be applied to such representative.

D. Procedure to Establish Good Cause.--When a request for reconsideration is filed after the expiration of the time period, the following procedure should be utilized:

1. If the request contains a statement of the reasons for delay (or other evidence which establishes the reason), the determination of whether good cause may be found will be based primarily on that statement. When there is no adequate statement and there is no other sufficient evidence in the file, obtain an explanation of the reason(s) for delay from the claimant through the use of the SSA-1980, Carrier or Intermediary Request for Assistance. (See § 3706.)

2. Annotate the SSA-2649, Request for Reconsideration of Part A Health Insurance Benefits, in Item 10 on page 4 with the remark "60 days expired." Where the alternative method for finding good cause is used, enter the remark "timely filing questionable."

3. The good cause finding is to be made on the basis of a review of (a) the statement by the beneficiary or his representative of the reasons for delay, (b) any other evidence either already in file or

received with the request which relates to the late filing issues, and (c) any documentation in file regarding the particular claim. (Additional documentation regarding the claim need not be requested from the provider until the good cause finding is made.)

4. Where the statement of reasons for delay is not controverted by any other evidence and/or is substantiated by the record, the statement will be accepted as written in finding good cause. If evidence in the record of a particular case leads you to doubt the veracity of the statement, refer the issue—using the SSA-1980—to the social security office for an investigation of the facts. The SSO will obtain a statement from the beneficiary on an SSA-795, Statement of Claimant or Other Person. Evidence that a proper notice was mailed would not be sufficient reason to conclude that the notice was received.

5. On the SSA-2649, page 4, in Item 10, Remarks, enter the reason for the delay and the finding relative to good cause.

E. Examples of Situations Where Good Cause Exists.—Following are examples of cases where good cause for late filing should be found. This list is illustrative only and not exclusive.

1. Beneficiary is an amputee, and has no representative. Statement indicates that he planned to file for reconsideration. Request was filed less than 60 days late. Good cause is found by reason of disability.

2. Beneficiary is deceased. Her husband, who would be the likely person to file as her next of kin, died during the 60-day period. Request was filed 2 months late by the deceased husband's executor. Good cause is found by reason of the death of the death of the representative.

3. Beneficiary is 76 years old and is not represented. Good cause is found by reason of his advanced age.

4. Evidence substantiates that the beneficiary was collecting additional documentation prior to filing. Good cause is found by reason of lack of awareness that evidence could be submitted after filing for reconsideration.

5. Beneficiary is deceased. His wife, who would be the likely person to file as his next of kin, is not fluent in English and did not comprehend the denial notice. Her daughter-in-law filed immediately on learning that no appeal had been made. Request was 3 months late. Good cause is found by reason of circumstances demonstrating that the individual could not reasonably be expected to be aware of the need to file timely.

6. The denial notice sent to the beneficiary did not specify the time limit for filing for reconsideration. Good cause is found by reason of incomplete information furnished by official sources.

NOTE: Whenever a beneficiary is not notified of his appeal right or of the time limit for filing, good cause must be found.

7. The initial notice denied payment; a subsequently issued SSA-1533 incorrectly indicated that payment was allowed. The beneficiary assumed the second notice was correct. Good cause is found by reason of the incorrect information furnished to him.

8. The beneficiary is 73, partially blind, and resides in a remote district of Alaska, where communication was dependent upon the availability of dog sled travel. Request was 7 months late. Good cause is found by reason of circumstances beyond the individual's control (i.e., significant communication difficulties).

F. Where Good Cause Is Not Found.—Where good cause for the late filing of a reconsideration request is not found, the beneficiary must be so advised. Send a written notice to the beneficiary stating that the request for reconsideration has been dismissed and giving (1) the reason for the dismissal, i.e., the reconsideration request was not filed within the 60-day time limit as required and good cause was not found for the failure to file timely. (2) An explanation of the initial determination. A copy of this notice must be attached to page 4 of the SSA-2649, Request for Reconsideration of Part A Health Insurance Benefits.

NOTE: Where good cause is not established, examine the case to determine whether there would be any basis for reopening and revising the initial determination. If reopening and revision are undertaken (see §§ 3799ff.), the notice of dismissal of the reconsideration request need not be sent.

Request for Reconsideration

3782. FILING THE REQUEST FOR RECONSIDERATION OF A PART A PAYMENT DETERMINATION

3782.1 Place and Manner of Filing Requests for Reconsideration.—The request for reconsideration must be made in writing and may be filed at any social security office, or in the case of a railroad retirement beneficiary, at an office of the Railroad Retirement Board, or at the office of the servicing intermediary. Most of the requests will be filed on the prescribed Form SSA-2649, Request for Reconsideration of Part A Health Insurance Benefits. (See § 3784, exhibit 1.) However, any signed, written statement whether it is on form SSA-2649, form SSA-795 (Statement of Claimant), or letter, etc., indicating that the beneficiary, or his authorized representative, or a provider is expressing disagreement with the initial determination or indicating that a review, a second look, or a reexamination should be made, constitutes a request for reconsideration. (See §§ 3789-3789.3 for definition of authorized representative and a party's right to representation.)

A. Oral Contacts and Unsigned Written Requests.—If the explanation you supplied at the time of the party's (as defined in § 3781.2) personal visit to, or telephone conversation with, your office answers the complaint to the satisfaction of the party, no further action is required on the case. If, after the explanation has been given, the party still believes that the determination made on the claim was incorrect (i.e., not in accordance with the law and regulations), your representative will assist the party in filing a Request for Reconsideration of Part A Health Insurance Benefits, Form SSA-2649. If this form is not available, your representative may take a dated written statement signed by the beneficiary expressly requesting that the initial determination be reconsidered and stating briefly the reason for dissatisfaction.

If the initial contact was by telephone, or if the party failed to sign the written request, send him a form SSA-2649 and explain that the form must be completed and signed.

The party should also be instructed that the local social security office or railroad retirement office will provide assistance if desired in filing the request.

B. Written Complaint or Inquiry.—A written communication from a party relating to a claim for payment may constitute an expressed request for reconsideration, an implied request for reconsideration, or simply a request for information. The first two warrant a "reconsideration" of the determination which may result in further appeal rights, while the request for information does not. The distinction between an implied request for a reconsideration and a request for information may, in some cases, be a difficult one to make.

A letter or note bearing the beneficiary's or his representative's signature will serve as an acceptable basis for a request for reconsideration when it asks either explicitly or implicitly that further action on the claim be taken, or when it indicates dissatisfaction with the intermediary's decision. Examples of the phrasing of such letter requests are:

1. "Please reconsider (review) my claim."

2. "Will you please review this denial to see if more payment can be made."

3. "I am not satisfied with the payment decision; please look at it again."

4. "Your decision is illogical."

5. "My neighbor got paid for the same kind of claim. Mine should be paid also."

6. "Last year I was hospitalized for the same condition and the claim was paid for by Medicare."

7. "According to my doctor I needed hospitalization and yet my claim was denied."

All letters which contain such phrases should be treated as valid requests for reconsideration. This list is not all-inclusive, since there are innumerable ways in which a party may express dissatisfaction or request that the initial determination be looked at again. In those instances where the reviewer is not certain whether the party has requested additional information or a reconsideration, the letter should be treated as a request for reconsideration and should be processed accordingly.

If it is determined that the communication is neither an expressed nor implied request for reconsideration, it requires an answer which is responsive to the issues raised by the writer. Simple matters may be responded to by telephone. In that case a report of contact should be prepared and included in the claim file along with the written inquiry. Similarly, a copy of any written response is to be included with the inquiry in the claim file. All such communications and responses must be retained in accordance with the instructions in Part A Intermediary Manual, Part 2, § 2982, Item 4 to protect the beneficiary's filing date if, later, it is determined that a request for reconsideration was intended or the same issues are raised. If during the course of a telephone conversation a claimant indicates a desire for a reconsideration, send the appropriate form with instructions for completing and signing it.

C. Provider Involvement as a Party to the Reconsideration.—When an intermediary receives a request for reconsideration from the beneficiary or his representative, the case must be reviewed to determine whether the provider is a party. Even if the provider takes no action, it is by definition a party if the conditions in § 3781.4 are met. When the provider is a party, it should be given written notice that the request has been received (see exhibit 3). The provider must also be sent a copy of the completed reconsideration determination.

If the initial determination is such that Medicare payment is made for all of the noncovered items or services under the waiver of liability provision (section 1879(a)), then the provider has no right to an appeal, nor is it made a party to the determination if the beneficiary appeals. However, the provider retains the right to appeal (or, it is made a party to the determination if the beneficiary appeals) an initial determination when Medicare payment is made for part of the noncovered items or services. Even if the provider is not a party to the determination if a beneficiary appeals, it may submit additional information on its own initiative in such a case. It may do so even though the beneficiary has not requested an appeal. Such information should be reviewed by the intermediary to determine if it constitutes new and material evidence and is submitted within the appropriate time limits and therefore warrants a reopening of the determination (§§ 3799ff.).

D. Beneficiary's Complaint Concerns His Discharge.—If the beneficiary complains that he was discharged by the provider and he believes he should have been permitted to remain in the institution longer, it is a matter between the beneficiary and the provider. Inform the beneficiary that the Medicare program makes reimbursement for covered services but does not determine which services should be provided or the length of an inpatient stay. Refer the beneficiary to the provider or his physician for an explanation.

E. Dismissed Request for Hearing Is an Implied Request for Reconsideration.—When an Administrative Law Judge of the Bureau of Hearings and Appeals dismisses a request for hearing on the grounds that no reconsideration has taken place, the dismissed request for hearing constitutes an implied request for reconsideration. When the Reconsideration Branch, BHI, receives the dismissed request for hearing, it will notify the responsible intermediary to institute reconsideration action. The intermediary will notify the party who requested the hearing that it is processing the dismissed request as a request for reconsideration.

A request for hearing dismissed for any other reason (e.g., lack of timeliness or the party is not eligible to request a hearing on beneficiary's behalf) does not constitute an implied request for reconsideration.

3782.2 Instructions for Completing Form SSA-2649, Request for Reconsideration of Part A Health Insurance Benefits.—Following are guides for completing the SSA-2649 when the intermediary receives only a signed statement (see § 3782.1) or assists a beneficiary in filing for reconsideration:

ITEM 1. BENEFICIARY'S NAME.
Enter the name of the beneficiary who received the services.

ITEM 2. HEALTH INSURANCE CLAIM NUMBER.
Show the claim number (including the suffix) of the beneficiary.

ITEM 3. REPRESENTATIVE'S NAME.
If the claimant has a representative, show his name and his relationship to the claimant. If a provider is filing, check the appropriate box.

ITEM 4. A COPY OF THE NOTICE.
If available, attach a copy of the denial letter or utilization notice the claimant received.

NOTE: Most information required in Items 1-9 may be ascertained from the notice.

ITEM 5. THIS CLAIM IS FOR.
Check the appropriate box. Check "emergency hospital" when the services are covered only under the emergency services or border resident services provisions. (See § 3013.) Check "health maintenance organization" in every case where the services were rendered or covered by an HMO, or where the issue is HMO coverage of services.

ITEM 6. NAME AND ADDRESS OF PROVIDER.
Give the complete name and address of the provider and provider number.

ITEM 7. NAME OF INTERMEDIARY.
Give the name, city, State, and the number of the intermediary which made the initial determination on the claim in question.

ITEM 8. DATE OF ADMISSION OR START OF SERVICES.
Show the date that the inpatient stay began or (for home health) the date that services were first rendered.

ITEM 9. DATE(S) OF THE NOTICE(S) YOU RECEIVED.
Show the date of any notice received by the claimant about his claim.

ITEM 10. REASON FOR DISAGREEMENT.
The claimant or his representative should state specifically why he believes the initial determination to be incorrect. If a provider is filing, the following language should be used: "Filed by (provider's name) in accordance with section 1879 because ____________________."

ITEM 11. ADDITIONAL EVIDENCE.
Indicate what additional evidence, if any, the claimant is submitting.

ITEM 12. TIMELY FILING.
If the request is not made within 65 days of the date of the claimant's notice, check "No" and obtain from the claimant a statement of the reason(s) for delay so that a determination on good cause can be made.

ITEM 13. SIGNATURE.
The form may be signed by either the beneficiary or his representative if applicable, or by the provider's representative. Check the appropriate block. NOTE: When a written communication forms the basis of the reconsideration request, the check in the signature block will indicate whether the written communication (which should be attached to the SSA-2649) was signed by the beneficiary or the representative. On the signature line, the following phrase should be clearly printed or typed: FORM COMPLETED BY INTERMEDIARY--SIGNED REQUEST ATTACHED. When the provider files, the appropriate block should be checked. The name and title of the provider's representative should be typed or printed in the signature area in addition to the required signature.

ITEM 14. ADDRESS.
Show the address of the person who signed the request for reconsideration.

ITEM 15. WITNESSES.
The witness block is on the reverse side of page 1 of the form. If the request is signed by mark, the signature and addresses of two persons witnessing the signing must appear in block 15B and 15C.

NOTE: Intermediary employees may act as witnesses when a request is completed in the intermediary's office.

ITEM 16. ROUTING.
Check the block which indicates the component with jurisdiction over the reconsideration. Space is provided to show the name of the intermediary.

NOTE: The name of the resident intermediary (i.e., the one making the initial determination on the claim) will be shown, even if another intermediary will prepare the reconsideration determination.

ITEM 17. ADDITIONAL INFORMATION.
Use this space to provide any other information which may be pertinent to the request.

ITEM 18. DATE STAMP.
Every request will be date stamped with the date of receipt of the request. Be sure this is reproduced on all copies. (On intermediary-completed forms, this is the date of receipt of the written communication.)

3782.3 Routing the Reconsideration Request.--As stated above, whenever you receive the reconsideration request directly (that is, not through a social security office), return page 2 of the request with the acknowledgment letter, and forward page 3 of the SSA-2649 immediately to this address:

Health Care Financing Administration
Reconsideration Branch, Medicare Bureau
Pending Control
P.O. Box 770
Baltimore, Maryland 21203

Pages 1 and 4, plus any additional information, statements, etc., become the basis for the reconsideration and should be routed according to the intermediary's regular system for processing such requests.

(See § 3782.6 for instructions on transferring, dismissing, and cancelling controls on requests for reconsideration filed on form SSA-2649 which involve issues or services over which you have either no jurisdiction or only partial jurisdiction.

3782.4 Acknowledging Receipt of Request for Reconsideration.--Upon initial receipt of a written request for reconsideration, acknowledge receipt to the beneficiary or his representative, or the provider, depending upon who signed the request. A short form letter may be used, but it must advise the person that the case will be reviewed and that he will receive official notice of the results of the reconsideration. Page 2 of the form SSA-2649 should be enclosed. Include a copy of this acknowledgment in the reconsideration file.

Also take the following steps when a request for reconsideration is initiated by the provider: (1) If the beneficiary's liability was waived entirely, send him or his representative a letter notifying him of the receipt of the provider's reconsideration request and telling him that he is a party to the determination. Advise him that he may submit any additional information if he so desires and that a copy of the completed determination will be sent to him; (2) If the beneficiary's liability was not waived for any part of the stay, ask the beneficiary or his representative whether he intends to file for reconsideration. The letter should explain that even if the beneficiary does not actually file a reconsideration request, he still will be a party to the determination and therefore may submit any additional information he desires and will receive a copy of the determination.

Advise the beneficiary that if he does not respond and indicate his intent within 2 weeks of the date of your letter, you will proceed with the reconsideration based on the provider's request. (If the beneficiary decides to file for reconsideration and so advises you, the provider becomes a party.)

In some cases, the initial determination of noncoverage for an inpatient stay allows Medicare payment under the waiver of liability provision for part of the stay but finds either the beneficiary or the provider liable for the remainder. If the provider requests a reconsideration for the entire noncovered stay, the request should be accepted and treated as described in § 3781.5.

3782.5 Procedures for the Resident Intermediary and the Reconsideration Intermediary.—

A. Functions of the Resident Intermediary.--Resident intermediaries are those which do not normally process their own Part A reconsideration requests, instead, the reconsideration determination is made by a reconsideration intermediary.

1. All Cases Except Full Reversals.—A resident intermediary uses the following procedures except where it determines it can fully reverse its initial denial decision:

a. All the procedures from §§ 3781.1 through 3783.9 and § 3784.10 are to be followed, as needed;

b. After the resident intermediary has assured itself that complete documentation has been obtained, or if such documentation is not available, has furnished detailed written explanation to that effect, the entire reconsideration file containing the original documents is then forwarded to the reconsideration intermediary for processing and adjudication of the reconsideration request.

2. Full Reversal Cases.--Upon receipt of additional evidence during the reconsideration process from the treating physician, provider, or other source, the resident intermediary may find that a complete reversal (i.e., from a fully or partially unfavorable determination to a fully favorable determination) is in order. In such cases, the resident intermediary:

a. Completes all the items of the form SSA-2649;

b. Prepares and issues the reconsideration determination and notices to the beneficiary or to his representative using the format of the model letter shown in exhibit 4;

c. Notifies the provider of the reversal using the format of the model letter shown in exhibit 6; and

d. Completes Items 10 through 20 of page 4 of the form SSA-2649 and sends the entire file to the Reconsideration Branch, Medicare Bureau.

B. Functions of the Reconsideration Intermediary.--Reconsideration intermediaries are those intermediaries which have been designated to process reconsiderations on claims initially adjudicated by resident intermediaries. These intermediaries, when processing reconsiderations for resident intermediaries, use the procedures listed in §§ 3783.5, 3783.6, 3783.9 through 3784.8, and 3784.10 with the following additions:

1. The reconsideration intermediary sends a copy of the reconsideration determination and cover letter to the resident intermediary at the same time the beneficiary or the representative is notified.

2. In situations involving a full or partial reversal of the resident intermediary's initial decision, the reconsideration intermediary instructs the resident intermediary to inform the provider of this reconsideration reversal.

3782.6 Transferring and Dismissing Requests for Reconsideration Which Involve Partial or No Jurisdiction, More Than One Component, Stay, or Issue.--The intermediary may receive a form SSA-2649 which involves multiple issues or matters over which it has no jurisdiction. In both situations, it is necessary to update or correct the case control established by the Reconsideration Branch, and to insure that adjudicative action will be taken by the proper office(s). Such situations may involve emergency services (RO jurisdiction); entitlement issues (which must be referred to a social security office); services which must be adjudicated by another intermediary who serves a different provider (which must be referred to that intermediary); more than one stay at a provider (which requires separate SSA-2649's); more than one period of home health services (requiring separate SSA-2649's) or a Part B claim for services (which requires transfer of information to a Part B carrier).

A. Acknowledging Receipt of Form SSA-2649.--Where multiple issues are raised on a form SSA-2649, additional SSA-2649(s) must be completed and transferred or the original form must be transferred to the component(s) responsible for making determinations on such issue(s). Send an acknowledgment letter to the beneficiary or person who filed the request for reconsideration advising him of the transfer(s) and reasons for the transfers, and that he will receive a separate determination in each issue. Attach page 2 of the original form SSA-2649 if you receive it and all page 2's of any additional SSA-2649's that you complete (as indicated in B and C below) to the acknowledgment letter. Send a copy of the acknowledgment letter with the copies of the request for reconsideration and copies of any related material to the other components having jurisdiction. Where the receiving intermediary has no jurisdiction, is transferring the request, and is required to send the Reconsideration Branch one photocopy of each of pages 1 (effective June 19, 1978) and 4 of the SSA-2649(s) being transferred, include a copy of the acknowledgment letter and copies of any related material. (See § 3782.6C(1), (2), (3), and (4).)

B. Receiving Intermediary Has Partial Jurisdiction.--When you have verified all form SSA-2649 data, and there are issues involving other jurisdictions, keep and adjudicate the original form SSA-2649. This should consist of pages 1 and 4, since page 2 has been detached and given to the filer, and page 3 forwarded to the Reconsideration Branch to establish the case control. Also take the following actions.

1. Reconsideration Issues Involve Another Intermediary.--The intermediary that adjudicates the original form SSA-2649 prepares separate form SSA-2649's for each partial jurisdiction. Additional forms SSA-2649 need not be signed, provided the beneficiary's signature appears on the original SSA-2649, letter, or statement requesting reconsideration. Attach photocopies of the signed request to pages 1, 3, and 4 of all unsigned SSA-2649's and forward to the other intermediary with a copy of the letter to the filer acknowledging receipt of the request for reconsideration and advising him of its disposition. Detach page 2 of the additional form SSA-2649's and send to the filer with the acknowledgment letter. Upon receipt of the referred material, the second intermediary will immediately dispatch page 3 to the Reconsideration Branch to establish a new control.

2. Reconsideration Issues Involve HI Regional Office.--Prepare a separate form SSA-2649 for the HIRO where emergency services are involved. Forward pages 1 and 4 to the HIRO with a copy of the letter to the filer acknowledging receipt of the request for reconsideration. Detach page 2 and send it with the letter to the filer. Discard page 3 of the SSA-2649 since the Reconsideration Branch is not notified in this situation. Branch controls will be completed when the original form SSA-2649 is forwarded after all issues are settled.

3. Reconsideration Issues Involve Social Security Office.--Photocopy page 1 of the original form SSA-2649 you are retaining, and forward the copy to the appropriate social security office with a copy of the acknowledgment letter advising the filer of this referral and the reason for it. Also instruct the social security office to handle and resolve the issue being referred.

4. Reconsideration Issues Involve Part B Carrier.--Photocopy page 1 of the original form SSA-2649 you are retaining, and forward the copy to the appropriate Part B carrier with a copy of the acknowledgment letter. Also instruct the carrier to handle and resolve the issues being referred.

C. Receiving Intermediary Has No Jurisdiction.--When the intermediary has verified all form SSA-2649 data and established that it has no jurisdiction over any issue, the following actions should be taken:

1. Reconsideration Issues Involve Another Intermediary.--Forward the original form SSA-2649 (pages 1 and 4) to the intermediary having

jurisdiction over the issue under appeal with a copy of the acknowledgment letter advising the filer of the transfer of the request for reconsideration and reasons for it. Photocopy pages 1 and 4 of the form SSA-2649 being transferred and route it to the Reconsideration Branch with a copy of the acknowledgment letter and copies of any related material. On the photocopy, annotate Item 10 "WRONG JURISDICTION--SSA-2649 TRANSFER," and check the "DISMISSAL" box in Item 17. Prong-file the material in a properly labeled case folder, as with any completed case file, and route immediately to the Reconsideration Branch (use the address in § 3782.3.)

2. Reconsideration Issues Involve Regional Office.--Forward the original form SSA-2649 (page 1) to the regional office having jurisdiction over the emergency services issue under appeal. Attach a copy of the acknowledgment letter advising the filer of the transfer of the request for reconsideration and the reasons for it. Detach page 4 of the form SSA-2649 being transferred and route it and 1 photocopy of page 1 of the SSA-2649 to the Reconsideration Branch, Medicare Bureau, with a copy of the acknowledgment letter and copies of any related material. On page 4, annotate Item 10 "EMERGENCY SERVICES--FORM SSA-2649 TRANSFER TO RO," and check the "DISMISSAL" box in Item 17. Prong-file the material in a properly labeled case folder, as with any completed case file, and route the folder immediately to the Reconsideration Branch (use the address in § 3782.3).

3. Reconsideration Issues Involve Social Security Office.--Forward the original form SSA-2649 (page 1) to the social security office for processing of the entitlement issues under appeal. Attach a copy of the acknowledgment letter which advised the filer of the transfer of the request for reconsideration and the reasons for it. Detach page 4 of the form SSA-2649 being transferred and route it and 1 photocopy of page 1 of the SSA-2649 to the Reconsideration Branch with a copy of the acknowledgment letter and copies of any related material. On page 4 annotate Item 10, "ENTITLEMENT ISSUE--FORM SSA-2649 TRANSFER TO DO," and check the "DISMISSAL" box in Item 17. Prong-file the material in a properly labeled case folder, as with any completed case file, and route it immediately to the Reconsideration Branch (use the address in § 3782.3).

4. Reconsideration Issues Involve Part B Carrier.--Forward the original form SSA-2649 (page 1) to the appropriate Part B operation for processing of the Part B medical insurance claim issue under appeal. Attach a copy of the acknowledgment letter which advised the filer of the transfer of the request for reconsideration and the reasons for it. Detach page 4 of the form SSA-2649 being transferred and route it and 1 photocopy of page 1 of the SSA-2649 to the Reconsideration Branch with a copy of the acknowledgment letter and copies of any related material. On Page 4 annotate Item 10, "PART B ISSUE--FORM SSA-2649 TRANSFER TO CARRIER," and check the "DISMISSAL" box in Item 17. Prong-file the material in a properly labeled case folder, as with any completed case file, and route it immediately to the Reconsideration Branch (use the address in § 3782.3).

3782.7 Processing a Reconsideration Request That Was Filed Before Initial Determination Issued.--Occasionally a beneficiary may express dissatisfaction or request reconsideration before the intermediary receives the bill (e.g., the form SSA-1453), before the initial coverage determination is made, or before a disallowance letter is sent. This may occur if he feels strongly, either on the basis of his own opinion or notification by the provider and/or utilization review committee, that an adverse initial determination will be made. In such cases, the reconsideration intermediary processes the reconsideration concurrently with the initial determination in the same manner as any other properly filed request for reconsideration. The reconsideration cover letter is to be modified to show that the initial and reconsideration determinations have been combined as a result of the beneficiary's request.

3782.8 Dismissal of Reconsideration Request--No Amount in Controversy--Beneficiary Appeals After Initial Favorable Coverage Determination Is Made, But Before He Is Notified.--A request for reconsideration may be filed after you make a favorable initial coverage determination but before the beneficiary is notified that full payment has been made on his behalf. In such a case, send the beneficiary a letter explaining that because full payment has been made, no further action will be taken on the reconsideration. This letter of explanation must include a paragraph informing the beneficiary of his right to request a reconsideration if he is still dissatisfied with the coverage determination.

On the form SSA-2649, enter "No Amount in Controversy" in Item 10 and check the block "Dismissal" in Item 17 of page 4. The beneficiary's or representative's original request for reconsideration (if informal), a copy of any letter of explanation, and pages 1 and 4 of the form SSA-2649 should be prong-filed in a case folder, as in a completed case file, and the folder immediately routed to the Reconsideration Branch. This procedure permits cancellation of the central case control established with the original filing of the form SSA-2649.

3782.9 Withdrawal of Request for Reconsideration.--A request for reconsideration may be withdrawn by the person who filed the request, by his authorized representative, or by the provider. The request for withdrawal must be in writing, signed, and filed with the intermediary, HCFA, SSA, or the Railroad Retirement Board.

When you receive such a request either directly or from any of the above sources, send a letter to the beneficiary, representative, or provider acknowledging receipt of the withdrawal request, and advising that reconsideration action will be terminated. Check the block entitled "WITHDRAWAL" on page 4, Item 17 of the SSA-2649. The original withdrawal request, a copy of the intermediary's acknowledgment letter, and pages 1 and 4 of form SSA-2649 will be prong-filed in a case folder similar to a completed case file, and the folder immediately routed to the Reconsideration Branch. This will permit effective cancellation of the central case control established with the original filing of the HCFA-2649.

If a provider wishes to withdraw more than one request, one letter of acknowledgement to the provider is sufficient, so long as it includes the name and H.I. number of each beneficiary and the stays involved. A photocopy of the request and acknowledgement should be made a part of each individual's file.

3782.10 Notifying Provider or Beneficiary Where There Is a Withdrawal.--

A. If a provider was made a party to a request for reconsideration (see § 3781.4) which is subsequently withdrawn, it may then request reconsideration per § 3781.5. It is, therefore, necessary that you advise the provider of its appeal rights. This can be done via a short notice similar to the following:

> "This is to advise your facility that (beneficiary's name) has withdrawn his/her request for a reconsideration of the claim about which we advised you in our letter (exhibit 3) on (date).
>
> "Since the Medicare program has not assumed full liability for payment of the noncovered services rendered at your facility, you now have the right to file a request for reconsideration on behalf of your institution.
>
> "You may file such a request within 60 days of the date you receive this letter."

B. If a provider submits a request for withdrawal, prepare a short notice to the beneficiary or his representative similar to the following:

> "This is to advise you that (facility's name) has withdrawn its request for reconsideration of the claim about which we advised you in our letter (dated)." (See § 3782.4.)
>
> "Since the Medicare program has not assumed full liability for payment of the noncovered services you received at (facility's name), you now have the right to file a request for reconsideration. You may file such a request within 60 days of the date you receive this letter."

Documentation

3783. DOCUMENTING PART A RECONSIDFRATION REQUESTS

A. General.--The reconsideration of the amount of payment under Part A is based on (1) information in your possession at the time the initial determination was made; (2) any statements or information that may be submitted by the party or parties; and (3) the medical and other records that are found to be required during the course of the reconsideration. In cases where the evidence taken as a whole is not clear and convincing, a statement from the treating physician is to be obtained in which the points at issue are discussed. (See § 3784.1B.)

B. Documentation Sources.--Contact the provider to obtain any clarifying information needed if the beneficiary's allegation in the request for reconsideration raises an issue which has not been sufficiently documented.

The written request to the provider for additional information should mention that the photocopying services of the local social security office may be utilized if the provider lacks photocopy equipment. Social security offices have been instructed to honor requests for use of their photocopying facilities when a provider states that it does not have photocopy equipment.

There may be cases where contact with the physician involved is necessary. (See § 3783.3C.) There may also be cases in which contact with the beneficiary is necessary to obtain additional information. In most cases, contacts with the claimant and his physician can be by letter, although you may desire to use your own representative to secure information. In some instances, the social security office may be utilized where necessary to assist you to obtain additional information. Since the provider prepares the bill and submits the claim, the medical documentation supporting the claim is generally provided by the hospital, skilled nursing facility, or home health agency.

C. Complete Documentation.—Complete documentation is vital to the total claims process. It is the foundation upon which determinations are made and sustained. Inadequate documentation leads to improper and inconsistent determinations, delays in the claims process and reversals at the higher appellate levels. All written materials in the intermediary's possession at the time of initial claims action together with all written materials obtained during the course of the reconsideration should be included in the file sent to SSA after the reconsideration action has been completed. It is also important that the documents included in any file should be responsive to the claimant's allegation of covered services.

D. Medical Evidence.—In the vast majority of cases, the medical evidence required would generally include some diagnostic information, information relative to the condition of the patient, the therapeutic regimen, and any other information which discloses the medical needs of the patient and the services rendered to meet these needs. No complete listing can be devised covering all possibilities since the amount of documentation needed varies with each case.

It is imperative that the need for medical documentation be promptly recognized and requests be followed-up without delay. Follow-up requests may be made by telephone and, as a last resort, by personal contact. Memorandums of personal contacts or telephone calls should be included with the medical documentation if the information relates to the condition of the patient or the services furnished.

3783.1 Listing of Documentation Required for Reconsideration.—The listing below shows the minimum documentation which should be obtained before a reconsideration decision is made. Additional suggested items that may be warranted depending on the particular issue involved are also listed. Any evidence listed or any other evidence which the intermediary feels is necessary to make a review of its initial claims action should be requested by the intermediary. If any of the evidence deemed necessary is not in existence or is otherwise unobtainable, this should be fully documented and explained.

The documentation should include the following:

A. Documentation Pertaining to Inpatient Hospital Care.—

1. Report of Eligibility

2. Billing forms, including the last payment bill preceding a disallowed bill. In no-payment situations where the beneficiary is still an inpatient, the notice of admission form should be in the file. When a patient has not been discharged, the reconsideration case should be processed even though the no-payment bill has not yet been received. (See § 3783.9 for necessary documentation where the no-payment bill has not been received.)

3. Admission History and Physician Examination

4. Doctor's Orders and Progress Notes

5. Nurses' Notes, Medication, and Graphic Charts

6. Utilization Review Committee Reports, Minutes of Meetings, and Notices of Decisions. (If there are no utilization review committee documents, a statement should be included explaining their absence.)

7. Discharge Summary or cause of death where applicable.

B. Additional Records Pertaining to Inpatient Hospital Care.—The following additional records should also be included if pertinent to the issues in the case:

1. Special Studies and Reports (i.e., blood and urine analysis, radiology, pathology, etc.)

2. Emergency Service Sheets

3. Consultation Reports

4. Operative and Anesthetic Reports

5. Social Service Notes

6. Doctor's Certification and Recertification, if at issue

7. Therapy Treatment Plan and Treatment Record, if available.

C. Documentation Pertaining to Noncovered Dental Stays.—In addition to the documentation required under A and B above, evidence establishing the existence, severity, and relationship of a non-dental impairment alleged to require proper medical management, control, or treatment must be contained in the file. This may involve obtaining a record of prior treatment of the non-dental impairment as well as assuring that records of all treatment for such an impairment during the stay in question are included in the file. In writing the determination, the issue of relationship between the non-dental condition and the services provided must be substantively addressed.

D. Documentation Pertaining to Skilled Nursing Facility Care.—

1. Report of Eligibility

2. Billing Forms (see Item A2)

3. Hospital Discharge Summary, Transfer Evaluation Sheet, or Skilled Nursing Facility (SNF) Admission Record

4. Doctor's Orders and Progress Notes

5. Nurses' Notes, Medication, and Graphic Charts

6. Utilization Review Committee Reports, Minutes of Meetings, and Notices of Decisions

7. Medical Information Questionnaire, where applicable.

E. Additional Records Pertaining to SNF Care.—The following additional records should also be included if pertinent to the specific issue in the case under reconsideration:

1. Special Studies and Reports (i.e., blood and urine analysis, radiology, pathology, etc.)

2. Consultation Reports

3. Social Service Notes

4. Disposition Transfer Sheet

5. Discharge Summary or cause of death where applicable

6. Therapy Treatment Plan and Treatment Record

7. Doctor's Certification and Recertification, if certification is at issue.

F. Documentation Pertaining to Home Health Services Care.—

1. Report of Eligibility

2. Billing Forms (see Item A2)

3. Plan of Treatment

4. Nursing, Physical Therapy, or Speech Therapy Notes

5. HHA Referral Form

6. Doctor's Orders.

3783.2 Documentation Pertaining to Private Room Issue.—In addition to the documentation itemized above under the hospital or SNF level of care, if the beneficiary or his representative protests a charge for a private room on the grounds that the privacy was medically necessary, the following additional evidence must be in file: (Also see § 3101.1B and C.) A statement from the admitting officer of the facility concerning the circumstances with regard to the private accommodations furnished. The evidence in file should also indicate whether the doctor's order for the private room (either oral or written) existed at the time the patient was admitted to the private room. If the doctor did not order the private room at the time of admission, an explanation should be secured from the facility or from the physician.

3783.3 Beneficiary Waiver of Liability Documentation.—In cases which fall under § 3781.3L (items or services excluded from coverage because they constitute custodial care or are not reasonable and necessary) the original coverage determination must be evaluated prior to a consideration of the liability question. If after this evaluation it is found that the items or services are not covered because they were not reasonable and necessary or were custodial in nature, the following documentation is also to be obtained if it is not in the file:

A. From the Provider.--

1. A dated copy of any written communication which the provider may have furnished the beneficiary or his representative.

2. A dated copy of the URC's notice to the beneficiary, if applicable.

B. From the Intermediary's Own Files.--

1. Where available, evidence that the intermediary sent the beneficiary a denial notice in connection with a prior claim for the same noncovered service as currently under reconsideration,

2. Indication of whether or not the provider meets the criteria for presumption of waiver.

3. If not, information indicating whether or not a nonwaiver provider meets the denial criterion.

C. From Other Sources (If Applicable).--

1. Evidence from the beneficiary himself if he or she states that pertinent evidence is in his possession or the facts of the case indicate that the beneficiary has such evidence.

2. Evidence from the beneficiary's attending physician if the facts of the case warrant such a contact.

3783.4 Provider Waiver of Liability Documentation.--The intermediary should document the file:

A. Indicating whether or not the provider has met the criteria for presumption of waiver.

B. Regardless of whether or not it meets the presumption criteria, whether it is clear and obvious that the provider should have known that the services were not covered, that is, the intermediary advised the provider in a previous case that payment for the same type of services or items could not be made. (If this is the case, the reconsideration file is to be documented with a dated copy of the prior notice to the provider.)

C. Include evidence of notification to the provider, (i.e., telephone and/or written contacts) of coverage or noncoverage of the services rendered.

3783.5 Obtaining Evidence from Providers Serviced by Other Intermediaries.--To fully document the reconsideration file, it is sometimes necessary for one intermediary (the requesting intermediary) to obtain evidence from a provider serviced by another intermediary (the servicing intermediary). For example, in a skilled nursing facility case, a hospital discharge summary is needed in order to adjudicate the reconsideration action, but a different intermediary (the servicing intermediary) services the hospital. In such instances, the requesting intermediary should contact the servicing intermediary in writing. The request should state the beneficiary's name, the health insurance claim number, the provider name, the dates of the stay, and the nature of the evidence required.

The servicing intermediary should process the request as expeditiously as possible. If the requesting intermediary has not received a reply within 21 days from the date of mailing the request, it will send a copy of the request to its regional office for assistance. That RO will contact the servicing intermediary or, if the servicing intermediary is not in its region, it will contact the servicing intermediary's regional office for assistance. If after an additional 15 days (20 days when another region is involved) the requesting intermediary has still not received a reply from the servicing intermediary or a status report from the RO, the requesting intermediary should follow-up by telephoning its RO.

Those intermediaries, which have found that it is more expeditious to have the provider which submitted the original claim contact the other provider in question, may continue to do so.

3783.6 Additional Documentation--Follow-up Procedures.--It is imperative that the need for medical documentation be promptly recognized and requests be followed up without delay. Except for unusual circumstances, no more than 14 days should be allowed to elapse before a follow-up request by mail or by telephone. If these follow-ups are unsuccessful, a personal or telephone contact by an intermediary provider relations specialist is to be undertaken no later than 14 days after the last follow-up.

3783.7 Prohibition Against Marking on Claim Files.--Intermediary personnel must not in any way mark, underline, write on , alter, obliterate, or otherwise deface any record, document, letter, or other paper received in support of a claim for health insurance benefits, except see § 3605.4 for situations in which corrections on billing forms may be made. The use of coding entries is also acceptable if they do not obliterate other information on the bill. Also, the date stamping required by & 3783.8 is an acceptable marking on a claim file. Such claims materials are subject to both the administrative appellate process within SSA and to judicial review; and to the extent that documents are underlined or editorial comments are added, the claims adjudication process is compromised.

The provisions with regard to the improper marking and the obtaining of legible evidentiary documents must be applied beginning with the initial claim and not deviated from throughout the entire claims process.

3783.8 Assembling the Reconsideration File.--The reconsideration file is assembled by the intermediary which is responsible for making the reconsideration determination. All reconsideration requests (formal or informal) are to be placed in manila folders as soon as possible. Each folder will bear the beneficiary's HI claim number (the numeric and suffix letter) on the top line of the folder tab in the upper right-hand corner and the beneficiary's last name, first name, and middle initial, if any, is to be shown directly beneath the number. Example:

H.I. 300-00-7777A
Doe, Mary A.

All claims material pertaining to the services in question, including the envelope in which the request for reconsideration was received in cases where the postmark would have a bearing on the timeliness for filing an appeal, will be prong-filed in this folder in chronological order by type of evidence (see below). The file should include only the original documents whenever possible and should not include any duplicate papers.

The date of receipt must be stamped on each document or category of documents received at the initial claims level and at the reconsideration level. Unless the format of a particular document or the intermediary's claim processing system dictates otherwise, the date of receipt is to be stamped in the upper right-hand corner of each document or category of documents.

All papers are to be grouped by individual categories and arranged in chronological order within each category, building the file from the oldest piece of a particular category on the bottom and the most recent on the top.

The major categories are as follows (listed in order--category 1 would appear on the bottom of all other documents):

1. All billing forms or summary in lieu thereof (see § 3783.9)
2. Report of Eligibility
3. Doctor's orders
4. Progress notes
5. Nurses' notes
6. Medication charts
7. Laboratory reports and other studies
8. Therapy treatment plan and treatment record

9. Utilization Review Committee reports

10. In beneficiary waiver cases

    a. Provider and/or URC notices to the beneficiary

    b. Copies of prior intermediary notices to the beneficiary, if available

11. In provider waiver cases--documentation that the provider was previously notified that similar services were not covered, if applicable

12. Other evidence, such as medical information forms, questionnaires

13. Intermediary denial notices

14. The request for reconsideration (page 1 of Form SSA-2649)

15. Copy of the reconsideration acknowledgment letter

16. Request(s) for further evidence

17. Intermediary physician evaluation and worksheet

18. Reconsideration determination and cover letters

19. Page 4 of Form SSA-2649

3783.9 Inclusion of Billing Forms in File.--Except for no-payment bill situations in which the beneficiary is still confined, the reconsideration file should contain all appropriate billing forms. If a completed bill is not available (e.g., the initial determination was based on the admission notice per § 3719.2) the intermediary will prepare a summary data sheet listing the charges for the various services rendered, as well as any applicable deductible and coinsurance amounts. This information can be obtained from a copy of the provider's bill to the beneficiary (if it was attached to the reconsideration request) or, if the approximate length of stay is known, a "not-less-than" statement can be based on the intermediary's knowledge of the provider's charges per day (visit).

If it is not possible to ascertain from the file that the amount in question (i.e., the amount charged the beneficiary for the items and services received less the deductible and coinsurance amounts applicable) comprises at least $100, the intermediary should contact the provider to obtain this information and attach it to page 4 of Form SSA-2649, Request for Reconsideration of Part A Health Insurance Benefits. If the beneficiary subsequently requests a hearing, this will facilitate the administrative law judge's determination as to whether the monetary requirements necessary for a hearing are present (i.e., whether $100 or more is in controversy).

Making the Reconsideration Determination

3784. EVALUATING THE EVIDENCE AND MAKING THE RECONSIDERATION DETERMINATION

3784.1 General.--Once the evidence as discussed in § 3783 has been obtained, the reconsideration reviewer will make a new, independent, and thorough evaluation of the evidence and prior findings. To insure such a review, the reviewer must be free from any bias in favor of the initial denial decision. On reconsideration, the reviewer is not to rely on any screening assumptions, presumptions, or tolerance rules. Rather, the evidence in file must be sufficient to convince the reviewer and support the finding of the fact that the services were or were not covered under the Medicare law. The reconsideration process, therefore, is not a mechanical application of the same screening guides and tolerance rules as were used in arriving at the initial determination, but all the facts pertaining to the claim must be considered as a whole in order to reach the reconsideration decision. Whenever possible, the reviewer should include original evidence of all material since the reconsideration file represents the entire bureau position.

A. Obtaining an Independent Review.--If possible, the intermediary should maintain a separate and distinct unit to process reconsiderations. This processing unit should not have the same supervisor as the unit processing initial claims. If the size of the reconsideration workload does not warrant the establishment of such a separate unit, the intermediary may use experienced claims reviewers who have had no part in the initial adjudication of the particular claim for which the reconsideration request has been filed. The reconsideration reviewer must be given complete independence to revise the initial determination should the review warrant this action.

If the intermediary has more than one physician-consultant involved in the Medicare claims process and the case is one that must be reviewed by a physician under the guidelines in paragraph C below, a different physician-consultant than the one involved at the initial processing level should review the claim. If the intermediary has the services of only one physician-consultant, the case may be referred to him or her again for expert medical opinion evidence, or to a physician from another program administered by the intermediary, or to a peer review panel. This evidence is then evaluated independently by the reconsideration reviewer together with all the other evidence in the case in order to make the reconsideration determination.

B. Consulting-Physician Review.--The following types of medical issue cases are to be sent to the intermediary's consulting physician for expert medical opinion evidence:

1. All hospital inpatient stay cases in which the intermediary's reconsideration reviewer feels that the full denial of the entire hospital stay should be affirmed, and

2. All partial denial hospital cases and all skilled nursing facility cases in which the amount in controversy (see § 3785.1A) is over $1,000, and

3. If the intermediary's reconsideration reviewer, after examining a reconsideration case which is complete according to the instructions above, has a question concerning the medical facts as presented. If necessary, the consulting physician may seek other expert medical opinion, e.g., from a peer review group.

A case falling into category 1 or 2 above need not be reviewed again by a physician-consultant if during the initial adjudication it was reviewed by a physician-consultant, a complete discussion of the medical facts and a convincing rationale is in file, and no additional medical evidence has been obtained. If, however, the attending physician or the provider has submitted new information, the case is to be reviewed again by a physician-consultant where the criteria in 1 through 3 above apply.

Only those denials which require medical judgment should be referred to a consulting physician. Non-judgmental issues are those based on technical or statutory provisions, such as a qualifying hospital stay and extent of available benefits, and those exclusions contained in the Coverage Issues Appendix.

C. Processing Additional Evidence Submitted by the Physician.-- Cases where the beneficiary's attending physician has submitted additional evidence (e.g., a statement giving his medical opinion or additional clinical findings) should be processed in accordance with the following guidelines:

1. Where the attending physician has submitted evidence other than the provider's medical record supporting a covered level of care, and this information is consistent with the body of evidence obtained from the provider and any other sources, the initial denial should be reversed;

2. If the physician's statement that care was "covered" or was "skilled nursing care" is not supported by the medical facts described in the rest of the evidence obtained, and that evidence established that the services were not covered under the health insurance program, the initial denial decision is to be affirmed;

3. Where the physician submits evidence which is consistent with the preponderance of the evidence obtained from the provider, although there may be some isolated facts, which in the absence of the remaining evidence would support a denial decision (e.g., the nurses' notes indicate that the patient was able to sit up, the doctor's orders show: "may soon be ready for discharge," etc.), the physician's evidence should be given sufficient weight to overcome the reviewer's doubts regarding the reimbursement for the services;

4. If the attending physician has submitted a statement but in light of the other evidence a conflict exists so that the reconsideration reviewer is unable to draw a conclusion regarding the coverage of the services, the attending physician should be requested to clarify the matter. If the physician does not respond, the provider may be able to furnish clarifying information.

D. Documentation Resulting from Physician's Review.-- Upon completion of the intermediary's consulting physician's review, each case should contain the following documentation; (a) a summary of the pertinent facts obtained from the medical record (this may be written by the nonmedical reconsideration reviewer, a nurse or other medical reviewer or the consulting physician); (b) a statement of the medical significance of these facts; and most important (c) a convincing rationale in which the reasons for the physician's conclusion are explained. (These items may be prepared by a nonmedical person in consultation with the physician but the rationale must be signed by the latter.) A mere statement of the consulting physician's conclusion pertaining to the coverage issue adds very little to the evidence in the case.

No reconsideration case should be affirmed or reversed where an unresolved conflict of evidence exists (except as outlined in C3 above) and where evidence essential to adjudication is available but has not been submitted. Furthermore, in cases in which, after careful and reasonably complete documentation, the question of coverage is still in doubt, the doubt should be resolved in favor of the beneficiary.

NOTE: In review of claims no comments, underlinings, or marks of any kind should be placed on evidence since the documents in file may ultimately become exhibits before an administrative law judge or a part of the record in court. (See § 3783.7.)

3784.2 Evaluating the Evidence.-- As indicated above, the reconsideration reviewer will examine the evidence with an open mind. How much weight the reviewer gives to one piece of evidence as compared to another depends on its factual content relative to the primary issue. (For example, the treating physician's opinion that the beneficiary needed a covered level of care, while given considerable weight, is not conclusive in the face of the other evidence to the contrary, e.g., nurses' notes showing that the beneficiary only needed assistance in meeting the activities of daily living.) What the reviewer must look for is evidence and rationale that is clear and convincing. Therefore, there should be no reason to doubt the truth of a fact or set of facts.

If the reviewer is not convinced, or if he believes that additional evidence is needed to establish the facts, the additional evidence is to be requested. Such evidence might be obtained by soliciting the attending physician to answer specific questions in writing. Although reasonable inferences can be drawn in the review of the case, the inference should not extend to the point where presumptions and speculations are used for the basis of the decision rather than documentary evidence. The reviewer, therefore, should not affirm an initial denial decision where an unresolved conflict of evidence exists or where any evidence essential to adjudication has not been submitted or secured. Where, after careful and reasonably complete documentation, the question of coverage is still in doubt, the doubt should be resolved in favor of the beneficiary.

A. Consultation With HCFA.—In those reconsideration cases in which a question of law or policy arises which is not provided for in current instructions, the intermediary may request advice from HCFA. Direct such requests to the appropriate RO. In very complex cases, forward the reconsideration file with the intermediary inquiry to facilitate study of the situation.

B. Correctness of Initial Determination Is Questioned.—On occasion, an independent review of an initially denied portion of a stay may raise questions in the mind of the intermediary's reconsideration examiner as to the correctness of the initial payment decision. It was not intended that the appeals procedure be used as a vehicle to audit favorable initial determinations to the detriment of the party which is appealing the denied portion of the claim. Also, since the beneficiary and the provider would have initially been notified that part of the stay and services were covered under the Medicare program, a subsequent reversal of the initial favorable action could generate serious problems affecting not only the beneficiary and the provider, but the intermediary and HCFA as well.

A reconsideration determination more adverse to the party than the initial determination might cause the party to feel that he has been penalized for requesting that the claim be reconsidered. Very sensitive questions could be raised as to why such corrections are made only at the time the party is appealing the denied part of the claim. In addition, negative conclusions regarding the integrity of the initial adjudicative process might also be drawn. In light of these possibilities, every effort must be undertaken to dispel such impressions.

3784.3 Review Prior to Reversal of Initial Payment Determination.-- To assure that the closest professional attention is given to reconsideration cases which apppear to warrant a reversal of the initial payment decision, the following multi-level review procedure is to be made a part of the intermediary claim processing operation before the reconsideration determination is completed.

- o Review the file carefully to determine whether there was any evidence that supported the decision with respect to the prior allowed services. The intermediary's reconsideration reviewer should use the adjudication principles which existed at the time the initial decision was made.

- o If the reviewer cannot justify the initial payment decision in whole or in part and if the question at issue is a medical one, refer it to the intermediary's consulting physician for his expert opinion on whether the initially approved stay was, in fact, covered.

- o If the physician also finds that the initial payment decision should be reversed, refer it to the Medicare Coordinator for his review and written evaluation.

- o When the reviewer is questioning cases involving nonmedical issues and believes that there is no basis for the initial payment, refer the case to the Medicare Coordinator as in the preceding case.

- o Where a case has been reviewed as indicated above, and despite careful documentation the question of coverage is still in doubt, the doubt should be resolved in favor of the original payment decision.

3784.4 Preparing the Reconsideration Determination.-- The determination is to be written using guide determination outlines and standard paragraphs furnished by HCFA whenever possible. Individual case circumstances may warrant certain adaptations in the standard material and you may exercise judgment in such cases.

A. Contents of the Determination.-- The determination should basically include:

- o A statement of the jurisdictional factors--dates on which both provider and intermediary notices relating to the initial determination were provided the beneficiary or his representative (see Exhibit 5 for an illustration), reason for the denial, date of the request for reconsideration;
- o Basis for the reconsideration request;
- o The issue involved;

- A brief nontechnical statement of the applicable provisions of the law and regulations. (If an attorney or other professional person is acting on the party's behalf, include specific references to the Act as indicated in the parenthetical phrases in the guide language.);

- A statement of the facts and evidence as presented (place specific emphasis on the pertinent medical evidence in file which is to be related in chronological order);

- The rationale (see subsection B.);

- Conclusions based on findings of fact and applicable law and regulations;

- In cases involving a full or partial denial on the basis of not medically necessary care or custodial care, a brief nontechnical explanation of the waiver of liability provision and its applicability to the case (see exhibit 5 for an illustration of this);

- Liability determination. In making the required determinations on the extent and assignment of the liability of both the beneficiary and provider at the reconsideration level, it may be necessary to review and utilize the initial denial notice preparation procedures including those on indemnification actions described in § 3443, where assignments of liability were not made initially or are being modified or revised; and

- Where applicable, consider the intermediary's determination whether a provider is without fault with respect to an overpayment. (See §3708.)

B. Rationale.-- Explain, based on the law, regulations, guidelines, and the facts of the case, the reasons for the decision reached. Describe the weight attributed to those items in the medical evidence determined to be significant in arriving at the decision. Reconcile any significant inconsistency or conflict. Be fully responsive to the beneficiary's and, if applicable, the attending physician's allegations.

C. Sensitive Issues and Use of Lay Terminology.-- Omit any information that may be disturbing or embarrassing to the beneficiary or to the source of the medical information, as well as any references that might interfere with medical management or impair the doctor-patient relationship. For example, if the evidence shows that the beneficiary has a malignancy, and there is no indication that the beneficiary is aware of his affliction, do not make specific reference to it.

Also, the diagnosis and other medical information included in the reconsideration determination should be written in lay terms, e.g., concussion, broken hip, arthritis, heart condition. Do not use diagnoses such as hypochloremia with alkalosis, focal atelectosis in both lungs. A reconsideration determination addressed to the beneficiary's attorney or other professional representative (as distinguished from a familial representative) can be more explicit as far as the diagnosis is concerned.

3784.5 Completing the Reconsideration Determination.--

NOTE: A reconsideration decision that noncovered care will be totally or partially paid for under the waiver of liability provision requires a full determination and cover letter since the coverage decision remains unfavorable.

A. Signature.-- The reconsideration determination should bear the signature of the supervisor of the person writing it (use exhibit 5) while the cover letter and the statutory exclusion determinations should bear the signature of the Medicare Coordinator (or the equivalent). (See exhibit 10.) The appropriate title is to be shown under the person's name.

B. Copies.-- Prepare at least three copies of the determination. (If prepared by a reconsideration intermediary for a resident intermediary, send one of the copies to the latter.) Send the original to the party which initiated the reconsideration request, place one in the case file, and keep one copy. Additional copies are required if there is another party involved.

C. The Reconsideration Determination Cover Letter.-- Prepare the reconsideration determination cover letter on standard Medicare letterhead. The name of the resident intermediary appears at the upper right-hand corner of the letter. (See exhibit 10.) Address the letter to the party which initiated the request. Send a copy of the cover letter and determination to any other party or the authorized representative. The cover letter should bear the signature of the resident intermediary's Medicare Coordinator (or the equivalent). All cover letters should include a statement referring post determination questions and beneficiary correspondence to the resident intermediary. (See exhibits 4 and 10.)

Prepare at least three copies of the cover letter (four if prepared by the reconsideration intermediary). The file copy of the letter must be identical to the original sent to the party including the date shown on the upper right-hand side. Attach the cover letter to the reconsideration determination and distribute as shown in subsection B. In partial reversal cases, modify the language in the cover letter accordingly.

3784.6 Full Reversal Determinations.-- In cases where the resident intermediary or the reconsideration intermediary determines that the initial determination should be completely reversed, that is, from a fully or partially unfavorable determination to a fully favorable one, the reconsideration determination and cover letter may be combined in one document. It need only give a brief statement of the facts, the applicable legal provisions, and the rationale used in making the determination (see exhibit 4).

Should you find a long form reconsideration determination necessary and appropriate in fully reversing the initial decisions of coverage and liability in an individual case, use a cover transmittal letter similar to exhibit 4. Instead of including facts and rationale as indicated for a single short form document, the cover letter should include the opening and closing paragraphs as shown in exhibit 4 with an inserted statement similar to "The revised determination is enclosed."

3784.7 Notice of Further Appeal Rights.—

A. Beneficiary.—The cover letter to the reconsideration determination (exhibit 10) notifies the beneficiary that if he believes that the determination is not correct and the amount of benefits in question is $100 or more, he has a right to a hearing. If a hearing is desired, it must be requested within 60 days of the date of receipt of the reconsideration notice. If you receive any post reconsideration determination correspondence requiring a reply, the reply must include a statement informing the beneficiary of his right to a hearing, the date of the original reconsideration determination notice, and an appropriate explanation where the time limit has expired or is nearing expiration. (See § 3781.9.)

B. Provider in Waiver of Liability Cases.—A provider dissatisfied with the reconsideration determination made pursuant to its request, or to which it is a party, has the same right to a hearing as the beneficiary.

If the provider is a party to the reconsideration (i.e., the beneficiary has filed for reconsideration) and the reconsideration determination provides that Medicare payment will be made for the entire stay under the waiver of liability provision, the provider has the right to further appeal.

3784.8 Instructions for Completing Form HCFA-352 Part A Reconsideration Input Record (see exhibit 1).—The following instructions pertain to the preparation of this form. The information supplied will be processed by computer and is used by HCFA for statistical purposes. Since it is imperative that the coded information be as accurate as possible, no single document should be used solely without cross verification of data. Upon completion of a reconsideration determination or revised reconsideration determination, complete this form, the reconsideration intermediary makes a copy for the claim file and mails the original immediately to :

Health Care Financing Administration
Reconsideration Evaluation Branch, BPO
P.O. Box 770
Baltimore, MD 21203

NOTE: The preparation of the HCFA-352 supersedes the completion of page 4 of the HCFA-2649. A future revision to the HCFA-2649 will reduce it to a 2-part form with the elimination of pages 3 and 4.

Complete the following data elements. They are left justified, and do not use embedded blanks or special characters unless specifically stated. Also, code all alphabetical letters as CAPITAL letters.

1. INITIAL OR REVISION RECORD.—Check the appropriate block.

2. RECORD IDENTIFIER.—This field is pre-printed and constant.

3. HEALTH INSURANCE CLAIM NUMBER.—These positions are alpha-numeric and contain a maximum of 12 (including the suffix) positions. Once this number is entered into the system it cannot be changed by submitting a revision form. Examples of HI Claim Numbers are:

218401964A
WD234565983
218401987W7
MA123456

NOTE: In situations involving another reconsideration determination with the same HI Claim Number and Admission/HHA Date, an override "A" must be placed in the 12th position of the HI Claim Number field to allow acceptance into the system. Any subsequent reconsideration determinations must consecutively show the override letters "B" through "I".

4. ADMISSION/HOME HEALTH AGENCY DATE.—These positions are numeric and contain a 6-position valid date—MMDDYY. On Home Health Agency (HHA) cases enter the first day of the period in question. The Admission/HHA Date must be earlier than the current date. Once this date is entered into the system, it cannot be changed by submitting a revision form.

5. SURNAME.—Enter the last name of the beneficiary (up to 12 characters) who received the services.

6. GIVEN NAME.—Enter the first name of the beneficiary (up to 5 characters) who received the services.

7. AMOUNT IN CONTROVERSY.—This field consists of one numeric character. Code it based on the amount in controversy following the reconsideration dertermination, since its purpose is to show whether further appeal is possible.

8. PROVIDER NUMBER.—Enter the providers assigned 6-position number. If the case coded involves a provider which does not participate in the Medicare program, show 990999 (hospital), 995999 Skilled Nursing Facility (SNF), and 997999 (HHA). However, the identification numbers assigned to Federal and emergency-only facilities consist of 6-position alpha-numeric numbers, e.g., 21521F or 21001E. The 3rd numeric position always determines the type of facility:

0, 1, 2, 3, 4 = Hospital
5, 6 = (SNF)
7 = (HHA)

9. REQUESTED BY.—This field is blank or contains a one numeric character based on who filed the request for hearing.

10. RECONSIDERATION FILED.—These positions are numeric and contain a 6-position valid date—MMDDYY. Code the date the claim is received by the Social Security office. If a Social Security office date stamp is not available, or if not filed at a Social Security office use the date received by the intermediary. This date MUST be later than the Admission/HHA date.

11. RESIDENT INTERMEDIARY.—This field is completed by the reconsideration intermediary in cases where they are servicing a resident plan. Otherwise, it is blank.

12. RESIDENT INTERMEDIARY RECEIPT DATE.—This field is only completed when the resident intermediary number is present and it contains a 6-position valid date—MMDDYY. It can either be equal to or greater than the reconsideration filed date.

13. RECONSIDERATION INTERMEDIARY.—This field contains the 5-position number assigned to the plan responsible for processing the Reconsideration Determination.

14. RECONSIDERATION INTERMEDIARY RECEIPT DATE.—Complete this field always with a date that is equal to or later than the Reconsideration Filed Date and the Resident Intermediary Receipt Date (if present).

15. RECONSIDERATION COMPLETED DATE.—These positions are numeric and contain a 6-position valid date—MMDDYY. Enter the date you completed your final action and mailed the reconsideration determination. This date MUST be equal or later than the reconsideration intermdiary receipt date.

16. RECONSIDERATION DECISION.—This item consists of one numeric character which describes the determination made on the reconsideration.

NOTE: A waiver of liability determination (section 1879 of the Act), either favorable or unfavorable, is made by the intermediary at the initial processing level for those cases involving custodial services or services not medically necessary or reasonable. If the initial determination was unfavorable but on reconsideration a favorable decision is made permitting payment under the waiver of liability provision, the case should be considered a reversal or partial reversal (depending on number of days reversed). It is considered a reversal or partial reversal notwithstanding the fact that the initial coverage denial is reaffirmed. In those cases where only the beneficiary's liability is waived (i.e., the provider is still found liable) and no program payment can be made under the waiver of liability provision, the case is still counted as a reversal or partial reversal.

17. ISSUE.—This item consists of one numeric character which reflects the primary issue involved. Often, more than one issue is in question on the same period of services or provider stay. However, enter only the primary issue.

18 GOOD CAUSE.—Enter a 1 in this position if as a result of the reconsideration determination the facts show that "good cause" was developed and allowed. Leave this position blank if there is no indication that "good cause" is an issue.

19. PSRO INVOLVEMENT.—Enter a 1 in this position if the initial determination reflects PSRO involvement. Otherwise, this position is blank.

20. WAIVER OF LIABILITY.—Enter a 1 in this position if the file indicates the intermediary has approved and is making payment for services under the waiver of liability provision at the reconsideration processing level. Leave this position blank if there is no indication that waiver of liability was involved in the reconsideration decision.

21. CONGRESSIONAL INTEREST.—Enter a 1 in this position if there is any evidence of Congressional interest or involvement in the claim at the reconsideration level. Otherwise, this position is blank.

PART A RECONSIDERATION INPUT RECORD

☐ INITIAL ☐ REVISION

RECORD IDENTIFIER
A A

H I CLAIM NUMBER
☐☐☐☐☐☐☐☐☐☐☐☐

ADMISSION/HHA DATE (MMDDYY)
☐☐☐☐☐☐

SURNAME
☐☐☐☐☐☐☐☐☐☐☐☐

GIVEN NAME
☐☐☐☐☐

AMT. IN CONTROVERSY
☐ 1. UNDER $100
2. $100 to $1000
3. OVER $1000

PROVIDER NUMBER
☐☐☐☐☐☐

REQUESTED BY
☐ BLANK BENEFICIARY
1. ATTORNEY 3. PROVIDER
2. RELATIVE 4. OTHER

RECON. FILED (MMDDYY)
☐☐☐☐☐☐

RESIDENT INTER.
☐☐☐☐☐

RESIDENT INTER. RECEIPT DATE - (MMDDYY)
☐☐☐☐☐☐

RECON. INTER.
☐☐☐☐☐

RECON. INTER. RECEIPT DATE - (MMDDYY)
☐☐☐☐☐☐

RECON. COMPLETED DATE - (MMDDYY)
☐☐☐☐☐☐

RECON. DECISION
☐ 1. AFF 3. P/R 5. DIS
2. REV 4. WD

ISSUE
☐ 1. MEDICAL
2. TECHNICAL

GOOD CAUSE
☐ 1. YES

PSRO
☐ 1. YES

WAIVER OF LIABILITY
☐ 1. YES

CONGRESSIONAL INTEREST
☐ 1. YES

FOR RECONSIDERATION EVALUATION BRANCH USE ONLY

DATE REC'D IN REB (MMDDYY)
☐☐☐☐☐☐

REVIEW
☐ 1. YES

REVIEW SELECTED DATE (MMDDYY)
☐☐☐☐☐☐

REVIEWER
☐☐☐☐☐☐

CORRECTION
☐ BLANK - GOOD
2 - BAD

☐☐ CODING CLERK

☐☐ DATA ENTRY CLERK

FORM HCFA - 352 (2-82) (FORMERLY HCFA - 4530)

3784.9 Preventing Duplicate Payment in Reversal Cases.—Prior to making payment to a provider of services in full or partial reversal cases, ascertain in each case whether the provider has been reimbursed for the previously denied services from another source and, if so, withhold the Medicare reimbursement until the provider has assured, in writing, that the prior payment has been refunded. (See § 3401.)

3784.10 Reconsideration Follow-Ups.—A beneficiary or his representative may contact a Social Security office for the status of a reconsideration request. When 90 days or more have elapsed since the date the reconsideration action request was filed, that office prepares a Form HCFA-2442, Part A Reconsideration Status, and forwards it to the intermediary making the initial determination. (See exhibit 9.) Enter the expected completion date for processing the reconsideration. If it is not possible to furnish the date, give an explanation for the delay. When a resident intermediary receives a request for the determination status and the reconsideration case file has been forwarded to the reconsideration intermediary for processing and adjudication, call the reconsideration intermediary for status. The resident intermediary completes the form HCFA-2442 and returns it to the Social Security office. Where the reconsideration has been completed and the case file has been sent to the reconsideration intermediary, show this on the form HCFA-2442. Include the date the file was sent and return the form HCFA-2442.

3784.11 Correspondence Received Concerning a Reconsideration Request.—

A. Inquiry Received While Reconsideration Is Pending.—Prepare a reply and include the original incoming correspondence and a copy of the reply in the reconsideration folder. Ordinarily reconsideration intermediaries do not receive correspondence on a case being processed for a resident intermediary. However, if they do, prepare a reply on behalf of the resident intermediary, and include the original incoming correspondence and a copy of the reply in the case folder. Send copies to the resident intermediary.

B. Inquiry Received After the Reconsideration Case Has Been Completed.—If an inquiry is received and the reconsideration case has been completed, route the original inquiry to the intermediary which processed the reconsideration request.

3784.12 Effect of a Reconsideration Determination and Effectuation.—A reconsideration determination is a final and binding determination of the Secretary unless it is reopened and revised, or unless a hearing is requested by a party entitled to do so. Where a reconsideration determination revises an initial determination, effectuate the determination at the earliest possible moment. Do not delay the effectuation because a hearing has been requested.

3784.15 STANDARD RECONSIDERATION DETERMINATION GUIDE LANGUAGE.—The section contains standard Reconsideration Determination guide language similar in many respects to the standard initial denial language except for the listing of statutory citations. Additionally, it contains an outline of the proper paragraphs and sequence for use, determination letters for use in technical denials, cover letters, and a Reconsideration status form.

It is recognized that the material, as guide language and model cover letters, are subject to some modification by the respective intermediaries without HCFA approval, if necessary to properly address specific issues and/or special circumstances which may arise with respect to individual case determinations.

(STANDARD PARAGRAPHS TO BE USED IN SEQUENCE)
AS SHOWN BELOW
(IF ADDITIONAL OR OPTIONAL GUIDE LANGUAGE PARAGRAPHS ARE USED,
INSERT AS NECESSARY IN THE STANDARD SEQUENCE)

GENERAL HOSPITAL SERVICES
STANDARD PARAGRAPHS: 1, 2, 3, 17 - 21

REHABILITATION HOSPITAL SERVICES
STANDARD PARAGRAPHS: 1, 2, 3, 7, 17 - 21

TUBERCULOSIS HOSPITAL SERVICES
STANDARD PARAGRAPHS: 1, 2, 4, 5, 17 - 21

PSYCHIATRIC HOSPITAL SERVICES
STANDARD PARAGRAPHS: 1, 2, 3, (5 or 5A), 17 - 21 or 1, 2, 5B, 18, 21

PRIVATE ROOM SERVICES
STANDARD PARAGRAPHS: 2, 16, 17, 18, 21

DENTAL INPATIENT HOSPITAL SERVICES
STANDARD PARAGRAPHS: 1, 2, 7, 17, 18, 21

INPATIENT DIAGNOSTIC STUDY SERVICES
STANDARD PARAGRAPHS: 1, 2, 8, 17 - 21

COSMETIC SURGERY HOSPITAL SERVICES
STANDARD PARAGRAPHS: 1, 2, 9, 17, 18, 21

SNF LEVEL OF CARE SERVICES
STANDARD PARAGRAPHS: 1, 2, 10A, 10B, 14, 16, 18-21

HOME HEALTH SERVICES
STANDARD PARAGRAPHS: 1, 2, 11 (A-1 through I-2), 16, 17 - 21 (Paragraph 21 is used only when "waiver of liability" applies.) - Note some paragraphs apply only to services rendered before July 1, 1981.

LATE TRANSFER TO SNF FROM HOSPITAL - (Medical appropriateness allegations)
STANDARD PARAGRAPHS: 1, 2, 12A, 12B, 14, 16, 18, 19, 21

SNF CARE NOT A CONTINUATION OF TREATMENT
STANDARD PARAGRAPHS: 1, 2, 13, 14, 16, 18, 19, 21

NOTE: WHERE SOMEONE OTHER THAN THE PATIENT WAS NOTIFIED, INSERT THE PATIENT'S NAME AND HIS OR HER OR HE OR SHE INSTEAD OF YOU OR YOUR, AS NEEDED.

EXHIBIT II

STANDARD PARAGRAPHS FOR RECONSIDERATION DETERMINATIONS

STANDARD PARAGRAPH 1

A. USE IF NO PROGRAM PAYMENT - WAIVER OF LIABILITY (SECTION 1879) APPLIES (PROVIDER IS LIABLE FOR ALL OF STAY). On (date) the (name of intermediary) notified you/M________ that no hospital insurance benefits could be allowed for your/his/her stay at (name of provider) (from date through date). The notice also stated that the provider must bear the cost for these services.

B. USE IF NO PROGRAM PAYMENT - WAIVER OF LIABILITY (SECTION 1879) APPLIES (PROVIDER IS LIABLE FOR PART OF THE STAY AND THE PATIENT IS LIABLE FOR THE REMAINDER OF THE STAY). On (date) the (name of intermediary) notified you/M________ that no hospital insurance benefits could be allowed for your/his/her stay at (name of provider) from (date through date). The notice also stated that the provider must bear the cost of these services from (date through date) and that you/he/she are responsible for the remainder of your/his/her inpatient stay.

C. USE IF PARTIAL PROGRAM PAYMENT (PART OF THE STAY WAS PAID FOR UNDER THE WAIVER AND PROVIDER IS LIABLE FOR PART OF THE STAY AND THE PATIENT IS LIABLE FOR THE REMAINDER OF THE STAY). On (date) the (name of intermediary) notified you/M________ that Medicare would pay for the services provided at (name of provider) from (date through date) but the cost of services provided from (date through date) would be the provider's responsibility.

D. USE IF PARTIAL PROGRAM PAYMENT (SOME OF THE SERVICES WERE NONCOVERED AND THE PATIENT IS LIABLE). On (date) the (name of provider) notified you/M________ that Medicare benefits would be paid for the services you received from (date through date), but the services you/he/she received after that date were not covered and you/he/she were responsible for the charges. On (date), the (name of intermediary) also notified you/him/her of this decision.

E. USE IF PARTIAL PROGRAM PAYMENT (SOME OF THE SERVICES WERE NONCOVERED AND THE PROVIDER IS LIABLE). On (date) the (name of intermediary) notified you/M________ that Medicare would pay for the services provided at (name of provider) from (date through date) but the services you/he/she received after that date were not covered. The notice also stated that the cost of these services was the provider's responsibility.

F. USE IF NO PROGRAM PAYMENT (PATIENT IS LIABLE FOR ALL OF STAY). On (date) the (name of provider) notified you/M________ that the services you/he/she received from (date through date) were not covered by Medicare. On (date) the (name of intermediary) advised you/him/her that it agreed with that decision.

G. USE IF NO PROGRAM PAYMENT (WAIVER DOES NOT APPLY). On (date the (name of intermediary) notified you/M________ that hospital insurance benefits could not be paid for your/his/her stay at (provider) beginning (date).

STANDARD PARAGRAPH 2

A. BENEFICIARY FILED. On (date) you/M________ requested reconsideration of your/his/her claim for hospital insurance benefits, including the determination as to the party liable for the services. (On (date) the (name of provider) was notified that the request had been filed and that it would be considered a party to the reconsideration determination.)

B. PROVIDER FILED. On (date) the (name of provider) requested reconsideration of your/his/her claim for hospital insurance benefits including the determination as to the party liable for the services. On (date) you/he/she were notified the request had been filed and that you/he/she are considered as a party to the determination.

STANDARD PARAGRAPH 3

There are two issues that must be considered in this determination. The first issue to be determined is whether the level of inpatient hospital care the beneficiary received is covered by Medicare. Inpatient hospital care furnished a patient is covered under Medicare, but only if such care is reasonable and necessary for the treatment or diagnosis of the patient's illness or injury and is of a type that can only be provided on an inpatient hospital basis. Inpatient hospital care is not considered reasonable and necessary if it can be safely and adequately provided in a skilled nursing or less costly type of facility or on an outpatient basis. The second issue, if the case is found to be noncovered, is whether (M_______) (name of provider) knew or could reasonably be expected to know that the services (he/she/you) received for the period in question were not covered by the Medicare program.

STANDARD PARAGRAPH 4

There are two issues that must be considered in this determination. The first issue to be determined is whether the inpatient tuberculosis hospital care the beneficiary received is covered under section 1814(a)(2)(B) of title XVIII of the Social Security Act. Inpatient tuberculosis hospital care is covered if it must be provided on an inpatient basis, by or under the supervision of a physician, for the treatment of tuberculosis, during periods when the care can reasonably be expected to improve the condition or render it noncommunicable. The second issue, if the case is found to be noncovered, is whether (M_______) (name of provider) knew or could reasonably have been expected to know that the services (he/she/you) received for the period in question were not covered by the Medicare program.

STANDARD PARAGRAPH 5

There are two issues that must be considered in this determination. The first issue to be determined is whether the inpatient psychiatric hospital care the beneficiary received is covered by section 1814(a)(2)(A) of title XVIII of the Social Security Act. Inpatient care in a psychiatric hospital is covered by Medicare only if it constitutes "active treatment". "Active treatment" means that the patient received physician-supervised and evaluated services under an individual treatment or diagnostic plan which are expected to improve the patient's condition.

The second issue, if the case is found to be noncovered, is whether (M_______) (name of provider) knew or could reasonably be expected to know that the services (he/she/you) received for the period in question were not covered by the Medicare program.

STANDARD PARAGRAPH 5A

There are two issues that must be considered in this determination. The first issue to be determined is whether the inpatient psychiatric hospital care the beneficiary received is covered under section 1814(a)(2)(A) of title XVIII of the Social Security Act. Inpatient care in a psychiatric hospital for a patient needing nonpsychiatric medical or surgical care is covered by Medicare if a hospital level of care is required, the hospitalization in a psychiatric rather than a general hospital is required due to the patient's mental condition, and a physician certifies that these condition are met. The second issue, if the case is found to be noncovered, is whether (M_______) (name of provider) knew or could reasonably be expected to know that the services (he/she/you) received for the period in question were not covered by the Medicare program.

Standard Paragraph 5B

There are two issues that must be considered in this determination. The first issue to be determined is whether payment can be made under section 1812(b)(3) of the Social Security Act for inpatient psychiatric hospital care the beneficiary received after (date of beneficiary's 190th psychiatric hospital day). Medicare will make payment for up to 190 days of covered care in a participating psychiatric hospital during a beneficiary's lifetime. The second issue, if the case is found to be noncovered, is whether (M_______) (name of provider) knew or could reasonably be expected to know that the services (you/he/she) received for the period in question were not covered by the Medicare program.

Standard Paragraph 6

The issue to be determined is whether the beneficiary's use of a private room was medically necessary. When Medicare makes payment under the provisions of section 1861(v)(2)(A) of title XVIII of the Social Security Act to a hospital or skilled nursing facility for care provided in a private room, the provider may charge the beneficiary an additional amount for private accommodations requested by the beneficiary unless ordered by a physician for reasons of medical necessity. Medical reasons exist where semiprivate accommodations:

1. Would endanger the beneficiary's health or recovery,
2. Would endanger another patient's health or recovery,
3. Would be inappropriate because the beneficiary suffers from a communicable disease; or
4. Are not available and the beneficiary requires immediate inpatient care.

Standard Paragraph 7

The issue to be determined is whether the inpatient care the beneficiary received is covered by Medicare, or is excluded under section 1862(a)(10) of title XVIII of the Social Security Act as services provided in connection with the care, treatment, filling, removal or replacement of teeth or structure directly supporting teeth. Inpatient hospital services in connection with noncovered dental care are covered by Medicare only when a beneficiary requires active inpatient hospital treatment of an underlying medical condition.

Standard Paragraph 8

The issue to be determined is whether the level of inpatient hospital care the beneficiary received is covered under section 1862(a)(1) of title XVIII of the Social Security Act. Inpatient hospital care furnished a patient is covered by Medicare only if such care is reasonable and necessary for the treatment or diagnosis of the patient's illness or injury and can only be provided on an inpatient hospital basis. Inpatient hospital service in connection with a diagnostic study would be considered reasonable and necessary only if the patient's condition or the nature of the diagnostic procedures requires the constant availability of physicians as well as the use of complex medical equipment and the type of care generally associated with inpatient hospitalization.

Standard Paragraph 9

The issue to be determined is whether the inpatient hospital services the beneficiary received are covered by Medicare or excluded by a provision of the law (section 1862(a)(10) of title XVIII of the Social Security Act) which prohibits payment for services received in connection with cosmetic surgery not required for the prompt repair of an accidental injury or for improvement of the functioning of a malformed body member.

Standard Paragraph 10A - (Applicable to SNF Stays Begun Prior to December 5, 1980)

There are two issues that must be considered in this determination. The first issue to be determined is whether the care the beneficiary received is covered by Medicare. Skilled nursing benefits are covered under section 1814(a)(2)(C) of title XVIII of the Social Security Act for individuals, who, following hospitalization, need on a daily basis for a condition treated in the hospital, skilled nursing services or skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis. Skilled services must be furnished by or under the general supervision of professional medical personnel to assure the safety of the patient and to achieve the medically desired result. When individuals do not require such skilled services on a daily basis following hospitalization (or within 14 days following the last of a covered period of extended care services) or when, as a practical matter, the provision of such services does not require that they be admitted as inpatients to a skilled nursing facility, their care in such a facility is not covered by Medicare. The second issue, if the case is found to be noncovered, is whether (M _____) (name of provider) knew or could reasonably be expected to know that the services (you/he/she) received for the period in question were not covered by the Medicare program.

Standard Paragraph 10B - (Applicable to SNF Stays Begun December 5, 1980 and later)

There are two issues that must be considered in this determination. The first issue to be determined is whether the care the beneficiary received is covered by Medicare. Skilled nursing benefits are covered under section 1814(a)(2)(C) of title XVIII of the Social Security Act for individuals, who, following hospitalization, need on a daily basis for a condition treated in the hospital, skilled nursing services or skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis. Skilled services must be furnished by or under the general supervision of a professsional medical personnel to assure the safety of the patient and to achieve the medically desired result. When individuals do not require such skilled services on a daily basis following hospitalization (or within 30 days following the last day of a covered period of extended care services) or when, as a practical matter, the provision of such services does not require that they be admitted as inpatients to a skilled nursing facility, their care in such a facility is not covered by Medicare. The second issue, if the case is found to be noncovered, is whether (M ____) (name of provider) knew or could reasonably be expected to know that the services (you/he/she) received for the period in question were not covered by the Medicare program.

Standard Paragraph 11

There are two issues that must be considered in this determination. The first issue is whether the home health services the beneficiary received are covered under § 1861(n) of Title XVIII of the Social Security Act.

A-1 (Applicable to services rendered prior to July 1, 1981) Prior to July 1, 1981, an individual was eligible for home health benefits only if he required intermittent skilled nursing care or physical or speech therapy. Skilled nursing care is that type of service which must be performed by or under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired results. Services which can be rendered safely and effectively by a nonmedical person may not be considered skilled nursing services, regardless of who actually performs or supervises them.

A-2 (Applicable to services rendered July 1, 1981 and later) An individual is eligible for home health benefits only if he requires intermittent skilled nursing care or physical, speech or occupational therapy. Skilled nursing care is that type of service which must be performed by or under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired results. Services which can be rendered safely and effectively by a nonmedical person may not be considered skilled nursing services, regardless of who actually performs or supervises them.

B-1 (Applicable to services rendered prior to July 1, 1981) Prior to July 1, 1981, an individual was eligible for home health benefits only if he required skilled nursing care on an intermittent basis or physical or speech therapy. "Intermittent" is defined as the need for a medically predictable skilled nursing service at least once every 60 days. Where a condition exists which would clearly establish that the recurring need for skilled nursing services is medically predictable less frequently than once every 60 days such services would not be covered by Medicare.

B-2 (Applicable to services rendered July 1, 1981 and later) An individual is eligible for home health benefits only if he requires skilled nursing care on an intermittent basis or physical, speech or occupational therapy. "Intermittent" is defined as the need for a medically predictable skilled nursing service at least once every 60 days. Where a condition exists which would clearly establish that the recurring need for skilled nursing services is medically predictable less frequently than once every 60 days such services would not be covered by Medicare.

C-1 (Applicable to services rendered prior to July 1, 1981) Prior to July 1, 1981, an individual was eligible for home health benefits only if he required skilled nursing care on an intermittent basis, or physical or speech therapy. Physical therapy is defined as those services prescribed by a physician which require the skills of a qualified physical therapist and are peformed by or under the supervision of such a therapist.

C-2 (Applicable to services rendered July 1, 1981 and later) An individual is eligible for home health benefits only if he requires skilled nursing care on an intermittent basis, or physical, speech, or occupational therapy. Physical therapy is defined as those services prescribed by a physician which require the skills of a qualified physical therapist and are performed by or under the supervison of such a therapist.

D. (Applicable to services rendered prior to July 1, 1981) Prior to July 1, 1981, home health services are covered by the hospital insurance part of Medicare only if the person has previously had a medically necessary inpatient stay in a qualified hospital. The inpatient stay must have been for a period of at least 3 consecutive days. The day of discharge from the hospital is not counted as a hospital inpatient day.

E. Applicable to services rendered prior to July 1, 1981) Prior to July 1, 1981, home health services are covered by the hospital insurance part of Medicare only if a physician has established a plan of treatment within 14 days after the patient's discharge from a medically necessary 3 day qualifying hospital stay, or if later, within 14 days after a covered stay of any duration in a skilled nursing facility; the day of discharge from the hospital or skilled nursing facility is not counted as an inpatient day.

F. For home health benefits to be covered by Medicare, a beneficiary must be confined to his home. Generally, a beneficiary will be considered to be confined to his home if he has a condition due to an illness or injury which restricts his ability to leave his home except with the aid of supportive devices such as crutches, cane, wheelchair, walker, the assistance of another person, or the use of special transportation.

G. To be covered by Medicare, home health services must be furnished in a place of residence used as the beneficiary's home. A beneficiary's home may include an apartment, a relative's home or a home for the aged. A hospital or skilled nursing facility, whether participating in Medicare or not, may not be considered a place of residence.

H-1 (Applicable to services rendered prior to July 1, 1981) Prior to July 1, 1981, home health services are covered under Medicare only if a person needs intermittent skilled nursing care or physical or speech therapy services for a condition for which he was treated when he was an inpatient in a hospital or skilled nursing facility.

H-2 (Applicable to services rendered July 1, 1981 and later) Home health services are covered under Medicare only if a person needs intermittent skilled nursing care or physical, speech, or occupational therapy services.

I-1 (Applicable to services rendered prior to July 1, 1981) Prior to July 1, 1981, home health benefits are covered by Medicare only if an individual requires skilled nursing care on an intermittent basis or physical or speech therapy. The giving of intramuscular injections of medication is considered skilled nursing care. However, for the services of the nurse to be covered under Medicare, the injection must be a reasonable and necessary treatment for the condition for which it is given. Vitamin B-12 injections are considered an effective treatment for only certain medical conditions such as certain anemias, gastrointestinal disorders or neuropathies. If vitamin B-12 injections are not given to treat one of these conditions, the injections are not considered to be reasonable and necessary. The second issue, if the case is found to be noncovered, is whether (M ____) (name of provider) knew or could reasonably be expected to know that the services (you/he/she) received for the period in question were not covered by the Medicare program.

I-2 (Applicable to services rendered July 1, 1981 and later) Home health benefits are covered by Medicare only if any individual requires skilled nursing care on an intermittent basis or physical, speech, or occupational therapy. The giving of intramuscular injections of medication is considered skilled nursing care. However, for the services of the nurse to be covered under Medicare, the injection must be a reasonable and necessary treatment for the condition for which it is given. Vitamin B-12 injections are considered an effective treatment for only certain medical conditions such a certain anemias, gastrointestinal disorders or neuropathies. If vitamin B-12 injections are not given to treat one of these conditions, the injections are not considered to be reasonable and necessary. The second issue, if the case is found to be noncovered, is whether (M ____) (name of provider) knew or could reasonably be expected to know that the services (you/he/she) received for the period in question were not covered by the Medicare program.

Standard Paragraph 12A (Applicable to SNF Stays Begun Prior to December 5, 1980)

The issue to be determined is whether the admission of the beneficiary to the skilled nursing facility after discharge from the qualifying hospital or earlier SNF stay was a timely admission as defined in section 1861(i) of title XVIII of the Social Security Act. Skilled nursing services are covered by Medicare only if admission to the skilled nursing facility and the receipt of a covered level of skilled nursing care occur within a specified period of time. Admission and receipt of covered care must occur:

1. within 14 days after discharge from a 3-day qualifying hospital stay; or

2. within 28 days after discharge from a 3-day qualifying hospital stay if appropriate skilled nursing facility accommodations were not available within 14 days in the area in which the patient resides, provided covered care was required within 14 days of such a discharge and continued to be required through the time of admission; or

3. within such time as it would be medically appropriate to begin an active course of treatment where the patient's condition is such that skilled nursing facility care would not be medically appropriate within 14 days after discharge from a qualifying hospital stay.

Standard Paragraph 12B (Applicable to SNF Stays Begun December 5, 1980 and Later)

The issue to be determined is whether the admission of the beneficiary to the skilled nursing facility after discharge from the qualifying hospital or earlier SNF stay was a timely admission as defined in section 1861(i) of title XVIII of the Social Security Act. Skilled nursing services are covered by Medicare only if admission to the skilled nursing facility and the receipt of a covered level of skilled nursing care occur within a specified period of time. Admission and receipt of covered care must occur:

1. within 30 days after discharge from a 3-day qualifying hospital stay; or

2. within such time as it would be medically appropriate to begin an active course of treatment where the patient's condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a qualifying hospital stay.

Standard Paragraph 13

The issue to be determined is whether the care the beneficiary received is covered under ¢ 1814(a)(2)(C) of Title XVIII of the Social Security Act, for the period in question. Medicare does not cover skilled nursing care unless it is required for the continued treatment of a condition for which the patient received covered inpatient hospital care prior to transfer to the SNF or unless it is care for the treatment of a condition which arose while the patient was receiving covered care in a skilled nursing facility.

Standard Paragraph 14

Following a stay at ___________ Hospital from _______ through _____ M _______ was admitted to the skilled nursing facility on ____ with the diagnosis/diagnoses of _______

Standard Paragraph 15

Following a stay at ___________ Hospital/Skilled Nursing Facility form through _____ M ______ began receiving home health services on ____.

Standard Paragraph 16

The medical evidence in M ___________ file shows. (CONTINUE WITH RECITATION OF PERTINENT MEDICAL EVIDENCE WITH APPROPRIATE PARAGRAPHING).

Standard Paragraph 17

The medical evidence in M __________ file shows that M ______ was admitted to the ____________ Hospital on ______________ with the diagnosis/diagnoses of ________. (CONTINUE WITH RECITATION OF PERTINENT MEDICAL EVIDENCE WITH APPROPRIATE PARAGRAPHING).

Standard Paragraph 18

A review of the medical records shows ______________________ (CONTINUE WITH THE RATIONALE AND/OR APPLICABLE GUIDE LANGUAGE WITH APPROPRIATE PARAGRAPHING).

Standard Paragraph 19

Based on the above medical evidence, it is found that the services rendered M _____ from (date) through (date) (beginning date), do not constitute covered care under the Medicare program.

In conclusion, it is determined that:

(Discuss specifics) ____________________________________.

Standard Paragraph 20

Because certain care has been found to be (not reasonable and necessary/custodial), a determination must be made in accordance with section 1879 of title XVIII of the Social Security Act, with respect to the issue of whether the beneficiary and/or the provider knew or could reasonably have been expected to know that the services would not be covered under Medicare. It has been determined that (discuss specifics). Consequently, liability for the noncovered services provided from (date) through (date) (or beginning date) rests with (provider, beneficiary or Medicare).

Standard Paragraph 21

In conclusion, it is determined that:
(Discuss specifics) ____________________________________.

Exhibit III

OPTIONAL GUIDE LANGUAGE PARAGRAPHS TO BE USED IF APPROPRIATE IN PART A RECONSIDERATION DETERMINATIONS

1. SKILLED NURSING CARE AND OTHER SKILLED REHABILITATION SERVICES. Although (M______________) (you) received skilled nursing care and/or other skilled rehabilitation services consisting of (discuss name of drugs, if intramuscular and other skilled services rendered with specific reference to frequency given) ___________, these procedures were not required or furnished on a daily basis as required by law to permit payment.

2. VITAMIN B-12 INJECTIONS (FOR HHA SERVICES ONLY). Although (M______) (you received vitamin B-12 injections, there is no indication that those injections were given for any specific medical condition for which vitamin B-12 injections are recognized as specific and effective treatment such as in treating certain anemias, gastrointestinal disorders or neuropathies. Therefore, no program payment can be made for skilled nursing care as this service was not considered medically necessary in this case.

3. CATARACT CONVALESCENT. During (M__________) (your) period of normal, uncomplicated convalescence following (your/his/her) hospital stay for cataract surgery, the only care required consisted of the administration of eye drops and application of protective dressings and loca ointments. Since this type of care can be safely and effectively provided by the average nonmedical person, such care would not be considered skilled nursing care.

4. ORAL MEDICATIONS WITHOUT OBSERVATION. Services in connection with the administration of routine oral medications that can be self-administered are not considered skilled nursing services since the act of providing the medication does not require special professional health training.

5. PERSONAL SERVICES. (M______) (You) received personal services including (_______), which were primarily designed to assist (you/him/her) in meeting the activities of daily living. Since these services can be performed by the average nonmedical person and do not require the continuing attention of trained medical personnel, they would not constitute skilled care. Such services are instead considered to be supportive in nature and as such constitute custodial care which is specifically excluded from coverage under the Medicare program.

6a. SNF-MORE THAN 14 DAYS NONCOVERED CARE. (Applicable to SNF Stays Begun Prior to December 5, 1980) The above medical evidence established that skilled nursing and other skilled rehabilitative services were not required on a daily basis within the prescribed 14-day period following (discharge from the (hospital), (the last covered day in the skilled nursing facility).

6b. SNF-MORE THAN 30 DAYS NONCOVERED CARE. (Applicable to SNF Stays Begun December 5, 1980 and later) The above medical evidence established that skilled nursing and other skilled rehabilitative services were not required on a daily basis within the prescribed 30-day period following (discharge from the (hospital), (the last covered day in the skilled nursing facility).

7. PAYMENT OF CONTINUED HOSPITAL STAY - SNF LEVEL OF CARE REQUIRED. However, when a bed is not available in a participating skilled nursing facility located in the area (i.e., a facility participating in the Medicare program) payment of a continued inpatient hospital stay is permitted for a patient who no longer requires a hospital level of care but who does require covered skilled nursing facility care. A patient in need of covered skilled nursing facility care is one who requires, on a daily basis, skilled nursing care or skilled rehabilitation services that, as a practical matter, can only be provided on an inpatient basis in a skilled nursing facility. Payment may be made, within the limit of the number of hospital benefits days available to the patient for which program payment may be made, for so long as the patient needs this type of care and a skilled nursing facility bed continues to be unavailable. Accordingly, payment can be made for services provided from ________ through ________.

NOTE: WHERE PARAGRAPH IS APPROPRIATE, DETERMINATION MUST BE SUPPORTED BY ALL AVAILABLE DOCUMENTATION (URC RECORDS, PHYSICIAN COMMENTS, RECORDS OF SOCIAL SERVICES PLACEMENT EFFORTS, ETC.).

8. ATTENDING PHYSICIAN STATEMENT SUBMITTED FOR PROTEST/REVIEW PURPOSES. In his letter of __________ Dr. __________ addressed himself to the beneficiary's need for continued (inpatient care) (home health) services. He indicated that such services were needed because __________.

NOTE: USE AS SEPARATE PARAGRAPH IMMEDIATELY FOLLOWING RATIONALE SECTION OF DETERMINATION.

9. UTILIZATION REVIEW COMMITTEE DECISION. The provider's Utilization Review Committee or Professional Standards Review Organization on (show all dates of decision) ____________ found that the beneficiary's stay was medically necessary.

NOTE: USE AS A SEPARATE PARAGRAPH WHEN APPLICABLE, IMMEDIATELY FOLLOWING RECITATION OF MEDICAL EVIDENCE.

Although the Utilization Review Committee or the Professional Standards Review Organization found (M_______'s) (your) stay to be medically necessary, it is the responsibility of the intermediary to determine whether the services received by the beneficiary were in fact covered under the Health Insurance Program. The evidence cited above does not support a finding that these services are covered under the Medicare law because ________________.

NOTE: USE AS A SEPARATE PARAGRAPH IMMEDIATELY FOLLOWING RATIONALE SECTION OF DETERMINATION.

EXHIBIT IV - EXCLUSIONS

RECONSIDERATION DETERMINATION: 1

PRIVATE DUTY NURSING CHARGES/SERVICES

____
____
____

Dear ________________:

RE:____________________H.I.Claim Number ________________________________

In response to your request for reconsideration of (your) (M____________'s) claim for payment of private duty nursing charges at ____________________ (beginning ______,) (from ________ through _______,) a complete review of all the facts and evidence has been completed. It has been determined that these charges are not covered by Medicare.

Although hospital insurance will help pay for inpatient nursing services for up to (90)(100) days during any benefit period, these nursing services are defined as the services usually given by the (hospital)(skilled nursing facility) for the care and treatment of the patients. The Medicare law section 1861(b)(5) of title XVIII of the Social Security Act specifically excludes private duty nursing services from the health insurance program. The law permits no exception to this exclusion. Therefore, the claim cannot be approved even though you state (basis for request).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals pamphlet)

EXHIBIT IV - EXCLUSIONS

RECONSIDERATION DETERMINATION: 2

3-DAY HOSPITAL STAY

____
____
____

Dear ____________:

Re:________________________H.I. Claim Number________________________

In response to your request for reconsideration of (your)(M__________'s) claim for payment of extended care benefits, a complete review of all the facts and evidence has been completed.

It has been determined that the charges for the stay at (Name of Facility) (beginning ______,) (from ______ to ______,) are not covered by Medicare. Under the Medicare law (section 1861(i) of title XVIII of the Social Security Act) there are specific conditions that must be met before the services given in a skilled nursing facility may be covered. One of the conditions is that the patient must have had a medically necessary inpatient hospital stay of at least 3 consecutive days in a qualified hospital before his/her/your day of discharge and transfer to a skilled nursing facility. The law permits no exception to these provisions. Therefore, the claim cannot be approved even though (Basis of Request) .

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeal Pamphlet)

EXHIBIT IV - EXCLUSIONS

RECONSIDERATION DETERMINATION: 3

PRE-ENTITLEMENT SNF ADMISSION

____
____
____

Dear _____________:

Re:___________________H.I. Claim Number ____________________

In response to your request for reconsideration of (your)(M__________'s) claim for payment of extended care benefits, a complete review of all the facts and evidence has been completed.

It has been determined that the charges for the stay at (Name of Facility) (beginning __________,) (from __________ to __________,) are not covered by Medicare. Under the law, (section 226 of title II of the Social Security Act) there are specific conditions that must be met before the services given in a skilled nursing facility may be covered. One of the conditions is that the discharge from the qualifying hospital stay must have occurred on or after the first day of the month on which the beneficiary became entitled to hospital insurance under Medicare.

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV

EXCLUSIONS--RECONSIDERATION DETERMINATION: 4

LATE TRANSFER TO SNF FROM HOSPITAL (AVAILABILITY ISSUE)

(Applicable to SNF Stays Begun Prior to
December 5, 1980)

____
____
____

Dear ____________:

Re: ____________________ H.I. Claim Number ________________

In response to your request for reconsideration of (your) (M_________'s) claim for payment of extended care benefits, a complete review of all the facts and evidence has been completed.

It has been determined that the charges for the stay at (name of facility) (beginning ________,) (from ____________ to ___________,) are not covered by Medicare. Under the Medicare law (section 1861(i) of title XVIII of the Social Security Act) there are specific conditions that must be met before the services provided in a skilled nursing facility may be covered.

One of the conditions is that the patient must have entered the skilled nursing facility generally within 14 days after discharge from a medically necessary qualifying hospital stay. However, an extension of up to 14 additional days is permissible when it is determined that appropriate skilled nursing facility bed space was not available within the general geographic area in which the patient lives.

Our records show that (you were) (M_________ was) discharged from the facility on __________ and entered the skilled nursing facility on __________. The evidence does not show that appropriate skilled nursing facility bed space in facilities which ordinarily would be utilized in (your) (M_________________'s) general georgraphic area was unavailable. Therefore, (your/his/her) claim cannot be approved even though you state (basis for request).

If you believe this reconsideration determination is not correct and the amount of benefits in questions is $100 or more, you may request a hearing before an administrative law judge of the Bureau of Hearings and Appeals. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the day you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV

EXCLUSIONS—RECONSIDERATION DETERMINATIONS 5A

SNF 14 DAY TRANSFER REQUIREMENT NOT MET
(Applicable to SNF Stays Begun Prior to December 5, 1980)

Use in all cases denied because of not meeting 14 day transfer requirement except availability cases or delay for medical appropriateness allegations.

____
____
____

Dear ____________:

In response to your request for reconsideration of (your) (M____________'s) claim for payment of extended care benefits for services furnished at (name of facility) (beginning ____________,) (from ____________ to ____________), a complete review of all the facts and evidence has been completed.

It has been determined that the charges for the stay at (name of facility) are not covered by Medicare. Under the law (section 1861(i) of title XVIII of the Social Security Act), there are specific conditions that must be met before the services in a skilled nursing facility may be covered. One of the conditions is that admission to a skilled nursing facility must generally take place within 14 days after the date of a patient's discharge from a hospital where the patient had a stay that included at least 3 consecutive days of medically necessary inpatient hospital care or after discharge from an earlier skilled nursing facility confinement. Therefore, the claim cannot be approved even though you state (basis of request).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing before an administrative law judge of the Bureau of Hearings and Appeals. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, your must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coodinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV

EXCLUSIONS—RECONSIDERATION DETERMINATION: 5B

SNF 30 DAY TRANSFER REQUIREMENT NOT MET
(Applicable to SNF Stays Begun December 5, 1980 and Later)

Use in all cases denied because of not meeting 30 day transfer requirement except in delay for medical appropriateness allegations.

____
____
____

Dear __________:

In response to your request for reconsideration of (your) (M__________'s) claim for payment of extended care benefits for services furnished at (name of facility) (beginning ________,) (from __________ to __________), a complete review of all the facts and evidence has been completed.

It has been determined that the charges for the stay at (name of facility) are not covered by Medicare. Under the law (section 1861(i) of title XVIII of the Social Security Act), there are specific conditions that must be met before the services in a skilled nursing facility may be covered. One of the conditions is that admission to a skilled nursing facility must generally take place within 30 days after the date of a patient's discharge from a hospital where the patient had a stay that included at least 3 consecutive days of medically necessary inpatient hospital care or after discharge from an earlier skilled nursing facility confinement. The law permits only one exception to these provisions, which is not applicable in this case. Therefore, the claim cannot be approved even though you state (basis of request).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing before an administrative law judge of the Bureau of Hearings and Appeals. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, your must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coodinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

3-261.33a19.1

EXHIBIT IV

EXCLUSIONS--RECONSIDERATION DETERMINATION: 6

NONPARTICIPATING PROVIDER

____
____
____

Dear ______________:

Re: ________________, H.I. Claim Number __________________

In response to your request for reconsideration of (your) (M_____________'s) claim for payment of benefits for services furnished by ____________, a complete review of all the facts and evidence has been completed.

It has been determined that the charges for services provided at the (name of facility) (beginning ___________,) (from ___________ to _____________,) are not covered under the hospital insurance provisions of the Medicare program. The Medicare law (section 1814(a) of title XVIII of the Social Security Act) limits payment for services furnished Medicare beneficiaries to those providers of services who are eligible participants in the Health Insurance Program. The law (section 1866) also specifies the necessary requirements that a provider must meet in order to participate in the program. (There is an exception which allows nonparticipating hospitals furnishing emergency services to receive payment from the program, providing certain conditions are met. This exception does not apply to facilities other than hospitals.)

(Our records show that the (facility) is not participating in the Medicare program.) (Our records show that the (hospital) is not participating in the Medicare program, and there is no reference that emergency services were rendered.) Therefore, the claim cannot be approved even though you state (basis for request).

If you believe the reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing before an administrative law judge of the Bureau of Hearings and Appeals. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV - EXCLUSIONS

RECONSIDERATION DETERMINATION: 7

NONCERTIFIED PORTION OF A PROVIDER FACILITY

____
____
____

Dear ____________:

Re:____________, H. I. Claim Number ____________________

In response to your request for reconsideration of (your) (M_________'s) claim for benefits under the Hospital Insurance Program, a complete review of all the facts and evidence has been completed.

It has been determined that the charges for your stay at (facility) (beginning __________) (from _________ to _________) are not payable under the provisions of the Hospital Insurance Program.

The Medicare law (section 1814(a) of title XVIII of the Social Security Act) limits payments for services furnished Medicare beneficiaries to those providers of services who participate in the health insurance program. The law (section 1861) also provides that an institution may enter into an agreement with the Health Care Financing Administration to include all or only a specific portion of its facilities in the coverage agreement to participate in the Medicare program.

(Our records show that (you were) (the beneficiary was) not admitted to the portion of the (facility) which was covered by the participation agreement. Instead, you (he/she) were (was) placed in a part of the facility that was not certified for use by Medicare patients.) Our records show that (you were) (the beneficiary was) transferred on ________ to a part of the facility that was not certified for use by Medicare patients.) Therefore, the claim cannot be approved even though you state (Basis for Request).

If you believe the reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this letter. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding the enclosed determination should be referred to:

(Name and address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV

EXCLUSIONS--RECONSIDERATION DETERMINATION: 8

NONPARTICIPATING HHA

____
____
____

Dear ____________________:

Re: ______________________, H. I. Claim Number ____________________________

In response to your request for reconsideration of (your)(M___________'s) claim for payment of home health services, a complete review of all the facts and evidence has been completed.

It has been determined that the cost of the services provided by (name of agency) (beginning ___________) (from ___________to____________) are not covered by Medicare.

Under the law (section 1814(a) of title XVIII of the Social Security Act) payment for home health services furnished a person may be made only to those agencies participating in the Health Insurance Program. Since the (name of agency) is not participating in Medicare, the cost of the services that agency provided are not reimbursable. The law permits no exception to this provision. Thus, the claim cannot be approved even though you state (give basis of request).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing before an administrative law judge of the Bureau of Hearings and Appeals. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV - EXCLUSIONS

RECONSIDERATION DETERMINATION: 9

EXHAUSTION OF INPATIENT HOSPITAL BENEFITS-CONTINUOUS STAY (LIFETIME RESERVE DAYS EXPLANATION IF APPROPRIATE)

____
____
____

Dear ________________:

Re:__________________H. I. Claim Number______________________________

In response to your request for reconsideration of (your) (M_____________'s) claim for payment of hospital insurance benefits, a complete review of all the facts and evidence has been completed.

It has been determined that reimbursement for (your)(M__________'s) stay at ____________ after ______________ cannot be made under the Medicare law.

The Medicare law (section 1812(a)(2) of title XVIII of the Social Security Act) provides payments for covered inpatient hospital services for up to 90 days during any one benefit period. A benefit period begins when a beneficiary is admitted to a qualified hospital or skilled nursing facility and it ends at the close of the first period of 60 consecutive days during which a beneficiary has not been an inpatient of either a hospital or a facility primarily engaged in providing skilled nursing or rehabilitation services. (A 60-day reserve is also provided, but these days may be used only once during a beneficiary's lifetime and are reduced accordingly. Our records show (you have) (the beneficiary has) utilized all of these "lifetime reserve" days).

(Your)(M_________'s) benefit period began _________ and (90) or (150) days were exhausted on _________. Since (your/his/her) benefit period had not ended, (and all "lifetime reserve" days were used) no further days were reimbursable. The law permits no exception to these provisions. Therefore, (your/his/her) claim cannot be approved even though you state (basis for request).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within

60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
Appeals Pamphlet

EXHIBIT IV - EXCLUSIONS

RECONSIDERATION DETERMINATION: 10

EXHAUSTION OF INPATIENT HOSPITAL BENEFITS-MULTIPLE STAYS (LIFETIME RESERVE DAYS EXPLANATION IF APPROPRIATE)

____
____
____

Dear ________:

Re:______________________ H. I. Claim Number ____________________

In response to your request for reconsideration of (your)(M_________'s) claim for payment of hospital insurance benefits, a complete review of all the facts and evidence has been completed.

It has been determined that (your)(M_________'s) stay at (facility) (after date of benefit exhausted), (beginning ________), is not covered by Medicare.

The Medicare law (section 1812(a)(2) of title XVIII of the Social Security Act) provides payment for covered inpatient hospital services for up to 90 days during any one benefit period. A benefit period begins when a beneficiary is admitted to a qualified hospital or skilled nursing facility and it ends at the close of the first period of 60 consecutive days during which a beneficiary has not been an inpatient of either a hospital or facility primarily engaged in providing skilled nursing or rehabilitation services. (A 60-day reserve is also provided, but these days may be used only once during a beneficiary's lifetime and reduced accordingly. Our records show (you have) (M________) has utilized all of these "lifetime reserve" days.

(Your)(______'s) benefit period began _______ when (you/he/she) entered (facility). A summary of the utilization of the 90 days (and "lifetime reserve" days) of covered inpatient hospital care follows:

Facility	Dates	Covered Days Utilized

Since this benefit period had not ended, no further benefits were payable. The law permits no exception to these provisions. Therefore, (your/his/her) claim cannot be approved even though you state (basis of request).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing.

Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV - EXCLUSIONS

RECONSIDERATION DETERMINATION: 11

EXHAUSTION OF SNF BENEFITS - CONTINUOUS STAY

____
____
____

Dear__________:

Re:_______ _________________H. I. Claim Number ________________.

This is in response to your request for reconsideration of (your) (M______'s) claim for payment for hospital insurance benefits for extended care services.

It has been determined that reimbursement for (your) (M_________'s) stay at __(facility)____ cannot be made under Medicare law after _________.

The law (section 1812(a)(2) of title XVIII of the Social Security Act) provides for payment for up to 100 days of covered post-hospital extended care services during any one benefit period. A benefit period (section 1861) begins when a beneficiary is admitted to a qualified hospital or skilled nursing facility and it ends at the close of the first period of 60 consecutive days during which a beneficiary has not been an inpatient of either a hospital or a facility primarily engaged in providing skilled nursing or rehabilitation services.

(Your) (M_________'s) benefit period began ________ when you (he/she entered) ______________ and all benefits were exhausted on _________, the 100th day.

No further payment can be made after the above date. Therefore, your (his/her) claim cannot be approved even though you state (basis of request_____).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV - EXCLUSIONS

RECONSIDERATION DETERMINATION: 12

EXHAUSTION OF SNF BENEFITS - MULTIPLE STAYS

____
____
____

Dear __________:

Re:____________________________H. I. Claim Number ____________________

In response to your request for a reconsideration of (your) (M________'s) claim for payment of hospital insurance benefits for extended care services, a complete review of all the facts and evidence has been completed.

It has been determined that (Your) (M__________'s) stay at (facility) after (date benefits exhausted) (beginning _____________,) is not covered by Medicare.

The law (section 1812(a)(2) of title XVIII of the Social Security Act) provides for payment for up to 100 days of covered post-hospital extended care services during any one benefit period. A benefit period (section 1861) begins when a beneficiary is admitted to a qualified hospital or skilled nursing facility and it ends at the close of the first period of 60 consecutive days during which a beneficiary has not been an inpatient of either a hospital or a facility primarily engaged in providing skilled nursing or rehabilitation services.

(Your)(M__________'s) benefit period began when (your/he/she) entered ______________on_______________. A summary of the subsequent 100 days of post-hospital extended care utilized is as follows:

Facility	Dates	Covered Days Utilized

(Your) (M____________'s) benefit period began ____________ when (you) (he/she) entered __(facility)__ and 100 days of covered extended care services were exhausted on (date benefits exhausted). The law permits no exception to these provisions. Therefore, (your/his/her) claim cannot be approved even though you state (basis of request).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT IV - EXCLUSIONS
RECONSIDERATION DETERMINATION: 13
EXHAUSTION OF HOME HEALTH VISITS
(Applicable only to services rendered prior to July 1, 1981)

____
____
____

Dear ________:

Re: ____________, H. I. Claim Number ____________

In response to your request for reconsideration of (your) (M _____'s) claim for Home Health Service Benefits under the Hospital Insurance Program, a complete review of all the facts and evidence has been completed.

It has been determined that reimbursement for the services provided by (Name of HHA) (after ____,) (beginning _____,) cannot be made under the hospital insurance benefits provisions of Medicare.

The law (§ 1812(a)(3) of Title XVIII of the Social Security Act) limits coverage under Medicare to payment for 100 home health service visits after the beginning of one benefit period and before the beginning of the next. These visits must be furnished an individual within 1 year after (your/his/her) most recent discharge from a hospital where (you/he/she) was an inpatient for not less than 3 consecutive days or (if later) within 1 year after (your/his/her) most recent discharge from a skilled nursing facility where (you/he/she) was an inpatient entitled to Medicare payment for posthospital skilled nursing care services. A benefit period (section 1861) begins when a beneficiary is admitted to a qualified hospital or skilled nursing facility and it ends at the close of a period of 60 consecutive days during which time a beneficiary has not been an inpatient of either a hospital or a facility primarily engaged in providing skilled nursing or rehabilitation services.

(Your) (M _____'s) benefit period began (date entered facility) when (you/he/she) entered (name of facility). (Your) (M ___'s) first home health visit occurred on _______ and (your/his/her) 100th visit on _________. Since no new benefit period began, no further home health benefits were payable under the Hospital Insurance Program. The law permits no exception to these provisions. Therefore, (your/his/her) claim cannot be approved even though you state (basis for request).

If you believe this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date you receive this notice. You should make your request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 1

Date

Beneficiary's (Representative's)
Name and Address

Dear M________________:

Re:__________________________, H. I. Claim Number ____________________

As a result of your request for reconsideration, a complete review of the claim for health insurance benefits has been made to determine whether the original decision was correct.

This reconsideration was an independent and thorough reexamination of all the evidence of record concerning this claim. It was made by a specially trained staff, different from the staff that made the original decision.

Upon review, it has been determined that the original decision (is correct) or (could be revised in part). The enclosed reconsideration determination fully explains the decision.

If you believe the reconsideration determination is not correct and the amount in controversy is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date of receipt of this letter. You may make such a request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding the enclosed determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosures 2 (Determination, Pamphlet)

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 2

USE: Full Reversal of Initial Coverage Denial
(Coverage Reversal Only, Waiver Provisions Inapplicable)

Date

Beneficiary's (Representative's)
Name and Address

Dear M______________:

Re:__________________H. I. Claim Number ______________Admission (Date)

In response to your request for reconsideration of the claim for hospital insurance benefits, a complete review of all evidence on the claim has been made. As a result of this review, we have determined that the services (you/beneficiary) received are covered under the Medicare program. Accordingly, the original decision denying coverage of services has been completely reversed. The provider of services will make whatever refund is necessary in the event direct payment was made by (you/the beneficiary) for all or part of the previously denied services.

(Include here a brief statement of the facts of the case, and include a brief statement of the rationale used in making your determination.)

If you believe that this reconsideration determination is not correct and the amount in controversy is $100 or more, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date of receipt of this letter. You should make any such request through your social security office. If you visit the office, please take this letter with you.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 3

USE: Notification to Provider of Full Coverage Reversal

Date

(Provider name/address)

____
____
____

Dear Administrator:

Re:____________________________, H. I. Claim Number ______________________

A request for reconsideration was filed on behalf of the Medicare beneficiary named above. As a result of our reconsideration review, we determined that the claimant's (hospital stay, SNF stay, HHA care, etc. __________________________), from (give dates of service, __________________________) is reimbursable under the Medicare program.

In order that the proper adjustment can be made, it is essential that you forward an adjusted bill based on the above stated determination in the enclosed self-addressed stamped envelope.

With the adjusted bill, please enclose a statement that either:

(a) You have not been paid by the beneficiary or anyone else acting on the beneficiary's behalf for the services other than the applicable deductible and coinsurance embraced by the adjusted bill, or

(b) You have refunded payment other than the applicable deductible and coinsurance received from the beneficiary or anyone else acting on the beneficiary's behalf, for the services embraced by the adjusted bill.

Such a statement is necessary as a safeguard against any future offsets due you from the Medicare program.

Sincerely yours,

Medicare Coordinator
(or equivalent)

best copy available

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 4

USE: Request for Part A Reconsideration Inapplicable -
No Amount in Controversy - Entire Claim Paid at Initial
Processing Prior to Receipt of the Request for Reconsideration

Date

Beneficiary's (Representative's)
Name and Address

Dear M ______________________:

Re: __________________________, H. I. Claim Number ____________

This is in reply to your request for reconsideration concerning health insurance payments for (hospital) (skilled nursing facility) (home health) benefits beginning ____________________.

A review of all the information at hand concerning this claim indicates that charges for all covered services were paid in full by Medicare except for the applicable deductible and/or coinsurance amounts which are the responsibility of the beneficiary. Since this claim has been satisfied and there is no longer any amount at controversy, we are taking no further action on your request for reconsideration.

Any questions regarding this determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 5

USE: Correction of Information in Reconsideration Determination Previously Issued on Claim

Date

Beneficiary's (Representative's)
Name and Address

Dear M ____________:
Re: ______________, H.I. Claim Number ________________________________

This is in regard to our reconsideration determination dated ________ which you recently received concerning (your/the beneficiary's) claim for hospital insurance benefits.

In reviewing the file, it was found the (an incorrect date)(incorrect information) appeared in paragraph(s) ________________.

The correct information should be :____________________________. We regret this error and any inconvenience this may have caused you.

If you believe the reconsideration determination is not correct and the amount in controversy is at least $100, you may request a hearing. Please read the enclosed pamphlet for a full explanation of your right to appeal. If you want a hearing, you must request it within 60 days of the date of receipt of this letter. You may make such a request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding the enclosed determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure
(Appeals Pamphlet)

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 6

USE: Request for Reconsideration Not Timely Filed Good Cause Not Established by Intermediary (Form SSA-1954 Involved)

Date

Beneficiary's (Representative's)
Name and Address

Dear M ___________:
Re: ___________, H.I. Claim Number ____________________________

This is in reply to your request for a reconsideration of (your/the beneficiary's) claim for hospital insurance benefits for the period beginning ___________.

The records show that (you/beneficiary's name) (were/was) notified on ___________, by means of a denial notice (SSA-1954), that payment could not be made beginning, (cite reason for denial).

Since you submitted your request for reconsideration of the claim on ___________, which is more than 60 days from the date of receipt of the denial notice, and it has been determined that good cause for late filing does not exist, a reconsideration determination cannot be made.

If you have any questions regarding this matter, please contact your social security office. If you visit the office, please take this letter with you.

Any questions regarding the determination should be referred to:

(Name and Address of Resident Intermediary)

Sincerely yours,

Medicare Coordinator
(or equivalent)

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 7

USE: Reconsideration of Overpayment
(Except when provider liable or a waiver request received)

Date

Beneficiary's (Representative's)
Name and Address

Dear M__________________:

Re: ______________________________, H. I. Claim Number______________

This is in reply to your request for reconsideration of the determination that a Medicare overpayment was made on your behalf to (Name of Provider). On _______________ we notified you that an overpayment had been made. A complete review of the overpayment determination has been made to determine whether the original decision was correct. This reconsideration was an independent and thorough reexamination of all of the evidence of record concerning the overpayment. It was made by a specially trained staff, different from the staff that made the original decision.

Upon reconsideration it has been determined that (use 1, 2, or 3)

1. The prior decision was correct and an overpayment of $__________ has been made on your behalf. Please read about your rights and responsibilities below.

2. The prior decision was only partially correct, the actual overpayment made on your behalf totals $____________. Please read about your rights and responsibilities below.

3. The prior decision was incorrect and no overpayment exists. You may disregard our previous letter.

(Whenever 1 or 2 is used a clear and complete explanation concerning the overpayment must be inserted here in a manner similar to that set forth in Part A I.M. 3711.5 ff. In every letter the following standard paragraphs are to be used in situations 1 and 2. If 3 is used, include only an appropriate explanation of the decision, hearing paragraph, and final assistance paragraph.)

Under the Medicare law, the beneficiary is responsible for overpayments made on his behalf if the provider of services was not at fault in causing the overpayment. In this case, (Name of Provider), was not at fault. Therefore you are liable for the amount incorrectly paid to this provider for the services you received there. Please send us a check or money order for $________ within 30 days. The check or money order should be made out to (Name of Intermediary) and may be mailed in the enclosed self-addressed envelope. If you do not repay this amount, this overpayment will be referred to the Social Security Administration (or Railroad Retirement Board) for further recovery action which, among other actions, may result in the overpayment being deducted from any monthly social security (or railroad retirement) benefits to which you may be entitled.

The law requires that you must repay an overpayment of Medicare benefits unless both the following conditions are met:

1. You were without fault in causing the overpayment in that the information you furnished in connection with the claim was correct and complete to the best of your knowledge, and

2. Paying back the overpayment would keep you from meeting your ordinary and necessary living expenses or would be unfair. If you claim that repayment will cause you serious financial hardship, it will be necessary at a later date to submit a statement to the Social Security Administration regarding your income, assets, and expenses.

If you believe that both of the above conditions are met, you may request that recovery of this overpayment be waived by contacting any social security office or by writing to us, giving a brief statement of your reasons. If you go to a social security office, please take this letter with you.

If you carry private health insurance to supplement your Medicare benefits, you may be able to recover the amount of this overpayment by claiming benefits from the other plan, or (Name of Provider) may be able to submit such a claim on your behalf. If you have supplemental insurance and plan to file a claim for benefits to use the proceeds to refund the overpayment, please let us know. (Note: This paragraph is not to be used where the intermediary has determined that the other insurer will not pay for the services.)

If you are unable to refund this amount in one payment, you may do so in regular installments. If you prefer this method of payment please notify us promptly how much you are able to pay.

If you believe that this determination is not correct, you have the right to request a hearing within 60 days of the receipt of this letter if the amount of benefits in question is $100 or more. You may make such a request by writing us or through any social security office. The people there will be glad to assist you or answer any questions you may have about this determination. If you go to a social security office, please take this letter with you.

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosures 2 (Appeals Pamphlet,
Return Envelope
Situations 1 and 2)

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 8

MODEL LETTER TO PROVIDER WHO IS A PARTY TO A RECONSIDERATION REQUEST FILED BY THE BENEFICIARY INVOLVING WAIVER OF LIABILITY UNDER SECTION 1879

____
____
____

Dear (Administrator):

A request for reconsideration has been filed by ______________________ (on behalf of ______________________), HI claim number ______________________, with regard to the services rendered by (name of provider) from (dates of service). The initial determination that these services were not covered was made on the basis that they were custodial care (not reasonable and necessary). It was also determined that liability for these services could not be waived for (beneficiary). (Change this sentence in accordance with the facts in the case.)

Since (name of provider) was a party to the initial determination, you are also considered a party to the reconsideration determination. We will review all the evidence and findings upon which the initial determination was based and any additional evidence submitted. Thus, you have the right to submit any additional information in this case prior to the determination.

Please submit any such information to this office no later than (15 days). If there will be a delay in submitting material, please advise us. If we do not hear from you by (15 days), we will go ahead with the reconsideration. A copy of the reconsideration determination will be sent to you. (Modify this language if additional medical information is being requested in order to conduct the reconsideration.)

Signature

EXHIBIT V

RECONSIDERATION DETERMINATION MODEL COVER LETTER: 9

SAMPLE NOTICE TO THE RESIDENT INTERMEDIARY OF FULL OR PARTIAL REVERSAL

____
____
____

Re: HI:__________________________ Name:________________________________

Enclosed is a copy of our reconsideration determination for the above named health insurance claimant.

The initial determination being appealed has been fully reversed (dates involved)/partially revised (dates involved).

The provider of services should be advised promptly of this decision. When you have completed your action, forward a copy of your notice to the provider and copies of the corrected billing to the Reconsideration Branch in Baltimore, Maryland for association with the case file.

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

Form Approved
OMB No. 72-R0956

REQUEST FOR RECONSIDERATION OF PART A HEALTH INSURANCE BENEFITS

INSTRUCTIONS: *Please type or print firmly.* Leave the block empty if you cannot answer it. Take or mail the WHOLE form to your Social Security office which will be glad to help you. Please read the statement on the reverse side of page 2.

1. BENEFICIARY'S NAME

2. HEALTH INSURANCE CLAIM NUMBER

3. REPRESENTATIVE'S NAME, IF APPLICABLE

(☐ RELATIVE ☐ ATTORNEY ☐ OTHER PERSON) ☐ PROVIDER FILING

4. PLEASE ATTACH A COPY OF THE NOTICE(S) YOU RECEIVED ABOUT YOUR CLAIM TO THIS FORM.

5. THIS CLAIM IS FOR ☐ INPATIENT HOSPITAL ☐ EMERGENCY HOSPITAL ☐ SKILLED NURSING FACILITY (SNF) ☐ HOME HEALTH AGENCY (HHA) ☐ HEALTH MAINTENANCE ORGANIZATION (HMO)

6. NAME AND ADDRESS OF PROVIDER *(Hospital, SNF, HHA, HMO)*

CITY AND STATE

PROVIDER NUMBER

7. NAME OF INTERMEDIARY

CITY AND STATE

INTERMEDIARY NUMBER

8. DATE OF ADMISSION OR START OF SERVICES

9. DATE(S) OF THE NOTICE(S) YOU RECEIVED

10. I DO NOT AGREE WITH THE DETERMINATION ON MY CLAIM. PLEASE RECONSIDER MY CLAIM BECAUSE

11. YOU MUST OBTAIN ANY EVIDENCE *(For example, a letter from a doctor)* YOU WISH TO SUBMIT.

☐ I HAVE ATTACHED THE FOLLOWING EVIDENCE:

☐ I WILL SEND THIS EVIDENCE WITHIN 10 DAYS:

☐ I HAVE NO ADDITIONAL EVIDENCE OR OTHER INFORMATION TO SUBMIT WITH MY CLAIM.

12. IS THIS REQUEST FILED WITHIN 60 DAYS OF THE DATE OF YOUR NOTICE?

☐ YES ☐ NO

IF YOU CHECKED "NO" ATTACH AN EXPLANATION OF THE REASON FOR THE DELAY TO THIS FORM.

13. ONLY ONE SIGNATURE IS NEEDED. THIS FORM IS SIGNED BY: ☐ BENEFICIARY ☐ REPRESENTATIVE ☐ PROVIDER REP.

SIGN HERE ➧

14. STREET ADDRESS

CITY, STATE, ZIP CODE

TELEPHONE

DATE

15. If this request is signed by mark (X), TWO WITNESSES who know the person requesting reconsideration must sign in the space provided on the reverse side of this page of the form.

DO NOT FILL IN BELOW THIS LINE – FOR SOCIAL SECURITY USE – THANK YOU

16. ROUTING

☐ INTERMEDIARY

☐ BHI, RO

☐ BHI, DDR.

17. ADDITIONAL INFORMATION

18. SSA OR INTERMEDIARY DATE STAMP

FORM SSA-2649 (6-77) INTERMEDIARY Page 1 of 4

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION

Form Approved.
OMB No. 72-[illegible]

REQUEST FOR RECONSIDERATION OF PART A HEALTH INSURANCE BENEFITS

INSTRUCTIONS: *Please type or print firmly. Leave the block empty if you cannot answer it. Take or mail the WHOLE form to your Social Security office which will be glad to help you. Please read the statement on the reverse side of page 2.*

1. BENEFICIARY'S NAME	2. HEALTH INSURANCE CLAIM NUMBER

3. REPRESENTATIVE'S NAME, IF APPLICABLE (☐ RELATIVE ☐ ATTORNEY ☐ OTHER PERSON) ☐ PROVIDER FILING

4. PLEASE ATTACH A COPY OF THE NOTICE(S) YOU RECEIVED ABOUT YOUR CLAIM TO THIS FORM.

5. THIS CLAIM IS FOR ☐ INPATIENT HOSPITAL ☐ EMERGENCY HOSPITAL ☐ SKILLED NURSING FACILITY (SNF) ☐ HOME HEALTH AGENCY (HHA) ☐ HEALTH MAINTENANCE ORGANIZATION (HMO)

6. NAME AND ADDRESS OF PROVIDER *(Hospital, SNF, HHA, HMO)*	CITY AND STATE	PROVIDER NUMBER
7. NAME OF INTERMEDIARY	CITY AND STATE	INTERMEDIARY NUMBER
8. DATE OF ADMISSION OR START OF SERVICES	9. DATE(S) OF THE NOTICE(S) YOU RECEIVED	

10. REMARKS:

PROVIDER MEETS WAIVER PRESUMPTION CRITERIA:
☐ YES ☐ NO
IF NO, DOES PROVIDER MEET DENIAL STATISTICS ?:
☐ YES ☐ NO

11. DIAGNOSIS	12. INITIAL SERVICES PAID THRU INITIAL SERVICES NOT PAID THRU ADDITIONAL SERVICES TO BE PAID THRU

13. DAYS PAID UNDER WAIVER	14. ISSUE	15. AMOUNT IN CONTROVERSY ☐ UNDER $100 ☐ UNDER $1000	16. CONGRESSIONAL INTEREST? ☐ YES ☐ NO
17. ACTION TO BE TAKEN ☐ AFFIRMATION ☐ PARTIAL REVERSAL ☐ WITHDRAWAL ☐ REVERSAL ☐ DISMISSAL	18. SIGNATURE		
	19. TITLE		20. DATE

RECONSIDERATION BRANCH, BHI – COMPLETION CONTROL

FORM SSA-2649 (6-77) INTERMEDIARY Page 4 of 4

MODEL LETTER TO PROVIDER WHO IS A PARTY TO A RECONSIDERATION REQUEST FILED BY THE BENEFICIARY

____
____
____

Dear (Administrator):

A request for reconsideration has been filed by ____________________ (on behalf of ____________________), HI claim number ____________________, with regard to the services rendered by (name of provider) from (dates of service). The initial determination that these services were not covered was made on the basis that they were custodial care (not reasonable and necessary). It was also determined that liability for these services could not be waived for (beneficiary). (Change this sentence in accordance with the facts in the case.)

Since (name of provider) was a party to the initial determination, you are also considered to be a party to the reconsideration determination. This will be a complete review of all the evidence and findings upon which the initial determination was based and any additional evidence submitted. Thus, you have the right to submit any additional information in this case prior to the determination.

Please submit any such information to this office no later than (15 days). If there will be a delay in submitting material, please advise us. If we do not hear from you by (15 days), we will conduct the reconsideration. A copy of the reconsideration determination will be sent to you. (Modify this language if additional medical information is being requested in order to conduct the reconsideration.)

Signature

SAMPLE LETTER TO BENEFICIARY
(REVERSAL)

February 28, 1974

Mr. John Jones
737 Fifth Avenue
Rutledge, New Jersey 07580

Dear Mr. Jones:

Re: HI Claim Number 000-00-0000A

In response to your request for reconsideration of your (or Mr. Blank's) claim for Part A Medicare benefits, we performed a complete review of all evidence on the claim and have determined that the initial determination was not correct. The (insert name of provider of services) will make whatever refund is necessary in the event it was paid for all or part of the previously denied services.

> (Include here a brief statement of the facts of the case; the applicable provisions of the Social Security Law; and include a brief statement of the rationale used in making your determination.)

If you believe that this reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing before an administrative law judge of the Bureau of Hearings and Appeals. If you want a hearing, you must request it within 60 days of the date you receive this letter. You should make any such request through your social security office.

Any questions regarding the enclosed determination should be referred to:

Name and Address
of
Intermediary

Sincerely yours,

Jim Smith
Medicare Coordinator

Enclosure

Form SSA-[illegible] (1-73)

RECONSIDERATION DETERMINATION

TYPE OF CLAIM Hospital Insurance Benefits	DISTRICT OFFICE ————
NAME OF CLAIMANT Ella Messon	HEALTH INSURANCE CLAIM NUMBER 977-43-1000B

DETERMINATION

Mrs. Ella Messon was an inpatient in the Meadow Heights Community Hospital from August 13 through September 13, 1973. On August 26, 1973, Mrs. Messon was notified in writing by the hospital administrator that she would no longer be receiving covered care after August 26. On October 26, 1973 (the intermediary) sent Mrs. Messon a written notice that Medicare benefit payments could be made for the period August 13, 1973 through August 26, 1973. The basis for this decision was that the services furnished from August 13 through August 26 were medically indicated and that her condition required that the care be furnished in a hospital. Beginning August 27, 1973 through September 13, 1973, the determination was made that Mrs. Messon's condition did not require that she be in an acute general hospital.

On January 8, 1974, Mrs. Messon requested reconsideration on the basis that she had been so ill that she had to be cared for in a hospital until her discharge September 13, 1973.

There are two issues that must be considered in this determination. The first issue is whether the services rendered from August 27, 1973 through September 13, 1973, constitute a covered level of care under Title XVIII of the Social Security Act. The second issue, if the case is found to be noncovered, is whether Mrs. Messon knew or could reasonably be expected to have known that the services she received for the period in question were not covered by the Medicare program.

The Social Security Act provides for payment of inpatient hospital services when they are required on an inpatient basis for an individual's medical treatment or for a medically necessary diagnostic study. Two criteria must be met to qualify for the hospital level of care: the services the patient received in the hospital must be medically indicated, and it must have been reasonable to provide the needed care in a hospital rather than in a less costly facility or on an outpatient basis.

Mrs. Messon was admitted to the Meadow Heights Community Hospital on August 13, 1973, with the diagnosis of ulcerations of the left leg secondary to vascular impairment.

The medical evidence in Mrs. Messon's file shows that she was admitted to the hospital because of indolent ulcerations of the left leg which had not responded to home treatment. Her treatment in the hospital included bed rest, an antibiotic ointment, maintenance dose digitalis, antihypertensives, antibiotics, an intramuscular pain medication, and skin care measures. The physician's orders allowed her to be up in a chair as tolerated by August 15, 1973, and to walk by August 17, 1973. The physician's orders during the period from August 15 through August 17, 1973, concerned periodic renewals of the pain medication, FORM SSA-2371a (2-71) **RECONSIDERATION DETERMINATION** Page 2

NAME OF CLAIMANT	HEALTH INSURANCE CLAIM NUMBER
Ella Nesson	977-43-1000B

the encouragement of ambulation, an authorization for a daily tub bath, and care to prevent bed sores. Progress notes by the physician indicate improvement by August 17, 1973, and discontinuation on August 20, 1973, of an antibiotic. Subsequent progress notes indicate that her condition had stabilized. A nurses' note of August 22, 1973, relates that the patient was ambulatory in her room, and that she was up in a chair for much of the day. The subsequent nurses' notes indicate that she ate well, rested comfortably and had few complaints.

In his letter of August 14, 1973, Dr. Marcus W. Miller addressed himself to the beneficiary's need for continued inpatient care. He indicated that observation and daily treatment by skilled nursing personnel was needed.

A review of the medical records shows that by August 23, 1973, Mrs. Nesson was able to be up and about in her room. There were no subsequent changes in her medications. The medications she received did not require an acute hospital setting for their administration. She continued to need medical care including observation of the ulcerated leg and the application of topical medications, but the medical evidence after August 22, 1973, does not indicate that such care could not have been provided in a facility of a different type, such as a skilled nursing facility. The progress notes indicate that her condition was slowly improving and that she was stable.

Based on these facts, it is found that the services rendered Mrs. Nesson from August 27, 1973 through September 13, 1973, do not constitute covered care because the care provided did not necessitate the setting of an acute general hospital.

Whenever it is determined that services are not covered for the reasons stated above, the Social Security Act (section 1879) provides that the individual will not have to pay the hospital for the cost of the noncovered services if he or she did not know nor could reasonably be expected to know that Medicare would not pay for the services. The evidence in this case shows that Mrs. Nesson was notified in writing by the administrator of the Meadows Heights Community Hospital on August 26, 1973, that after that date she would no longer be receiving a level of care which would be covered by the Medicare program in a hospital setting. This written notice to Mrs. Nesson gave her knowledge that the Medicare program would not pay for her care. Therefore, it is found that Mrs. Nesson is liable for the cost of the noncovered services.

FORM SSA-2371e (2-71) **RECONSIDERATION DETERMINATION** Page 3

NAME OF CLAIMANT Ella Masson	HEALTH INSURANCE CLAIM NUMBER 977-43-1000B

In conclusion, it is determined upon reconsideration that: (1) the services furnished Mrs. Masson by the Meadow Heights Community Hospital were covered by the Medicare program from August 13 through August 26, 1973, and that the services rendered from August 27 through September 13 are not reimbursable under the Medicare program; and (2) Mrs. Masson is liable for the cost of the noncovered services.

Michael J. Bruil
Reconsideration Section Supervisor
February 23, 1974

SAMPLE LETTER TO PROVIDER (Reversal Notification)

March 21, 1974

Mercy Hospital
777 Anywhere Street
Patterson, New York 01873

RE: John Jones, HI Claim No.: 000-00-0000A

Dear Administrator:

A request for reconsideration has been filed by the Medicare beneficiary named above. As a result of our reconsideration review, it was determined that the claim submitted to Medicare for payment of the beneficiary's claim from (give dates of service) is reimbursable under the Medicare program.

You will be reimbursed the amount due from the Medicare program as soon as we receive written assurance (as per section 405.620(a) of Regulations No. 5), that you have not already been reimbursed for these services by the beneficiary or any third party; or if you have been reimbursed, that the incorrect payment has been refunded.

Bella Smith
Medicare Coordinator

LETTER TO PROVIDER WHICH IS PARTY TO RECONSIDERATION AND MEDICARE PAYMENT IS BEING MADE UNDER WAIVER OF LIABILITY PROVISION

____
____
____

Dear (Administrator):

Upon reconsideration of (beneficiary's name) claim to which you were made a party, it has been affirmed that the services rendered were noncovered under the Medicare law.

You will, however, receive reimbursement for these noncovered services from the Medicare program as a result of the waiver of liability provision (section 1879) of the Social Security Act. This payment is being made to you because it was determined upon reconsideration that neither the beneficiary nor your organization knew or could reasonably be expected to know that the services rendered during the period in question were noncovered (see the reconsideration determination enclosed). (Guide language to be modified if only partial payment is made.)

You will be reimbursed the amount due from the Medicare program as soon as we receive written assurance (as per section 405.620(a) of Regulations No. 5), that you have not already been reimbursed for these services by the beneficiary or any third party; or if you have been reimbursed, that the incorrect payment has been refunded.

If you believe the reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing before an administrative law judge of the Bureau of Hearings and Appeals. If you want a hearing, you must request it within 60 days of the date you receive this letter. You may make such a request through any social security office.

Signature

Enclosures (Cover letter and Reconsideration Determination)

SAMPLE NOTICE TO THE RESIDENT INTERMEDIARY OF FULL OR PARTIAL REVERSAL

____
____
____

Re: HI: ______________________ Name: ______________________

Enclosed is a copy of our reconsideration determination for the above named health insurance claimant.

The initial determination being appealed has been fully reversed (dates involved)/partially revised (dates involved).

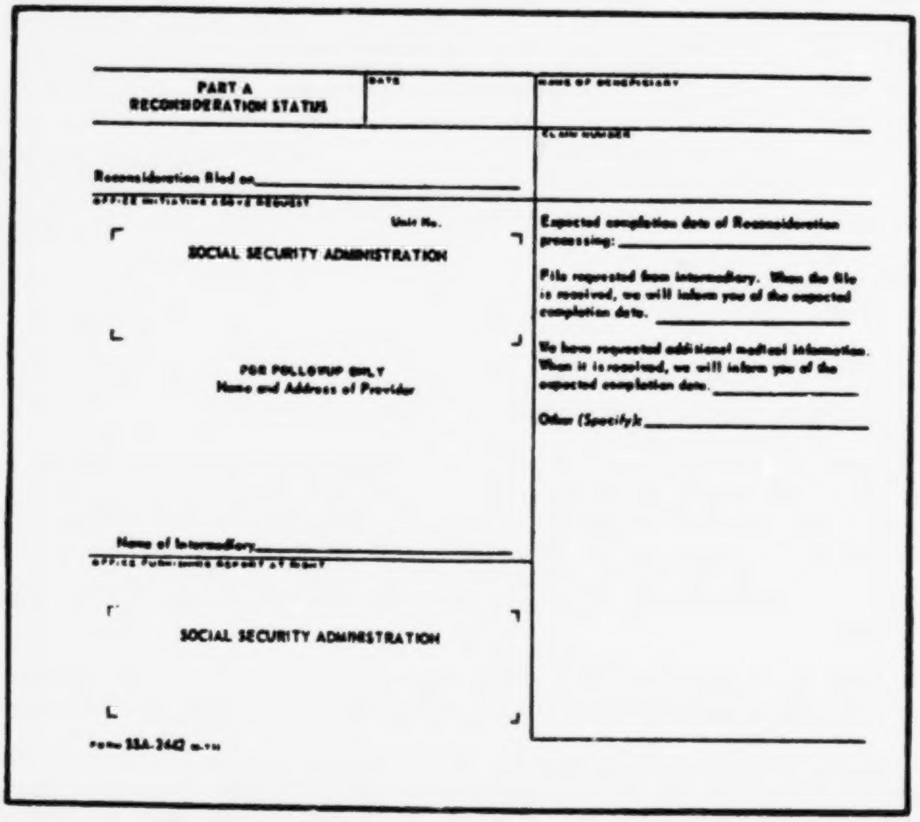
The provider of services should be advised promptly of this decision. When you have completed your action, forward a copy of your notice to the provider and copies of the corrected billing to the Reconsideration Branch in Baltimore, Maryland for association with the case file.

Sincerely yours,

Medicare Coordinator
(or equivalent)

Enclosure

FORM SSA-2442 PART A RECONSIDERATION STATUS



PART A
RECONSIDERATION STATUS

DATE

NAME OF BENEFICIARY

CLAIM NUMBER

Reconsideration filed on____________________

OFFICE INITIATING ABOVE REQUEST

Unit No.

SOCIAL SECURITY ADMINISTRATION

FOR FOLLOWUP ONLY
Name and Address of Provider

Name of Intermediary____________________

OFFICE FURNISHING REPORT AT RIGHT

SOCIAL SECURITY ADMINISTRATION

FORM SSA-2442 [illegible]

Expected completion date of Reconsideration processing: ____________________

File requested from intermediary. When the file is received, we will inform you of the expected completion date. ____________________

We have requested additional medical information. When it is received, we will inform you of the expected completion date. ____________________

Other (Specify): ____________________

LETTER TO ACCOMPANY RECONSIDERATION DETERMINATION

MEDICARE

FISCAL INTERMEDIARY FOR
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

February 23, 1974

Mrs. Ella Nesson
32 First Street
St. Joseph, Iowa 50010

Dear Mrs. Nesson:

Re: HI Claim Number 977-43-1000B

As the result of your request for reconsideration, a complete review of the claim for health insurance benefits has been made to determine whether the original decision was correct under the law and regulations. This reconsideration was an independent and thorough reexamination of all the evidence of record concerning this claim. It was made by a specially trained staff, different from the staff that made the original decision.

Upon review, it has been determined that the original decision is correct. The enclosed reconsideration determination fully explains the decision.

If you believe the reconsideration determination is not correct and the amount of benefits in question is $100 or more, you may request a hearing before an administrative law judge of the Bureau of Hearings and Appeals. If you want a hearing, you must request it within 60 days of the date you receive this letter. You may make such a request through any social security office. If you visit the office, please take this letter with you.

Any questions regarding the enclosed determination should be referred to:

Name and Address
of
Resident Intermediary

Sincerely yours,

Jim Smith
Medicare Coordinator

Enclosure

§ 3785, Exhibit 1

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

REQUEST FOR HEARING
PART A HEALTH INSURANCE BENEFITS

Take or mail original and all copies to your local Social Security office.

CLAIMANT'S NAME

WAGE EARNER'S NAME (Leave blank if same as above)

HI CLAIM NUMBER

NAME AND ADDRESS OF INTERMEDIARY

CLAIM FOR
☐ Hospital Services
☐ Extended Care Facility Services
☐ Home Health Agency Services
☐ Emergency Services

PERIOD IN QUESTION
FROM TO

NAME AND ADDRESS OF PROVIDER

I disagree with the determination made on the above claim and request a hearing before a hearing examiner of the Bureau of Hearings and Appeals. My reasons for disagreement are: (additional pages may be added if necessary.)

Check one of the following:

☐ I have additional evidence to submit. (Attach such evidence to this form or forward to the Social Security Office within 10 days.)

☐ I have no additional evidence to submit.

Check ONLY ONE of the statements below:

☐ I wish to appear in person before the hearing examiner.

☐ I waive my right to appear and give evidence, and hereby request a decision on the evidence before the hearing examiner.

Signed by: (Either the claimant or representative should sign-Enter addresses for both. If claimant's representative is not an attorney, complete Form SSA-1696)

SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ ATTORNEY ☐ NON-ATTORNEY	CLAIMANT'S SIGNATURE
ADDRESS	ADDRESS
CITY, STATE, AND ZIP CODE	CITY, STATE, AND ZIP CODE

TELEPHONE NUMBER	DATE	TELEPHONE NUMBER

Claimant should not fill in below this line

Is this request filed within 6 months of the reconsideration determination? ☐ Yes ☐ No
If "No" is checked: (1) attach claimant's explanation for delay, (2) attach any pertinent letter, material, or information in the Social Security Office.

ACKNOWLEDGMENT OF REQUEST FOR HEARING

Your request for a hearing was filed on ______________________ at ______________________
The hearing examiner will notify you of the time and place of the hearing at least 10 days prior to the date which will be set for the hearing.

[redacted]

For the Social Security Administration

By: ______________________________
(Signature) (Title)

____
(Street Address)

____
(City) (State) (ZIP Code)

INTERMEDIARY

3785. REQUEST FOR HEARING UNDER PART A.—
Under the law a beneficiary has a right to a hearing if he is dissatisfied with the reconsideration determination and the amount in controversy after the reconsideration action is $100 or more. (See § 3781.1.)

3785.1 Determining The Amount In Controversy.—Hearings are conducted by the Office of Hearings and Appeals of the Social Security Administration. The Administrative Law Judge (ALJ) decides whether the amount of benefits is $100 or more. The following principles are applied by the ALJ in determining the amount in controversy.

A. The amount in controversy is equal to the charges for items or services found not to be covered, less the applicable deductible and coinsurance amounts. Any payment made under Section 1879 of the Act (waiver of liability) is included in the amount in controversy.

B. If direct payment was made to the beneficiary for covered emergency services in a hospital that did not elect to bill the program, the amount in controversy is computed as 60% and 80% respectively of the reasonable charges for routine and ancillary services furnished after the deductible and coinsurance amounts have been applied.

C. Where the issue relates to provider services, all items or services in dispute arising from a single, continuous period of treatment are considered regardless of the provider's billing practices.

D. A service of posthospital home health visits is considered collectively.

E. Appeals from determinations pertaining to inpatient hospital services, extended care services, or home health services are not additive for determining the amount in controversy except when:

1. The denial of payment for inpatient hospital services prevents the individual from meeting a requirement for payment of extended care or home health services; or

2. The same factor is at issue in more than one claim for benefits by the individual. (For example, an individual is hospitalized twice in June. In each case his claim is denied on the grounds that the hospitalization occurred in the same benefit period which began before June and in which the beneficiary had used all available benefit days. The individual appeals, claiming he was in a new spell of illness and had the full number of benefit days available.)

F. Where services or items proposed to be provided have been disapproved by the Professional Standards Review Organization (PSRO), the amount in controversy is determined upon the basis of reasonable estimates of the amounts which would be charged the individual if such services or items were provided.

3785.2 Request Filed With Social Security Office.—After the Social Security office takes a request for hearing (Request for Hearing Part A Health Insurance Benefits—HA-5011-U6), or if the hearing request is sent to them by mail, the copies of the HA-5011-U6 are distributed immediately as follows:

a.	Claim File (White)	To the fiscal intermediary, PSRO or HMO . If a copy of the reconsideration is available, it is attached.
b.	Hearing Office (Pink)	To appropriate ALJ according to geographical location of the District Office.
c.	District Office (Yellow)	Retained in D/O; or mailed to resident D/O if hearing request was filed in nonresident office.
d.	Intermediary, PSRO or HMO (Blue)	Mailed to fiscal intermediary, PSRO or HMO.
e.	Regional Office (White)	To appropriate Regional Office according to geographical location of the fiscal intermediary.
f.	Claimant's/Representative's (White)	Given or mailed to claimant/representative

NOTE: The HA-5011-U6 is currently under revision. The above copy and distribution breakdown reflects the changes which will be incorporated in the revised form. Until such time as the new form is available, the Claimant's Copy should be utilized as the Regional Office Copy, and the Representative's Copy as the Claimant's/Representative's Copy.

3785.3 Request For Hearing Filed With Resident Or Reconsideration Intermediary.—A request for hearing must be in writing and signed by the beneficiary or his respresentative and indicate the reason(s) for disagreement.

When correspondence is received from a beneficiary, determine whether he wants a further explanation of the notice or if he is requesting a hearing. If the correspondence is treated as a request for information or clarification of a notice, explain the determination to the beneficiary in greater detail. Resolve any doubt as to whether the beneficiary's correspondence is an implied hearing request, by treating it as a hearing request. If the beneficiary contacts the intermediary in person and states he wishes to file for a hearing, take a written request to that effect.

When a beneficiary contacts the intermediary by telephone to request a hearing, refer to the Social Security office.

3785.4 Request For Hearings Received By The Intermediary Pertaining To PSRO or HMO.—Transmit all hearing requests pertaining to PSRO or HMO received to the appropriate PSRO or HMO. They will develop the request and forward the claim file to the Reconsideration Evaluation Branch for processing.

3785.5 Resident Intermediary Action On Incoming Requests.—Forward hearing requests received by the resident intermediary immediately to the reconsideration intermediary for processing along with any additional information not forwarded with the reconsideration claim file.

3785.6 Reconsideration Intermediary Action On Incoming Requests.—Upon receiving a request for hearing as described in SS 3785.3 & 3785.5, the reconsideration intermediary screens the incoming material and insures that the request for hearing is applicable to a Part A inpatient file maintained by them. When processing a hearing request (Form HA 5011-U6) received from the resident intermediary or completed by the reconsideration intermediary, the copies are not distributed as described in S 3785.2. Include the form, in its entirety in the claim file, with the exception of the (blue) Intermediary, PSRO or HMO copy which is retained by the intermediary for record purposes.

3785.7 Request For Claim File (Sent By Hearing Office).—Hearing request material referred by the hearing office will be: (1) sent to the reconsideration intermediary when received by the resident intermediary and (2) reviewed by the reconsideration intermediary to establish whether the hearing request is premature, does in fact relate to a Part A Hospital Insurance benefit claim, or may relate to other benefits. This usually requires coordination with the hearing office to determine what information may be available about the claim at issue. After all facts have been developed to establish that the hearing request is valid or invalid, premature, pertains to other benefits, or is not within the intermediary's jurisdiction, return the request to the hearing office according to the disposition of the action taken.

3785.8 Reconsideration Intermediary Prescreening And Documentation Of Hearing Request.—To insure that hearing offices receive claim files within a reasonable period of time (15 calendar days) after the receipt of a hearing request in amount in controversy cases, it is necessary that the reconsideration intermediary establish proper control procedures during the prescreening of cases.

3785.9 Assembling The Hearing Claim File.—All hearing requests when received by the reconsideration intermediary are sent to the hearing office in a folder. Each folder reflects the beneficiary's HI Claim Number on one line followed directly by the surname, first name and middle initial, (if shown). All claims material pertaining to the services in question, including the envelope in which the request for hearing was received are prongfiled in this folder in chronological order by type of evidence. The file includes, to the extent possible, only the original documents and no duplicate material.

3785.10 Examination Of Claim File.—Carefuly examine the files before they reach the hearing offices in order to assure that they contain all the pertinent documents which may be available. Complete the Health Insurance Case Summary (HCFA-383), (see S3785.17, Exhibit 2), on hearings being forwarded to the hearing office. This form reflects the pertinent facts concerning the beneficiary, the history of the claim, the evidence and the dates thereof, the services and medications prescribed, and any other relevant information. Include a copy of this form in the file and retain a copy for record purposes.

A. Documentation Not Needed.—If you determine that the file contains all pertinent documents and that further documentation is not needed, mail the claim folder to the appropriate hearing office. (See § 3785.14.)

B. Documentation Needed.—When further documentation is needed, prepare a development letter which describes the information desired and request the resident intermediary or provider of services to expedite and return the requested material as soon as possible. When requesting documentation to complete the file, furnish at least 35 days of records beyond the last covered day on all SNF cases and records to the extent of the review on all HOSPITAL and HHA cases.

C. Additional Evidence Requested From Hearing Office.—The hearing office, after receiving a claim folder, may wish additional evidence or records, even though the required documentation is in the file. They may do so by requesting the information from the regional office which in turn contacts the reconsideration intermediary. When the material is recieved, immediately forward the evidence to the hearing office.

D. Amount In Controversy Less Than $100.—Where the amount in controversy after reconsideration is less than $100 (see § 3785.1), route the file to the hearing office (see § 3785.14) for appropriate dismissal action.

E. Request for Hearing Not Timely Filed.--When a request for hearing is not timely filed and no further documentation is needed, forward the folder to the hearing office. (See § 3785.14.) If a late filed hearing request is received for processing and is accompanied by proper documentation explaining the delay, develop the claim file before forwarding it to the hearing office and follow the procedures previously described. (See § 3785.14.)

F. Part B Hearing Request.—Where the hearing request material (usually the blue claim file copy) and/or attachments and development clearly indicate that a Part B Claim or appeal and reimbursable is involved, send the original material to the Social Security office according to the geographical location of the beneficiary/representative for completion of proper appeal forms and routing action. This action results in forwarding copies of the material development to the hearing office for appropriate dismissal action. Where the hearing request is intact, and it is established that Part B is involved, do not send it to the hearing office since no further action is necessary. Return all material to the Social Security office for corrective action and proper routing.

G. Hearing Request Prematurely Filed.—When a hearing request is prematurely filed, make and use photocopies of the material as an implied request for reconsideration and process a reconsideration on the claim involved. Place the original material in a folder and route it to the hearing office. (See § 3785.14.)

H. Reconsideration in Process Not Completed By The Intermediary.—When a hearing request is received and a reconsideration is in process which cannot be completed within 5 working days after receipt of a hearing request, route the request to the hearing office. (See § 3785.14.) If the reconsideration can be completed within the time frame, follow the procedure in § 3785.10(G).

I. No Valid Request For Reconsideration Received By The Intermediary.—When a hearing request is received and it is determined that there was no valid request for reconsideration and/or the time frame to request same has expired, dismiss the appeal. Route the claim file to the hearing office. (See § 3785.14.)

J. Other Jurisdictional Problems.—In any situation or set of circumstances where existing procedures are not adequate to deal with the handling of a particular claim or hearing request material, use your best judgement as to the proper disposition of material at hand.

3785.11 Prehearing Case Review.—The reconsideration intermediary, when it receives all outstanding evidence and believes the claim file is complete, screens the case for possible action which would be fully favorable to the beneficiary before forwarding the case for hearing. Where the review discloses a situation in which such fully favorable action is indicated, prepare a covering memorandum detailing recommended revision and rationale, and forward the claim file with the memorandum to the regional office for review. There are three criteria by which to judge whether a determination will be reviewed:

A. Additional evidence is submitted with the request for hearing;

B. There is an allegation or indication that additional evidence is available; or

C. There are other indications that a revision may be in order, e.g., an error has been noted in the file or there has been a change in the law or regulations pertinent to the claim.

3785.12 Regional Office Action On Receipt Of Recommended Revision.—The regional office reviews the case and the reconsideration intermediary's recommendation and takes one of two actions:

A. If it disagrees entirely with the recommendation and believes that no revision of the determination is in order, it prepares a rebuttal and returns it, along with the claim file to the reconsideration intermediary for necessary action.

B. If it does agree, wholly or in part, with the recommendation, it prepares a rationale to that effect and sends it, along with the claim file for necessary action.

3785.13 Reconsideration Intermediary Action On Hearing Request After Recommended Revision From The Regional Office.—

A. If the regional office returns the claim file without having revised the reconsideration determination, remove and retain the recommendation, the rebuttal, and any other intermediary or regional office generated documents added to the file subsequent to the date of the request for hearing (e.g., physician opinions on which the recommendation or rebuttal was based). Route the claim file to the appropriate hearing office. (See S3785.14.)

B. When the regional office has revised the reconsideration determination, and decided that payment should be allowed in full on the bases of covered care, send a revised reconsideration determination, using Model Letter. (See S 3785.17, Exhibit 6.) Send copies of the revised determination to all parties of the reconsideration together with appropriate cover letters including appeals language. Use exhibit 6 letter only when the entire claim is to be fully covered. In such a case, the revised reconsideration determination may be made a part of the letter. Include a brief summary of the facts and a rationale for the amended decision. Prepare a Transmittal Notice -Hearing Case (HCFA-636) (See S 3785.17, Exhibit 3) dismissing the hearing request since there will be no amount in controversy. Forward this along with the revised reconsideration determination to the hearing office. Retain the claim as any other reconsideration file.

C. If the regional office has partially revised the determination, but there remains an issue or an amount in controversy, send a revised determination using Model Letter (See S 3785.17, Exhibit 7) to all parties of the reconsideration. (Use this letter in all revisions, even if liability is waived on behalf of all parties, as long as some item or service remains noncovered). After assuring that all documents pertinent to the revised reconsideration determination are in file, route the file to the appropriate hearing office. (See S 3785.14.)

3785.14 Routing The Hearing Claim File To The Hearing Office.—

A. When forwarding the claim file to the hearing office, place the claim file copy of the request for hearing, (HA-5011-U6) (see S 3785.17, Exhibit 1) on the top of the material in the folder. Complete the form HCFA-636, (see S 3785.17, Exhibit 3) checking the appropriate block according to the facts involved. Distribute copies of the HCFA-636 as follows:

1. Place the original copy in the file on top of the HA-5011-U6.
2. Retain the other copy for record purposes.

B. Prepare and duplicate an acknowledgement letter. (See S3785.17, Exhibit 4.) Send the original to the beneficiary/representative and place the other copy in the folder.

C. Attach to the front of the folder the Health Insurance Appeal Case Form (HCFA-3509). (See S 3785.17, Exhibit 8.) This form represents the routing instructions for the hearing offices after they complete their action on the request. It is very important to place this form in ALL folders sent to the hearing offices and to check the correct return address block.

D. Prepare a Part A Pre-Hearing Input Record (HCFA-353) (see §3785.17, Exhibit 5) on all hearing cases forwarded to the hearing offices. See § 3785.16 for completion of this form. Mail the claim file to the appropriate hearing office.

3785.15 Inquiries Or Status Requests Received By The Reconsideration Evaluation Branch.—When the Reconsideration Evaluation Branch receives inquiries pertaining to hearings (other than PSRO's) they direct these inquiries or status requests to the appropriate intermediary for response.

3785.16 Instructions For Completing Form HCFA-353 Part A Pre-Hearing Input Record (See § 3785.17, Exhibit 5).—The following instructions pertain to the preparation of this form. The information supplied is processed by computer and is used by the Reconsideration Evaluation Branch for statistical purposes. Since it is imperative that the coded information be as accurate as possible, no single document should be used solely without cross verification of data. Upon completion, a copy of the form should be made for the claim file and the original mailed immediately to:

Health Care Financing Administration
Reconsideration Evaluation Branch, BPO
P.O. Box 770
Baltimore, MD 21203

Complete the following data elements. They are left justified, and use no embedded blanks or special characters unless specifically stated. Also, code all alphabetical letters as CAPITAL letters.

1. INITIAL OR REVISION RECORD.—Check the appropriate block.

2. RECORD IDENTIFIER.—This item is pre-printed and constant.

3. HEALTH INSURANCE CLAIM NUMBER.—These positions are alpha-numeric and contain a maximum of 12 (including the suffix) positions. Once thi number is entered into the system it cannot be changed by submitting a revision form. Examples of HI Claim Numbers are:

218401964A
WD234567893
218401967W7
MA123456

NOTE: It is imperative that the HI Claim Number information (including suffix and any override letter) and the Admission/HHA Date be completed exactly as shown on the HCFA-352.

4. ADMISSION/HHA DATE.—These positions are numeric and contain a 6-position valid date—MMDDYY. On Home Health Agency (HHA) cases enter the first day of the period in question. The Admission/HHA Date must be earlier than the currrent date. Once the number is entered into the system it cannot be changed by submitting a revision form.

5. SURNAME.—Enter the last name of the beneficiary (up to 12 characters) who received the services.

6. Given Name.—Enter the first name of the beneficiary (up to 5 characters) who received the services.

7. Amount in Controversy.—This item consists of one numeric character. Code it based on the amount in controversy following the latest reconsideration determination, since its purpose is to show whether further appeal is possible.

8. Provider Number.—Enter the providers assigned 6-position number. If the case involves a provider which does not participate in the Medicare program, show 990999 (hospital) 995999 (SNF), and 997999(HHA). However, the identification numbers assigned to federal and emergency-only facilities consist of a 6-position alpha-numeric numbers e.g., 21521F or 21001E. The 3rd numeric position always determines the type of facility:

0, 1, 2, 3, 4 = Hospital
5, 6 = (SNF)
7 = (HHA)

9. REQUESTED BY.—This field is blank or contains a one numeric character based on who filed the request for hearing.

10. HEARING FILED.—These positions are numeric and contain a 6-position valid date—MMDDYY. Enter the date shown on the HA-5011-U6 under acknowledging request for hearing. If this date is not present, use the postmark on the envelope. When neither of these two dates is available, use the date the beneficiary/representative filed the request for hearing. When requests are received on anything other than Form HA-5011-U6, use the date on the correspondence. However, if the correspondence is undated, use the postmark on the envelope. This date must be later than the Admission/HHA Date.

11. INTERMEDIARY NUMBER.—This field contains the 5-position number assigned to the intermediary which processed the initial denial decision.

12. HA-5011-U6 RECEIPT DATE.—These positions are numeric and contain a 6-position valid date—MMDDYY. If the request was originally received by the resident intermediary, enter its receipt date. Otherwise, show the date received by the reconsideration intermediary. This date must be later than the Date Hearing Filed.

13. FOLDER ASSIGNED TO.—These positions can be blank or contain 6 alpha-numeric characters. If this field is present, it indicates the person responsible for the prehearing review.

14. ASSIGNMENT DATE.—These positions can be blank or contain a 6-position numeric valid date—MMDDYY. If the Folder Assigned To field is present, this date must also be present. This date must be equal to or later than the HA-5011-U6 Receipt Date.

15. DEVELOPMENT REQUESTED DATE.—Enter the 6-position numeric valid date—MMDDYY if additional evidence was requested. Otherwise, this field is blank. This date must be equal to or later than the HA-5011-U6 Receipt Date as well as the Assignment Date.

16. DATE REFERRED TO REGIONAL OFFICE.—These positions are numeric and contain a 6-position VALID DATE—MMDDYY. This date is present if the file is sent to the regional office. (See § 3785.11 Prehearing Case Review.) Otherwise, this field should is blank. If this date is present, it must be later than or equal to the HA-5011-U6 Receipt Date, the Assignment Date and the Development Requested Date.

17. DATE RETURNED TO INTERMEDIARY.—These positions can be blank or contain a 6-position numeric, valid date—MMDDYY. If this date is present, the Date Referred To Regional Office must also be present. The Date Returned to Intermediary must be later than the Date Referred to Regional Office.

18. DECISION MODIFIED.—This field is blank or contains a one numeric character based on the recommendation received from the regional office. (See § 3785.13 (B) (C). If this field is present, the Date Returned to Intermediary must also be present.

19. DATE HEARING SENT TO OHA.—These positions are numeric and contain a 6-position valid date—MMDDYY. This field is present when the file is sent to the Office of Hearing and Appeals (OHA). This date must be equal to or later than the HA-5011-U6 Receipt Date, Assignment Date (if present), Development Requested Date (if present), and the Date Returned to Intermediary (if present). This date cannot be later than the current date.

20. HEARING OFFICE.—These positions are alpha-numeric and when present indicates the hearing office to which the case was sent. If the Date Hearing Sent to OHA is present, this field must also be present.

3785.17 Standard Exhibits Referred To In §§ 3785- 3785.16.—The following exhibits are examples of the various forms used in the pre-hearing review function. Complete the required entries on these forms using current information available.

Exhibit No. 1	Form HA-5011-U6 - Request for Hearing Hospital Insurance Benefits Payable Under Part A of Title XVIII
Exhibit No. 2	Form HCFA-383 Health Insurance Case Summary
Exhibit No. 3	Form HCFA-636 Transmittal Notice - Hearing Office
Exhibit No. 4	Sample acknowledgement letter to beneficiary/representative when hearing is sent to the hearing office.
Exhibit No. 5	Form HCFA-353 Part A Pre-Hearing Input Record
Exhibit No. 6	Sample Letter — Full payment, revised reconsideration determination after request for hearing has been filed.
Exhibit No. 7	Sample Letter — Partial payment, revised reconsideration determination after request for hearing has been filed.
Exhibit No. 8	Form HCFA-3509 Health Insurance Appeal Case Folder (HCFA)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

SEE PRIVACY ACT NOTICE ON REVERSE SIDE OF FORM.

REQUEST FOR HEARING

HOSPITAL INSURANCE BENEFITS PAYABLE UNDER PART A OF TITLE XVIII

(Amount in Controversy, $100.00 or more)

Take or mail original and all copies to your local Social Security office

CLAIMANT	CLAIM FOR ☐ Inpatient Hospital Services ☐ Skilled Nursing Facility Services ☐ Home Health Agency Services ☐ Emergency Services ☐ Other (identify)
WAGE EARNER (Leave blank if same as above)	
HI CLAIM NUMBER	PERIOD IN QUESTION FROM TO
NAME AND ADDRESS OF INTERMEDIARY OR PROFESSIONAL STANDARDS REVIEW ORGANIZATION	NAME AND ADDRESS OF PROVIDER (INSTITUTION)

I disagree with the determination made on the above claim and request a hearing. My reasons for disagreement are

Check ONLY ONE of the statements below ☐ I have additional evidence to submit (Attach such evidence to this form or forward to the Social Security Office within 10 days.) ☐ I have no additional evidence to submit	Check ONLY ONE of the statements below ☐ I wish to appear in person ☐ I do not wish to appear at a hearing. I request that a decision be made on the basis of the evidence in my case

Signed by: (Either the claimant or representative should sign — Enter addresses for both. If claimant has a representative, Form SSA-1696-U3 (Appointment of Representative) must be completed.)

SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE ☐ Attorney ☐ Non-Attorney		CLAIMANT'S SIGNATURE
ADDRESS		ADDRESS
CITY, STATE, AND ZIP CODE		CITY, STATE, AND ZIP CODE
AREA CODE AND TELEPHONE NUMBER	DATE Claimant should not fill in below this line	AREA CODE AND TELEPHONE NUMBER

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

Is this request timely filed? ☐ YES ☐ No

If "No" is checked: (1) Attach claimant's explanation for delay; (2) Attach any pertinent letter, material, or information in the Social Security Office

Interpreter Needed ____________ (Language, including sign language)

ACKNOWLEDGMENT OF REQUEST FOR HEARING

This request for hearing was filed on ____________ at ____________

The Administrative Law Judge will notify you of the time and place of the hearing at least 10 days in advance of the hearing.

HEARING OFFICE COPY	TO ☐ Hearing Office ____________ (Location)	For the Social Security Administration By ____________ (Signature) ____________ (Title) ____________ (Street Address) ____________ (City, State, and Zip Code) ____________ Servicing Social Security Office Code ____________
CLAIM FILE COPY	TO ☐ HCFA, Bureau of Program Operations Attn: Recon and Eval Branch Box 770, Baltimore, Md. 21203 ☐ HCFA, Medicare Bureau Regional Office ____________	

Form HA-5011-U6 (10-82)
7/81 edition may be used

ATTACH A COPY OF THE RECONSIDERATION DETERMINATION (IF AVAILABLE) TO THIS COPY

HEALTH INSURANCE CASE SUMMARY

1. Health Insurance Claim No.

2. Beneficiary

3. Representative ☐ Yes ☐ No

Attorney ☐ Yes ☐ No

4. Date of Birth

Age (On Admission or When Services Began)

5. Date of Initial Determination

Number of Days/Visits Paid

Dates

6. Date of Recon Determination

Number of Days/Visits Paid

Dates

7. Date of Hearing Request

Waiver of Appearance ☐ Yes ☐ No

8. Number of Days/Visits at Issue

Dates

9. Provider Name

☐ Hospital ☐ SNF ☐ HHA

10. Intermediary Name

11. Qualifying Stay (Name of Facility)

Dates

12. Current Status
- ☐ Still Patient
- ☐ Discharged ______
- ☐ Died ______

13. Amount of Controversy
- ☐ ______
- ☐ Unknown, but at Least $100

14. Issue
- ☐ Level of Care
- ☐ Other ______

15. Hospital Diagnoses

Admission

Discharge

16. SNF Diagnosis (ES)

17. Pertinent Evidence and Dates

- ☐ A. Hospital Admission Record
- ☐ B. Hospital Discharge Summary
- ☐ C. Nurses' Notes From ______ To ______
- ☐ D. Medication Charts From ______ To ______
- ☐ E. Doctor's Orders From ______ To ______
- ☐ F. Doctor's Progress Notes From ______ To ______
- ☐ G. Physical Therapy Notes From ______ To ______
- ☐ H. Hospital to SNF Transfer Form
- ☐ I. Certification and Recertifications
- ☐ J. URC Decisions ______
- ☐ K. Eligibility Form
- ☐ L. Billing Form
- ☐ M. Other (i.e., M.D. Letters, Consultant's Reports, Lab Tests, Graphic Charts, Etc.)

18. Summary of Services

- ☐ A. Indwelling Catheter
- ☐ B. Tube Feeding
- ☐ C. IV Fluids
- ☐ D. Suction
- ☐ E. Oxygen
- ☐ F. Restraints
- ☐ G. Traction
- ☐ H. IM, IV, SC Medications
- ☐ I. Sterile Dressings
- ☐ J. Oral Medications Requiring Close Supervision
- ☐ K. Other

19. Comments and Other Pertinent Facts

FORM HCFA-383 (12-82)

TRANSMITTAL NOTICE - HEARING CASE

Health Insurance Claim Number

TO Hearing Office (City and State)

Beneficiary's Name

Appellant's Name

FROM Name and Address of Intermediary/R.E.B.

Type of Claim

Date of Reconsideration Notice

Date of Hearing Request

This File Has Been Examined And We Find That:

(Check Appropriate Block/s)

- ☐ 1. The documentation is adequate.
- ☐ 2. The documentation is not adequate to render a hearing decision. The necessary material has been requested and will be forwarded to you when received.
- ☐ 3. The sole issue appears to be whether your office has jurisdiction in this matter. Pursuant to section 1869 (b) of the Social Security Act, the beneficiary has no right to a hearing as the amount in controversy is apparently less than $100.
- ☐ 4. Although the documentation is adequate, the request for hearing appears to be not filed timely. It should be first decided whether "good cause" for late filing exists.
- ☐ 5. A dismissal action is necessary since the appeal request pertains to a Part B medical insurance claim. The original request has been returned to the Social Security Office for proper filing and routing.
- ☐ 6. A dismissal action is necessary since the beneficiary has no right to a hearing before a reconsideration determination has been rendered. We are initiating a reconsideration review of the Part A claim for which the hearing was prematurely filed.
- ☐ 7. The reconsideration claim is currently being processed. Therefore, the appeal should be dismissed since the beneficiary has no right to a hearing before a reconsideration determination has been rendered.
- ☐ 8. A dismissal action is necessary since the fiscal intermediary has determined that there was no valid request for reconsideration and/or the time frame to request same has expired.
- ☐ 9. Other (Give Reason)

Remarks:

ATTACHMENT, ☒ CLAIM FILE

Date HA-5011-U6 Received In This Office

Approved Or Certified By

Title

Date

Form HCFA-[illegible] (12-82)

Exhibit No. 4: SAMPLE ACKNOWLEDGEMENT LETTER TO BENEFICIARY/REPRESENTATIVE WHEN HEARING IS SENT TO THE HEARING OFFICE

Date__________

Name of Beneficiary/Representative

Dear__________

Re: H.I. Claim Number

This is in reply to your request for hearing.

We have completed our development on the claim and forwarded the file to the

____

____.

You will be notified by them as to the time and place of the hearing. If you have further questions concerning this matter, they will be glad to assist you.

Sincerely yours,

Medicare Coordinator
(or Equivalent)

PART A PRE-HEARING INPUT RECORD

☐ INITIAL ☐ REVISION

RECORD IDENTIFIER
B B

HI CLAIM NUMBER

ADMISSION/HHA DATE — (MMDDYY)

SURNAME

GIVEN NAME

AMT IN CONTROVERSY
1 UNDER $100
2 $100 to $1000
3 OVER $1000

PROVIDER NUMBER

REQUESTED BY
BLANK BENEFICIARY
1 ATTORNEY 3 PROVIDER
2 RELATIVE 4 OTHER

HEARING FILED (MMDDYY)

INTER NUMBER

5011 REC. DATE IN R.E.B. (MMDDYY)

FOLDER ASSG. TO

ASSG. DATE (MMDDYY)

DEV. REQ. DATE (MMDDYY)

INT. REMAND DATE (MMDDYY)

DATE RTN'D TO R.E.B. (MMDDYY)

DECISION MODIFIED
1. YES
2. NO

DATE HEARING SENT TO OHA (MMDDYY)

HEARING OFFICE

CORRECTION
BLANK — GOOD
— BAD

CODING CLERK

DATA ENTRY CLERK

FORM HCFA - 353 (2-82) (FORMERLY HCFA-4529)

Exhibit No. 6: SAMPLE LETTER — FULL PAYMENT, REVISED RECONSIDERATION DETERMINATION AFTER REQUEST FOR HEARING HAS BEEN FILED

Date__________

Name of Beneficiary/Representative

Dear__________

Re:

H.I. Claim Number

Following receipt of your request for hearing, the Bureau of Program Operations requested that we again review your claim before the heairng. We have now determined that the prior determination can be revised. (Brief summary of the facts and rationale may be inserted here if the intermediary prefers not to prepare a separate reconsideration determination .)

Accordingly, payment will be made to the provider (name of provider) for the entire cost of the services you received, less any applicable deductible or coinsurance, as soon as we receive verification from the provider that it has refunded to you any moneys paid by you or on our behalf in excess of such applicable deductible or coinsurance amounts. If you have paid (name of provider) for the services you received, you can expect a refund.

Because this determination leaves no amount or issue in controversy, the administrative law judge (ALJ) assigned to hear your case will dismiss your request for hearing unless you request in writing, within 30 days, that it not be dismissed.

You may request a hearing on this revised reconsideration determination before an ALJ of the Office of Hearings and Appeals within 60 days of the date you receive this letter if you believe that the amount of benefits in controversy is $100 or more. (Social Security regulations require that an explanation of appeal rights accompany every determination even if, as in this case, a fully favorable decision has been made.)

Any questions or requests regarding your claim or this determination may be referred to your social security office or:

Name and Address of Intermediary

Sincerely yours,

Medicare Coordinator
(or Equivalent)

Enclosure (No enclosure if the revision is included in the text of this letter.)

Exhibit No. 7: SAMPLE LETTER — PARTIAL REVISION, REVISED RECONSIDERATION DETERMINATION AFTER REQUEST FOR HEARING HAS BEEN FILED

NOTE: Only one of the two parenthetical remarks in paragraph 2 to this letter is to be used.

Date_________

Name of Beneficiary/Representative Address

Dear__________

Re: H.I. Claim Number

Following receipt of your request for hearing, the Bureau of Program Operations requested that we again review your claim before the hearing. We have now determined that the prior determination can be partially revised. The enclosed determination explains the revised determination we have made on your claim.

(Additional payment will be made to the provider (name of provider) for the previously denied services now found to be payable as soon as we receive verification from the provider that it has refunded to you any payment made by you or on your behalf for such services.)/(It has been found that your liability is not as extensive as was previously determined. The name of provider) will be responsible for the cost of the services you received from ______ to ______.) If you have paid for the care you received, you may expect a refund from (name of provider) for any amount over the charges for any applicable deductible and coinsurance or services still not covered or waived.

Your claim will be scheduled for a hearing by an administrative law judge of the Office of Hearings and Appeals in the near future unless you and all other parties to the reconsideration determination state in writing that you no longer wish to have such a hearing.

Any questions regarding this determination may be referred to your social security office or to:

Name and Address
of Intermediary

Sincerely yours,

Medicare Coordinator

Enclosure

HEALTH INSURANCE APPEAL CASE FOLDER (HCFA)

CLAIM NO. ____________________

IMPORTANT: TO ENSURE PROPER DISPOSITION OF THE ATTACHED FOLDER, THIS FORM SHOULD NOT BE REMOVED BY OTHER THAN REGIONAL OFFICE/REB PERSONNEL.

THIS IS A HEALTH INSURANCE APPEAL CLAIM FOLDER WHICH MUST BE RETURNED AFTER ACTION TO: ("X" APPROPRIATE BOX)

☐ HCFA REGIONAL OFFICE
JOHN F. KENNEDY FEDERAL BLDG.
ROOM 1309
BOSTON, MA 02203
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
ROOM 3800
26 FEDERAL PLAZA
NEW YORK, NY 10278
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
10th FLOOR
P.O. BOX 7760
PHILADELPHIA, PA 19101
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
7th FLOOR
101 MARIETTA STREET
ATLANTA, GA 30323
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
8th FLOOR
175 W. JACKSON BOULEVARD
CHICAGO, IL 60604
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
ROOM 2435
1200 MAIN TOWER BLDG.
DALLAS, TX 75202
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
ROOM 225
601 EAST 12th STREET
KANSAS CITY, MO 64106
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
FEDERAL OFFICE BLDG, RM 530
1961 STOUT STREET
DENVER, CO 80294
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
20th FLOOR
100 VAN NESS AVENUE
SAN FRANCISCO, CA 94102
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA REGIONAL OFFICE
MAIL STOP 407
2901 THIRD AVENUE
SEATTLE, WA 98121
ATTN: DIVISION OF PROGRAM OPERATIONS

☐ HCFA, BUREAU OF PROGRAM OPERATIONS
RECONSIDERATION EVALUATION BRANCH
P. O. BOX 770
BALTIMORE, MD 21203

DO NOT REMOVE FROM FOLDER

FORM HCFA-3509(12/82) PREVIOUS EDITION OBSOLETE

3786. SCOPE AND EFFECT OF OHA, SSA ADMINISTRATIVE LAW JUDGE DECISIONS UNDER PART A

A. Authority of Office of Hearings and Appeals.—The Office of Hearings and Appeals is one of the major components of the Social Security Administration. The Office is administratively responsible to the Commissioner of Social Security. By direct delegation from the Secretary of Health and Human Services derives and has final authority relating to the holding of hearings, the rendition of decisions, and the review of decisions in connection with administrative appeals from determinations made under Titles II and XVIII (Part A) of the Social Security Act as amended. The Appeals Council, is composed of 10 members, including the Director and Deputy Director of the Office of Hearings and Appeals, who serve as the Chairman and Deputy Chairman, respectively.

The Appeals Council, its members, and the administrative law judge (ALJ) have the authority delegated directly from the Secretary of Health and Human Services to exercise all duties, powers, and functions pertaining to holding of hearings, rendition of decisions, and reviews of decisions under provisions of Title II of the Act, and under provisions of Title XVIII of the act which relate to administrative appeals from determinations affecting rights of individuals to benefits or to the amount of benefits.

B. Responsibility of the Administrative Law Judge.—When a request for hearing is filed, jurisdiction of the case passes to the ALJ.

The responsibilities of the ALJ in the Office of Hearings and Appeals are different in one significant aspect from those of hearing examiners in regulatory agencies. In the usual hearing process of the regulatory agency the presence of counsel for the agency and for the respondent presumptively assures an adequate development of the record in order to present the facts and law from the point of each party. Through briefs or otherwise, the attention of the hearing examiner in a regulatory agency is invited by opposing counsel to pertinent statutory and regulatory provisions and relevant court decisions. In appeals by individuals under Title XVIII and Title II, the Department is never represented in the hearing and the individual claimant may or may not be represented by counsel.

The HCFA position (as well as the intermediary position) is reflected by the case file which includes the initial and reconsideration determination and the evidence upon which the determination actions were based. (This underscores the necessity and importance of a well documented file at the reconsideration level.) Since there is no appearance on behalf of HCFA, it receives no notice as to the time and place of the hearing. As described in § 3785.10, when the intermediary receives a hearing request, the claim file is reviewed to determine if additional documentation is required pursuant to the rules of evidence applicable to administrative proceedings. The intermediary requests such evidence as necessary and transmits the claim file promptly to the appropriate hearing office.

The ALJ in reaching his decision, considers the case file presented by HCFA, any additional documentation, and any evidence presented at the hearing by the claimant and his witnesses.

C. Effect of Administrative Law Judge's Decision.—The ALJ renders the decision, notifies the claimant in writing, and places a copy of the decision in the case file. The Office of Hearings and Appeals retains the case file on all ALJ decisions pending further action. In those cases where the ALJ reversed, in whole or in part, the intermediary's reconsideration determination, the case file is forwarded to the appropriate HCFA regional office. The HCFA regional office reviews all ALJ reversal decisions (See § 3786 D). All other files are retained by OHA until the expiration of the time allowed for a party to the determination to file an appeal. Upon completion of the Appeals Council's review or the expiration of the time limit to appeal, OHA forwards the case file to the HCFA regional office which notifies the appropriate intermediary to effectuate the ALJ decision or where applicable the Appeals Council decision.

Do not initiate any communication about a particular ALJ decision with the provider involved pending receipt of the notice to effectuate the decision. However, if a provider requests the status of the case, advise the provider of the ALJ decision, but not to take further action until the intermediary is notified by the HCFA regional office to effectuate the decision.

A decision of an ALJ of OHA is not a precendent opinion. In any case where the HCFA regional office requests an intermediary to effectuate an ALJ decision, it is effectuated only with respect to the case in which the decision was issued. ALJ decisions which are significant may be published by HCFA in the Health Care Financing Administration rulings and other pertinent publications. The rulings contain precedential case decisions, statements of policy and interpretations of the law and regulations and are to be followed by intermediaries. A ruling is not applicable to other cases where the facts are not substantially the same as those in the ruling. In applying the rulings, consider the effect of subsequent legislation, regulations, court decisions, and rulings. The rulings as published may be modified or superseded by subsequent rulings.

D. Appeals Council Review of Administrative Law Judge's Decisions.—A claimant dissatisfied with an ALJ's decision can request the Appeals Council of OHA, to review the decision. While HCFA does not have a similar right to appeal an adverse determination, each adverse decision is reviewed closely by HCFA to determine whether it is in conformity with the law and regulations.

The Appeals Council may, within 60 days from the date of the notice of an ALJ's decision, review such decision on its own motion. This action by the Appeals Council is discretionary, and no claimant or party dissatisfied with the action of the ALJ can rely on the Appeals Council taking such action. He must file his request for review within 60 days if he is dissatisfied.

Generally, the Appeals Council reviews a case on its own motion when it notes the ALJ's decision is not in accord with the law, regulations, or published precedent decisions, or the record indicates that the findings are not supported by substantial evidence, or in an appropriate case, for the same reason for which it would grant a request for review.

A claimant, dissatisfied with the Appeals Council's decision, may institute action in a Federal district court if the amount in controversy is $1,000 or more.

E. Effectuating Reversal Decisions.—In those cases where the ALJ, the Appeals Council, or a Federal Court reverses a reconsideration determination, take the following actions on being expressly advised by the HCFA RO to effectuate the decision. (However, see § 3787 for effectuation of reversal decisions, including reconsiderations, where there is subsequent utilization in the same benefit period.)

Notify the beneficiary and the provider (or a non-participating, billing, emergency hospital) in writing, based on the decision of the ALJ, Appeals Council, or a Federal Court that the provider will be reimbursed, exclusive of the deductible and coinsurance amounts for the services for which payment had been denied, or that the provider has been found liable under section 1879 of the Act (waiver of liability).

Prior to making payment to a provider of services in fully or partially reversed hearing decision cases, ascertain whether the provider has been reimbursed for the previously denied services from another source and, if so, withhold the Medicare reimbursement until the provider has assured in writing that the incorrect collection has been refunded or otherwise disposed of in accordance with § 3401. Advise the beneficiary that he should expect refund from the provider if payment in excess of the deductible and coinsurance amounts had been made to the provider for the services for which Medicare will pay or for which the provider has been found to be liable. In beneficiary-filed emergency service claims, send an explanatory notice to the claimant with any payment due as a result of the ALJ's, or Appeals Council's decision.

Since, effective April 4, 1983, intermediaries are housing their own reconsideration claim files, as soon as a corrected bill is received and processed prepare a duplicate and place it in the claim file. It is no longer necessary to forward copies to HCFA in Baltimore, MD.

F. Intermediary Questions About the Appeals Process.—Direct to the HCFA RO any questions regarding the proper response to an ALJ's request for information or evidence or with respect to effectuation of the decision of an ALJ, the Appeals Council or a Federal Court or questions relating to judicial review of a title XVIII Part A case.

3787. EFFECTUATION OF REVERSAL OF DECISION BY INTERMEDIARY, OHA OR FEDERAL COURT WHERE THERE IS SUBSEQUENT UTILIZATION OF BENEFITS IN THE SAME BENEFIT PERIOD

Where an intermediary, ALJ, Appeals Council, or Federal Court reverses a denial and there is subsequent utilization of benefits in the same benefit period which would otherwise prevent the decision from being fully effectuated, apply the following policies:

Make reimbursement as though the claim had been approved initially, i.e., pay the days of service as full days, coinsurance days, or lifetime reserve days, depending upon the benefits which were available at the time the services were rendered. This may result in the creation of an overpayment for the subsequent stay, e.g., where subsequent services which had been reimbursed in full become coinsurance days because an earlier denied stay is allowed. (See § 3816D.) Such overpayments are not recovered from any party. (See § 3709.3D.) Therefore, the notice to the beneficiary of the reversal decision contains no reference to the subsequent services or the resulting overpayment.

Although reimbursement is made for the subsequently allowed stay as if it had been allowed initially, the bill is only for the benefit days available at the time of effectuation. It will, therefore, be necessary to maintain a separate record of amounts paid in such cases so that a proper adjustment may be made in the departmental charges for the provider's final cost settlement.

EXAMPLE: Mr. D. was a patient at Valley Hospital from July 6, 1982 to August 31, 1982, a total of 56 days. Initially the program paid for 20 days (from July 6 through July 25) but denied benefits from July 26, 1982 through August 31, 1982, on the basis that the latter services constituted custodial care. On September 25, 1982, Mr. D. was admitted to State Hospital. State Hospital was paid for 63 covered days (40 days in full and 23 coinsurance days). Subsequently, an ALJ ruled that the services furnished by Valley Hospital from July 26, 1982 through August 31, 1982, were covered.

The ALJ decision should be effectuated as follows: Valley Hospital receives full reimbursement for the entire 56-day stay there (20 days initially approved and 36 days approved as a result of the ALJ decision). However, the bill should be for 7 coinsurance days and 29 lifetime reserve days (based on the amount of benefits shown as available on HCFA's records at the time of effectuation). To assure, however, that Valley Hospital receives proper credit in the final cost report, the intermediary must keep a record of the amounts paid so that a proper adjustment may be made to the provider's final cost report. State Hospital is relieved of liability for the resulting overpayment because it was without fault in billing for and accepting the overpayment. The overpayment is not recovered from the beneficiary.

3788. EFFECT OF COURT DECISIONS

A decision by the Supreme Court of the United States is unqualifiedly binding and is a precedent for all similar cases. A decision of a lower Federal Court is binding only for that case. Although other courts within the territorial jurisdiction of the court rendering the decision may use it as a precedent in similar cases, each case must be filed and an individual court decision made. The Secretary determines whether, and to what extent, the ruling is to be followed in other similar cases.

Where HCFA requests an intermediary to effectuate a court decision, whether of the Supreme Court or a lower court, the decision will be effectuated only with respect to that case. HCFA issues any necessary revisions or modifications of policies for application to other cases. Until received, continue to follow existing instructions.

C. Beneficiary Representation by Provider.—To be represented by a provider, the beneficiary must execute a form SSA-1696-U4, Appointment of Representative, which must contain the signed acceptance of an authorized official of the provider being appointed. Once a valid Appointment of Representative form is executed by the beneficiary and accepted by the provider, the provider may then file any appeal request on behalf of the beneficiary, if the beneficiary has not already done so.

When the denial involves either services that constitute custodial care or are not reasonable and necessary, or the denial involves a failure to meet homebound or intermittent skilled nursing care requirements and thus the application of the limitation of liability provisions under §1879 of the Act (see §3430ff.), the provider representative (attorney or non-attorney) must waive in writing any right to payment from the beneficiary for these services. You must obtain the written waiver even when the claim is initially paid under the limitation of liability provision, i.e., when you find that neither the provider nor the beneficiary is liable. This waiver requirement is intended to insure against conflict of interest.

A provider representative (including an attorney) cannot charge the beneficiary a fee in connection with such representation.

The costs incurred by a provider in representing a beneficiary in an unsuccessful appeal are not allowed as reasonable costs in determining the provider's Medicare reimbursement.

(This provision applies only to title XVIII appeals. Providers are precluded from representing beneficiaries in the appeal of PRO determinations under title XI.)

3789.1 Beneficiary Incapable of Pursuing His Own Appeal.—The file may indicate that the mental or physical ability of the beneficiary is so impaired that there is a prima facie showing of mental incompetency or physical inability to pursue his appeal rights. Consider the request for reconsideration filed on behalf of such beneficiary valid if it is signed by an individual who would qualify to execute a request for payment on behalf of the beneficiary as shown in §3302.5 except for the provider. In these cases, if the file is properly documented, form SSA-1696-U4 is not necessary.

3789.2 Beneficiary Deceased.—If the beneficiary is deceased, the request for reconsideration, hearing, or Appeals Council review may be filed by the legal representative of the estate. In the absence of a legal representative, it may be filed by any person who has assumed responsibility for settling the decedent's estate. In such instance, document the file to show the basis for that person's filing the appeal. If the explanation has not been forwarded to you, obtain it through the SSO by means of form SSA-1980. The SSO undertakes the necessary development to ascertain whether the person has in fact assumed responsibility for the liabilities and assets of the estate.

3789. BENEFICIARY'S RIGHT TO REPRESENTATION UNDER PART A

Any individual may appoint a qualified individual to act as his representative in pursuing a claim or a request for a reconsideration, hearing, or Appeals Council review. In addition, if a beneficiary has a representative payee appointed to receive his monthly social security checks, or has a legal guardian or conservator, a request from such a person is treated as a request by the beneficiary himself. Such a representative is authorized to act for, or in the place of, the beneficiary and all contacts are to be made with or through him.

Honor a request for reconsideration by someone other than the beneficiary or his duly appointed representative if it clearly shows it originated with the beneficiary (i.e., was made with his knowledge). The beneficiary's knowledge may be inferred from previous actions taken by the person on behalf of the beneficiary or from indications that the writer is aware of the facts involved. For example, correspondence received from a Congressman or an attorney which indicates that he is writing on behalf of his constituent or client is sufficient indication that the writer is representing the beneficiary. This also applies to a request for reconsideration from a relative or friend who arranged for the admission or services. When such requests are received, a formal Appointment of Representative, Form SSA-1696-U4 is not required. (See § 3789.1 for cases in which the beneficiary is incapable of pursuing his own appeal.)

A. Completing Form SSA-1696-U4 Appointment of Representative.--(See § 3789.3, Exhibit 1.) In all cases other than those described above, the beneficiary must execute form SSA-1696-U4 in addition to Form HCFA-2649, Request for Reconsideration, Form HA-5011-U6, Request for Hearing Part A Health Insurance Benefits; or Form HA-520, Request for Review of Hearing Examiner's Action. The SSA-1696-U4 must be signed by both the beneficiary and the person appointed. One SSA-1696-U4 suffices for all administrative appeals when the same representative is involved. The form SSA-1969-U4 is completed by the Social Security office. If the form is not in file, use Form SSA-1980, Carrier or Intermediary Request for SSA Assistance to obtain it. (See § 3706.)

B. Physician Inquiries.--A physician who writes regarding a denial of Part A benefits may merely be voicing his disagreement with the determination. Even when the physician explicitly requests a reconsideration, it does not necessarily mean that he is willing to become the beneficiary's representative and act in pursuing the beneficiary's appeal rights. If the physician does not indicate that he is acting as the representative, furnish him a complete explanation of the action. Include a reference that, if the beneficiary wishes to file a reconsideration request, he may do so by contacting a Social Security office. If in the course of your reply action, it is discovered that the initial determination can be reopened because the services (or some additional services) were covered, reopen the determination.

On the other hand, if a physician writes and indicates that his patient disagrees with the initial determination and wishes to have a reconsideration, a reexamination, or words to that effect, acknowledge the letter and refer it to the Social Security office. That office will undertake the necessary development to have a proper request for reconsideration filed if the beneficiary or his representative desires. If the physician is willing to act in behalf of the beneficiary, an SSA-1696-U4 must be obtained.

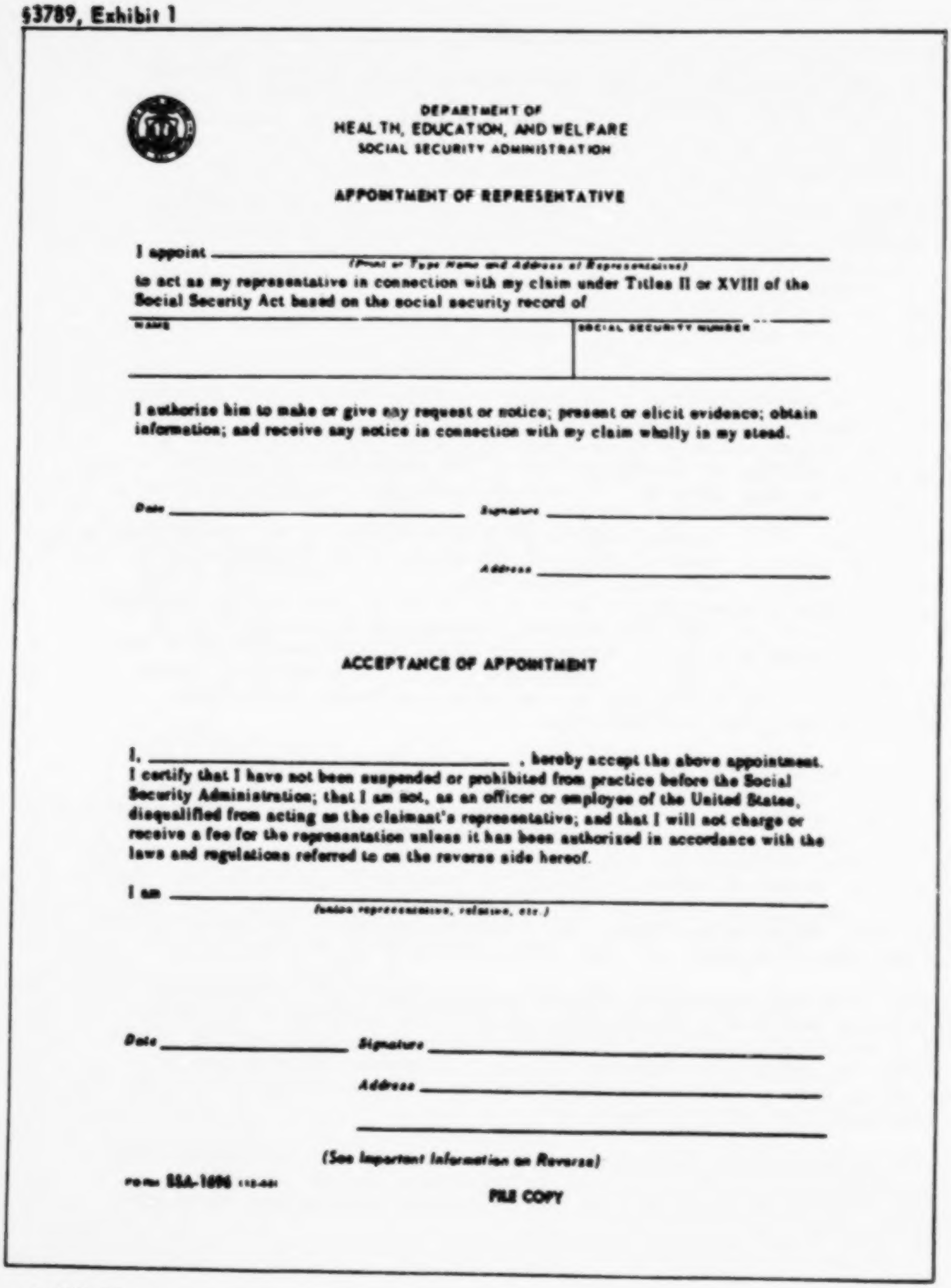
3789.3 *Fees Charged for Services Rendered by a Representative.*--Section 206(a) of the Social Security Act requires that fees for services performed in connection with a proceeding before the Secretary by the representative (attorney or other qualified person) of a beneficiary be regulated by SSA. Services performed before State or Federal courts, however, are not considered to be proceedings "before the Secretary." Similarly, matters pertaining to Part B, except for considerations dealing with entitlement and enrollment application, are not proceedings "before the Secretary." All other fees charged for representing a beneficiary in any proceeding dealing with an asserted right under title XVIII of the Act calling for an initial or reconsidered determination, or for a decision by a hearing examiner or the Appeals Council, are subject to this provision of the Act.

The regulation of fees applies even though a duly appointed representative who rendered services to the beneficiary in a title XVIII matter does not actually contact the intermediary or SSA. When the intermediary becomes aware that a representative is involved, it should assure that forms or documents pertaining to the appointment of the representative reports dealing with actions taken by the representative, and requests for fees for services are sent to the BHI Reconsideration Branch with the reconsideration file. If the reconsideration file is no longer in the intermediary's office, any material received should be forwarded to the Reconsideration Branch immediately. Forms which should be part of the claim file if the beneficiary has a representative are the SSA-1696, if this form is required per the above instruction, and SSA-1560, Petition to Obtain Approval of a Fee for Representing a Social Security Claimant, if the representative has concluded his services and is requesting a fee. (See Exhibit 2.) Where these forms are required but are not in file, the intermediary should request them using the form SSA-1980.

If the intermediary has made a full reversal of the initial denial after its review, and a petition for fee approval is received, the intermediary will also send the entire file to the Reconsideration Branch. Upon receipt of a fee petition, the Reconsideration Branch acknowledges the receipt of the petition, completes its reconsideration action, and forwards the entire file to the Bureau of Health Insurance, Division of Technical Policy. This office reviews the fee petition and recommends to the Division of Benefit Continuity, Bureau of Retirement and Survivors Insurance, the amount of the fee that should be approved. That office notifies the attorney.

In the event that a potential representative contacts the intermediary directly on behalf of a beneficiary, he should be informed of the above requirements and advised that he should contact the social security office in order to complete the necessary forms if he has not already done so. The social security office personnel have manual instructions pertaining to the completion of these forms.

If the beneficiary or the representative volunteers the information that the representative's services were performed on a gratuitous basis, a report is to be placed in file by the interviewer showing that there will be no fee involved.



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

APPOINTMENT OF REPRESENTATIVE

I appoint ______________________________
(Print or Type Name and Address of Representative)
to act as my representative in connection with my claim under Titles II or XVIII of the Social Security Act based on the social security record of

NAME	SOCIAL SECURITY NUMBER

I authorize him to make or give any request or notice; present or elicit evidence; obtain information; and receive any notice in connection with my claim wholly in my stead.

Date ______________ *Signature* ______________

Address ______________

ACCEPTANCE OF APPOINTMENT

I, ______________, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not, as an officer or employee of the United States, disqualified from acting as the claimant's representative; and that I will not charge or receive a fee for the representation unless it has been authorized in accordance with the laws and regulations referred to on the reverse side hereof.

I am ______________________________
(union representative, relative, etc.)

Date ______________ *Signature* ______________

Address ______________

____

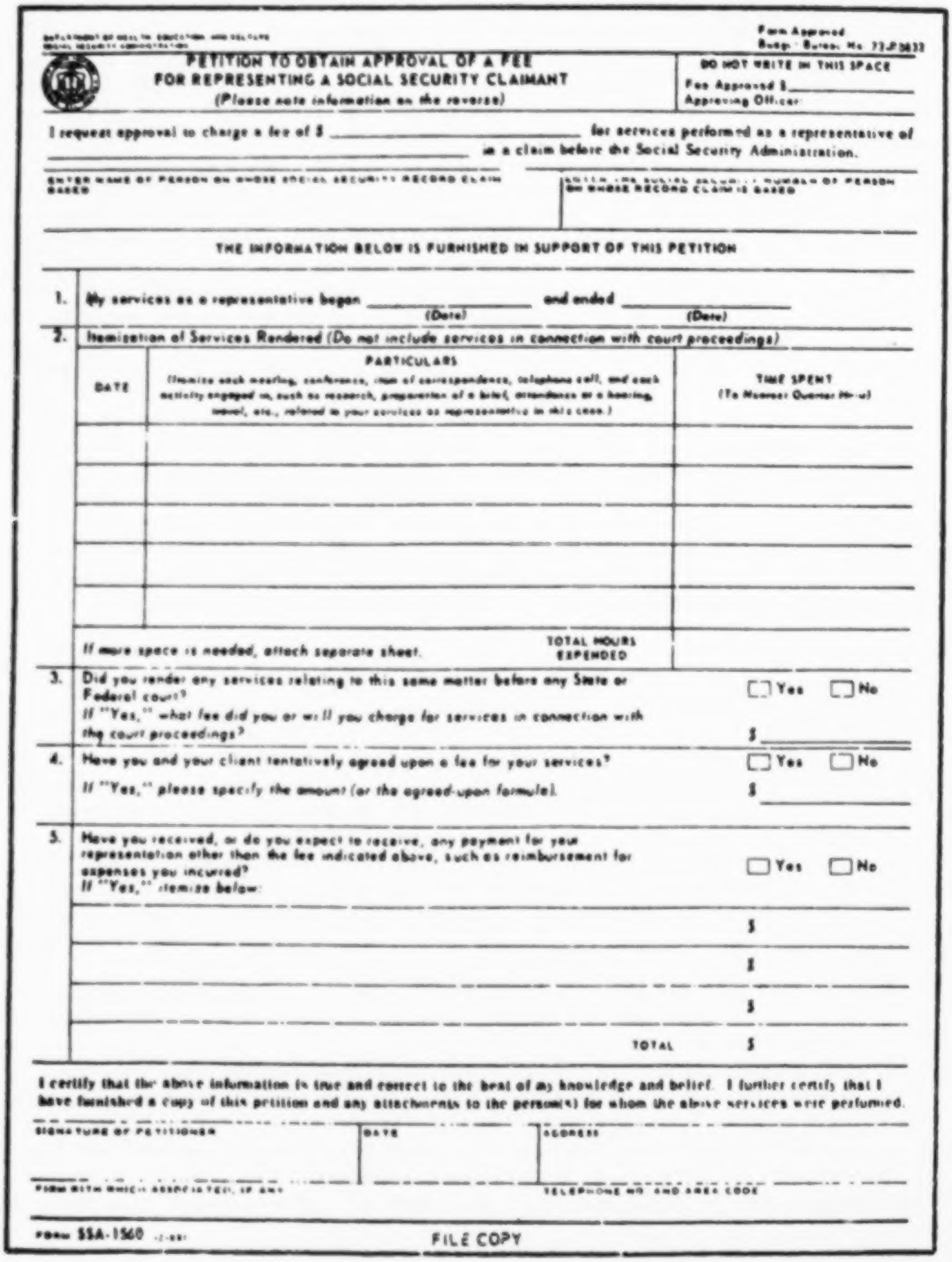
(See Important Information on Reverse)

Form SSA-1696 [illegible]

FILE COPY

§3789, Exhibit 2

SSA-1560 (Petition to Obtain Approval of a Fee for Representing a Social Security Claimant) *(Reverse of form gives general information and instructions for representative and claimant on their respective copies.)*



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
Budget Bureau No. 72-R0633

PETITION TO OBTAIN APPROVAL OF A FEE FOR REPRESENTING A SOCIAL SECURITY CLAIMANT

(Please note information on the reverse)

DO NOT WRITE IN THIS SPACE
Fee Approved $__________
Approving Officer:

I request approval to charge a fee of $ ____________________ for services performed as a representative of ____________________________ in a claim before the Social Security Administration.

ENTER NAME OF PERSON ON WHOSE SOCIAL SECURITY RECORD CLAIM BASED	ENTER THE SOCIAL SECURITY NUMBER OF PERSON ON WHOSE RECORD CLAIM IS BASED

THE INFORMATION BELOW IS FURNISHED IN SUPPORT OF THIS PETITION

1. My services as a representative began ______________ (Date) and ended ______________ (Date)

2. Itemization of Services Rendered *(Do not include services in connection with court proceedings)*

DATE	PARTICULARS (Itemize each meeting, conference, item of correspondence, telephone call, and each activity engaged in, such as research, preparation of a brief, attendance at a hearing, travel, etc., related to your services as representative in this case.)	TIME SPENT (To Nearest Quarter Hour)
	If more space is needed, attach separate sheet. TOTAL HOURS EXPENDED	

3. Did you render any services relating to this same matter before any State or Federal court? ☐ Yes ☐ No
If "Yes," what fee did you or will you charge for services in connection with the court proceedings? $__________

4. Have you and your client tentatively agreed upon a fee for your services? ☐ Yes ☐ No
If "Yes," please specify the amount (or the agreed-upon formula). $__________

5. Have you received, or do you expect to receive, any payment for your representation other than the fee indicated above, such as reimbursement for expenses you incurred? ☐ Yes ☐ No
If "Yes," itemize below:

	$
	$
	$
TOTAL	$

I certify that the above information is true and correct to the best of my knowledge and belief. I further certify that I have furnished a copy of this petition and any attachments to the person(s) for whom the above services were performed.

SIGNATURE OF PETITIONER	DATE	ADDRESS
FIRM WITH WHICH ASSOCIATED, IF ANY		TELEPHONE NO. AND AREA CODE

FORM SSA-1560 [illegible]

FILE COPY

PSRO Appeals Process

3790. RECONSIDERATIONS, HEARINGS, AND APPEALS WHERE A PSRO HAS REVIEW RESPONSIBILITY

A. General.--The Social Security Amendments of 1972 provide for the establishment of Professional Standards Review Organizations (PSRO's) throughout the country "in order to promote the effective, efficient, and economical delivery of health care services of proper quality," and to assure that payment under the Social Security Act for such services will be made only when they are medically necessary as determined in the exercise of reasonable limits of professional discretion, of acceptable quality, and, in the case of inpatient services, when they could not be provided on an outpatient basis or more economically in a different type of health care facility. More specifically, where and to the extent that a PSRO has assumed review responsibility, the responsibility lies with the PSRO, both at the initial and reconsideration level, for coverage determinations with respect to questions of the medical necessity of services, the necessity for their provision on an inpatient basis, or the appropriateness of the type of inpatient facility where the services are provided. Intermediaries will continue to make these medical necessity decisions only until such time as a PSRO assumes the function.

Except as otherwise noted hereafter, references to PSRO also apply to provider review committees designated by a PSRO to make binding medical necessity determinations.

3790.1 Appeals.--The legislation creating the PSRO program includes a provision for a new appeals process for decisions by PSRO's relating to the medical necessity of services and the appropriate type of facility in which such services are rendered. The PSRO appeals provision replaces the Medicare appeals process for such cases. However, all other issues relating to whether payment may be made on a claim will continue to be subject to appeal through the Medicare process (see §§ 3780ff.).

3790.2 Reconsiderations.--There may be a dual system of appeals at the reconsideration stage, depending upon the issue. That is, a claim may be denied by both the PSRO and the intermediary on different issues and be subject to reconsideration by each entity to the extent of its responsibility. A reconsideration requested by a party entitled to do so must be processed to completion in accordance with applicable instructions no matter what the other entity may determine in the areas of its responsibility, except that an Administrative Law Judge (ALJ) may halt an intermediary reconsideration and decide the issue in controversy if a request for hearing has been filed on a completed PSRO reconsideration determination.

A. PSRO Reconsiderations.--A determination by a PSRO that care is not medically necessary or should be provided in a different type of facility or on an outpatient basis may be reconsidered only by the PSRO at the request of the patient, provider, or attending physician. If a statewide PSR Council exists, adverse PSRO reconsideration determinations when the amount in controversy is $100 or more will be subject to review by that body. The results of all reconsideration determinations made by PSRO's or reviews by statewide PSR Councils where they exist will be provided the patient, the provider, and the attending physician, and the patient will be notified of his right to request a hearing before an Administrative Law Judge of the Bureau of Hearings and Appeals (BHA). PSRO reconsiderations are required to be in writing and filed in the office of the PSRO. The complete PSRO reconsideration file should be maintained by the PSRO until and unless it is requested as evidence in a hearing.

Where a PSRO or a statewide PSR Council reverses a prior determination, that result will be communicated to the intermediary immediately. Where appropriate, the intermediary will inform the provider to submit the necessary bill to be paid.

For more specific information about PSRO appeals, see Chapter XIX of the PSRO Program Manual.

B. Intermediary Reconsiderations.--Continue to make determinations and to perform reconsiderations on all issues for which you have previously been responsible except for determinations with respect to medical necessity and whether care could have been provided on an outpatient basis or in a lesser facility. For example, a patient's care might be determined to be medically necessary by the PSRO but fall under one of the exclusions (other than section 1862(a)(1) or (a)(9)) in section 1862 of the act (e.g., cosmetic surgery, routine foot care, etc.) or may not be payable because no benefits are available. Thus, you will be required to maintain a medical review capability for both initial claims and reconsideration activity. The intermediary makes such determinations at the appropriate times and notifies patients of such decisions and of their appeal rights. It may not make determinations or reconsidered determinations based on medical necessity, level of care, or appropriateness of type of facility on claims which have been ruled on by PSRO's.

In one respect, the intermediary reconsideration process will be affected on occasion by the fact that PSRO's are involved in the appeals process. When an Administrative Law Judge of the Bureau of Hearings and Appeals notifies you that a hearing has been requested on a PSRO determination and that he is taking jurisdiction of the entire claim, immediately cease all actions leading to a reconsidered determination, collect all of the information in your possession with respect to the claim and forward all such data as directed by the ALJ. (Such notification may come through the Reconsideration Branch and when this is the case, the instructions apply.)

C. Intermediary Reconsideration Notices.--When an intermediary performs a reconsideration, it must notify all parties to the determination of the results. Whether the reconsideration determination consists of a letter or a cover letter with a separate determination, the letter or cover letter must contain the following language where a PSRO is responsible for the medical necessity or appropriateness of care issue:

> This determination relates only to issues for which the fiscal intermediary is responsible. Because a Professional Standards Review Organization has responsibility for the (medical necessity/appropriateness of care) decision on this claim, you will receive notification with respect to any denial on that issue (those issues) from the Professional Standards Review Organization.

The letter must also describe the beneficiary's appeal rights and comply with all other requirements governing Part A beneficiary reconsiderations.

D. Misfiled Reconsideration Requests.--

1. When you receive a request for reconsideration or review relating to a PSRO determination or reconsidered determination, immediately forward such request to the appropriate PSRO. If the request for reconsideration has been filed on form SSA-2649, forward the original (page 1 and any attachments) to the PSRO with a brief explanation and a copy of

the letter acknowledging receipt and advising the filer that the request is being transferred to the proper adjudicating office.

Detach page 4 of the SSA-2649. Annotate Item 10 "PSRO RECON--FORM SSA-2649 TRANSFER." In Item 17, check the "DISMISSAL" box. Prong-file a photocopy of page 1, page 4, a copy of the acknowledgment letter, and any other related material in a properly labeled case folder, as with any completed case file, and route the folder immediately to the Reconsideration Branch (use the address in § 3782.3), to cancel the control.

2. When a PSRO receives a request for reconsideration relating to a determination for which an intermediary was responsible, it should forward it to that intermediary immediately.

3. Social security offices will be directed to forward requests for reconsideration to the appropriate entity, but you should nevertheless scan all requests for reconsideration received from such an office upon receipt to identify those which should have been directed to a PSRO.

3790.3 Hearings--General.--The PSRO legislation provides any beneficiary or recipient who is entitled to benefits under title XVIII or XIX of the Social Security Act with the right to a hearing by the Secretary if he is dissatisfied with the reconsideration determination by the PSRO, and the statewide PSRO Council where one exists, and the amount in controversy is $100 or more. The responsibility for holding such hearings has been delegated to the Bureau of Hearings and Appeals of the Social Security Administration. BHA Administrative Law Judges (ALJ's) will conduct the hearings. As in the past, any hearings requested on Medicare claims where the initial and reconsidered determinations have been made by an intermediary will continue to come under the jurisdiction of BHA (see §§ 3785ff.). Any claim involving both Medicare and Medicaid benefits on which a hearing is requested will be heard as one case and the decision will resolve the claim for both programs.

A. Time and Place of Filing the Request for Hearing.--A hearing request must be signed and filed in writing within 60 days of receipt of the reconsideration determination or, where a Statewide Council exists, within 60 days of receipt of notice of its review of the PSRO's reconsideration determination.

A request for hearing may be filed with the PSRO responsible for the initial and reconsidered determination; or, where one exists, with the Statewide Council; or with an Administrative Law Judge; or, in the case of a social security beneficiary, at any office of the Social Security Administration; or in the case of a Railroad Retirement Board annuitant, at any RRB office, or, in the case of a Medicaid recipient, at any office of the State agency responsible for his benefits. Any request for hearing received by an intermediary should be routed to an office designated to receive requests for hearings.

The time limitation may be extended by an ALJ for good cause.

B. What Constitutes a Request for Hearing.--Any written, signed expression of dissatisfaction with the results of a reconsideration, or request for "another look," "review," "reconsideration," or similar term is to be considered a request for a hearing unless the writer is clearly requesting only a clarification or explanation of some point in the reconsideration determination. Any question as to the intent of the writer should be resolved in favor of considering the document as a request for hearing. Since a determination as to what constitutes "good cause" for late filing is within the purview of the ALJ, neither the PSRO, the provider nor the intermediary is to delay or cease action on a request, whether specific or implied, because it does not appear to be timely filed.

C. Routing Requests for Hearing.--Requests for hearings on PSRO determinations involving Medicare beneficiaries will be handled in a different way than has been customary. The request for hearing will be forwarded to the PSRO which will compile the claim folder and forward it to Reconsideration Branch (BHI). The Reconsideration Branch will check its records to determine whether any appeal action on an intermediary action with respect to the claim is pending or has been completed. The Reconsideration Branch should then obtain from its files or from the intermediary all pertinent data with respect to the beneficiary's eligibility and availability of benefits and all data bearing on any completed reconsiderations by the intermediary with respect to the claim. All such evidence should then be compiled and forwarded with the PSRO file to the appropriate hearing office. If an intermediary reconsideration is pending or a request for hearing is pending on an issue which comes under the jurisdiction of the Medicare Bureau, the hearing office should be so notified in the letter transmitting the evidence.

The intermediary will continue any activity required of it on the claim unless and until it is specifically requested to cease its action and forward its records to the Reconsideration Branch or an ALJ. Make every effort to complete actions on claims as soon as you become aware that a hearing on the PSRO determination has been requested.

3790.4 Professional Consultation.--As required by law, the Secretary may render a final decision after a hearing on an appeal of a PSRO determination only after appropriate professional consultation on the matter. This consultation will be obtained by the ALJ hearing the claim.

Appeals under Part B

3791. PROTESTS, REVIEW, AND "FAIR HEARING"--MEDICAL INSURANCE

Since intermediaries administering the hospital insurance program also make payment for medical insurance items and services furnished by and under arrangements with providers, the intermediary must be prepared to handle protests and furnish the review and hearings necessary under the medical insurance program.

An individual in his own right (or his authorized representative, see § 3797) and a physician or nonparticipating provider as his assignee is to be provided with a review or hearing by the intermediary when he is dissatisfied with the intermediary's determination denying a request for payment, or with the amount of the intermediary payment under Part B, or when he believes that the request for payment is not being acted upon with reasonable promptness. "Acted upon" means that the intermediary made a determination paying or denying payment of a claim. It will be deemed unreasonable if the request for payment has not been acted upon within a period of 60 days after receipt by the intermediary of the request for payment. (The carrier which makes payment of physicians' bills will provide the fair hearing for beneficiaries whose protests concern payment for the services of physicians and suppliers. This carrier will also conduct the fair hearing on complaints of assignee physicians and suppliers.) The law does not provide an appeal to the Social Security Administration from an intermediary's decision, or judicial review of the "fair hearing" decision.

The following governing principles should be used as guidelines for establishing a review or fair hearing. These guidelines permit the intermediary to operate with a great deal of latitude, yet assure that the methods and procedures employed are, in fact, consistent with the governing principles established by SSA.

3792. REVIEW

A dissatisfied party to an initial determination may request that the intermediary review such determination. A request for review should be made in writing and filed with the intermediary which made the initial determination or a social security office.

A period of not less than 6 months after the date of the notice of the initial determination is to be allowed within which a review may be requested. The intermediary at its discretion may, upon request by the party affected, extend the period for requesting the review.

The review is to be a completely new, independent, and critical reexamination of the entire claim. Since the review is a review of a file without the presence of oral testimony of the claimant or other party, it is a less costly and a more expeditious device for handling complaints than a formal hearing and is particularly appropriate for handling benefit determination complaints arising under Part B since relatively small amounts of money will be involved in most cases.

A review is a prerequisite to a fair hearing.

3792.1 What Constitutes a Request for Review - Handling Beneficiary Inquiries.--Many beneficiaries will raise questions about initial claims determinations whenever a denial or partial denial of a claim is involved, and they feel the explanation given on the EOMB is not satisfactory.

In order to respond properly to such inquiries, intermediaries should keep in mind the requirements which are applicable to the various aspects of the appeal process in Part B. Following is a discussion of the methods for handling various types of contacts with beneficiaries.

A. Telephone Inquiries.--When an intermediary receives a telephone call, the basis for the denial or reduction should first be explained to the beneficiary. It may be necessary to refer to records on the claim in order to do this. Regardless of whether the beneficiary is or is not satisfied by the explanation given, the telephone conversation can never be considered to be a review and should not be reported as such on performance reports.

If the beneficiary appears satisfied, no further action is necessary. However, if the beneficiary does not appear to be satisfied, the intermediary should inform him that he may file for a review within 6 months (or whatever longer time period the intermediary has established) of the date of the notice he received. The beneficiary should be told that the intermediary will send him the request form and that he may file his request with either the intermediary or SSO.

If the time for filing a request for review has elapsed, the intermediary should inform the beneficiary that it will consider whether there is "good cause" for the late filing and should solicit all available facts that could assist in such consideration. (In the event that the intermediary is unable to find "good cause" for late filing, it may still consider the possibility of reopening and revising its initial determination. See § 3796.)

If the intermediary employee determines that there may be some basis for the complaint of the beneficiary, he should encourage the beneficiary to file for a review. He should not tell the beneficiary that the determination will be changed, but he should explain that a complete review will be made when the request is filed. The beneficiary should be informed that he will be furnished a copy of the review determination whether it affirms or reverses the initial determination.

A record should be made of the telephone contact and of any action taken by the intermediary based on such contact. This record serves to establish an earlier filing date for a beneficiary who later files a written request for review and documents subsequent actions in the case by the intermediary.

B. Personal Inquiries.--These should be handled according to the instructions for telephone calls. If a beneficiary wishes to file a request for review, the intermediary should supply the SSA-1964 and offer its assistance.

C. Written Inquiries.--In many cases, a beneficiary will write to the intermediary protesting the determination made on his claim instead of filing a Form SSA-1964. These letters can be handled in any one of several ways, depending on their content.

If the letter is clearly limited to a request for an explanation of the determination, the intermediary may so limit its reply (either by phone or letter) and need not consider the letter as a request for review.

All requests for information should receive a reply. This may be done by phone in order to save time. If a beneficiary asks for review during the call, the request form should be mailed to him. When a beneficiary asks only for a second copy of a notice, the intermediary employee may send the copy without including an additional written response to the letter.

A request for review, to be treated as such does not require completion of an official form SSA-1964. A letter will serve as an acceptable request for review when it asks the intermediary either explicitly or implicitly to take further action on the claim, or when it indicates dissatisfaction with the intermediary's decision. Common examples of the phrasing of such letter requests are:

1. "Please reconsider my claim."

2. "Will you review this bill to see if more payment can be made."

3. "I am not satisfied with the amount paid--please look at it again."

4. "Your decision is illogical."

5. "My neighbor got paid for the same kind of claim. My claim ought to be paid too."

Letters which contain such statements should be logged in, controlled, and acted upon as valid review requests. Where the intermediary is not certain whether a beneficiary is asking for a review or for information only, the letter should be treated as a request for review.

All written inquiries should be retained in the claims file after the necessary action is taken, since such a letter could be used as documenta evidence later. There should also be a notation as to what action was taken and when for possible subsequent evidentiary and administrative purposes.

3792.2 Elements of a Review.-- Refer the claimant to an SSO for assistance in writing out his complaint of the unfavorable decision. The SSO staff will give the claimant general program information and, if he wishes to request a review of the decision, will help him complete a form SSA-1964. (See §3795.)

When the claimant is dissatisfied and requests a review of the initial decision, the following guideline is provided as the essential elements you should consider in conducting an adequate review of the claim.

A. The purpose of the review is to provide a new, independent and critical reexamination of the claim. Therefore, reexamine all aspects of the claim, not only the point at issue.

To reduce unnecessary costs, the review will not provide for personal appearance and testimony by the claimant.

B. The employee who made the initial determination should not be the one to review the case.

C. Instruct the claimant to submit any material evidence and statements in writing by mail or through any SSO. Request additional evidence from the claimant and/or the physician, provider or other supplier of services if necessary for proper adjudication.

D. If the initial decision is not reversed, prepare a written determination and mail it to the claimant (and any other involved party). Write the determination at a 6th to 7th grade reading level so that the claimant can understand the reason why any of the Part B services are not covered or cannot be fully reimbursed and what action can be taken if he or she disagrees with the review determination. To ascertain the reading level of the letter, use the following formula which is a currently accepted procedure for measuring readability. The formula measures two factors—the average sentence length and a hard-word factor (words of three syllables or more).

Follow the steps below to establish the reading level.

1. Count the total number of words in the letter. Divide this total number by the number of sentences in the letter. The result is the average sentence length. (Generally, a sentence should not have more than 12-15 words.)

2. Count the number of words which include three syllables or more. There are exceptions—do not count words that are (a) capitalized, (b) combinations of short, easy words, or (3) verb forms which result in three syllables by adding 'ed or 'es. Take the number of hard words and divide by the total number of words in the letter to determine the percentage of hard words.

3. Total the above two factors (average sentence length and percentage (e.g., 5.0) of hard words) and multiply by .4. The resulting figure will be the reading level. It should be no higher than a 7 which would be comparable to the 7th grade reading level. For further reference, Technique of Clear Writing by Robert Gunning, McGraw-Hill, New York, Publisher (1952), or other similar text may be consulted.

The review determination letter must also advise the claimant about his/her right to request a hearing if he/she is not satisfied with the review determination and the amount in controversy is $100 or more. The notice must inform the claimant that claims may be combined with other claims that have been reviewed or reopened (see S 3799.14 regarding reopenings) within 6 months of the date of the hearing request to meet the $100 minimum requirement. Include the following appeal paragraphs in the review determination letter:

> "You may request a hearing if you do not agree with this decision. You must request the hearing within 6 months of the date of this letter. The amount of benefits in question must be $100 or more in order to have a hearing. To meet the $100 you may combine the amounts for any claims on which we made a determination within the past 6 months based on (1) a request for review or (2) a reopening of an initial or review determination.
>
> "Write to us or contact any Social Security Office if you want a hearing. You may attend the hearing in person. You may also take or send someone to represent you. This person may be a lawyer or anyone you choose. Please note on your request who will attend the hearing. You do not have to appear in person. You may ask that a decision be made based on the facts in the file. A copy of the decision will be sent to you."

E. The review determination is the final determination unless a hearing is requested or it is revised in accordance with S 3799.

F. Include in the claimant's file all evidence or findings you have considered in the review of the claim. This includes material such as all memoranda of conversations with medical consultants, papers, requests, reports, etc. arising out of the claims review process. This file will be forwarded to a hearing officer if a hearing is requested by the claimant.

3794. THE HEARING.

The fundamental purpose of the hearing process is to give an individual, dissatisfied with what he considered to be an adverse decision on his claim for payment, an opportunity to present in person the reasons for his grievance and to afford him an impartial review based on the substance of his claim. Therefore, the notice of an adverse review decision must give the individual notice of the right to a hearing, the place and manner of requesting the hearing, the time limit for requesting it, and the requirement that at least $100 must be in controversy. (See S 3794.1(A) for the manner of determining the amount in controversy.)

The principles set out in the following sections are to be applied by the intermediary in setting up the hearing to handle complaints by individuals dissatisfied with the review determination. The hearing officer, in exercising the authority to conduct a hearing, must comply with all the provisions of title XVIII of the Act and related regulations as well as with policy statements, instructions and other guides issued by HCFA in accordance with the Secretary's agreement with the intermediary.

3794.1 Request for Hearing.-- Individuals who are dissatisfied with a review determination and who meet the requirements outlined in A below can request a hearing in accordance with the procedures in C below.

A. Eligibility for a Hearing.-- A party to an intermediary's review determination shall be entitled to a hearing if he files a written request and if the amount in controversy at the time the request is filed is $100 or more. A review is a prerequisite to a hearing. Any person other than the parties to the review determination may be made a party to a hearing if his rights with respect to supplementary medical insurance benefits may be prejudiced by the decision, or if the hearing officer notifies him to appear at the hearing or to present such evidence and contention of law or fact as he may desire in support of his interests.

In order to have a hearing regarding benefits under Part B, the dollar amount in controversy must be $100 or more. There may be cases in which the amount in controversy at the initial determination is reduced to less than $100 as a result of a review or a revision. In such cases, the claimant would not be entitled to a hearing. However, if after the beneficiary filed a request for a hearing in which the $100 requirement was met, the intermediary revised its action and reduced the amount in controversy to less than $100, the beneficiary would still be entitled to a hearing.

B. Determination of Amount in Controversy.—The amount in controversy is determined by the hearing officer. When the intermediary receives a request for hearing on one or more claims from a beneficiary or from a provider in the case of claims involving the waiver of liability issue under section 1879 of the Act, the intermediary provides the hearing officer with all information in its files relating to the claim(s). The hearing officer determines the amount in controversy at that time.

The amount in controversy is determined by a two-step process as follows:

1. Determines the difference between the amount(s) charged the beneficiary and the amount(s) allowed by the intermediary.

2. Less the applicable coinsurance and any unmet deductible remaining at the time the hearing officer makes the determination.

This result is the amount in controversy.

In effect, the amount in controversy is the amount of the payment that would be made if the denial(s) were fully reversed at the time the hearing officer makes the determination.

A Part B hearing may be conducted on more than one claim at a time; i.e., the beneficiary or provider may have a hearing on several claims involving different services. The hearing officer will determine the total amount in controversy for all claims on which the beneficiary or provider has requested the hearing. It is not necessary that there be $100 in controversy for each claim. To combine claims to meet the $100 limitation, the following requirements must be met:

1. the claims must all belong to the same beneficiary or to the same provider; and

2. the claims must all have been through the review process; and

3. the 6-month time limit must be met for all the requests involved; and

4. the hearing request must identify the claims.

It should be noted that all the claims combined by a beneficiary do not have to involve the same provider. Likewise a provider may combine claims for purposes of a hearing that involve various beneficiaries.

At the time the hearing officer determines the amount in controversy, it may not be clear whether the deductible has been met subsequent to the time of the initial determination. If this factor is pertinent to the determination of the amount in controversy, the hearing officer will request the intermediary to ascertain the beneficiary's current deductible status.

The hearing officer determines whether the amount in controversy amounts to $100 or more at the time he considers the hearing request. He will dismiss the hearing request and not rule on the substantive issues of the protest if he determines that the $100 requirement is not met. The dismissal notice should state that although the $100 qualification amount has not been met, the claim(s) can be added to a subsequent claim(s) with which the claimant is dissatisfied, as long as the 6-month time limit from the date of the review notice(s) for requesting a hearing is met, in order to satisfy the $100 requirement in a future hearing request.

NOTE: Any party to an initial determination who received a notice of review dated prior to October 31, 1972, will not be subject to the $100 limitation and will be granted a hearing by the hearing officer regardless of the amount in controversy if the request for hearing was filed timely.

C. Manner of Requesting a Hearing .--A request for a hearing may be either any clear written expression of dissatisfaction with the intermediary review determination, or a filing of Form SSA-1965 (Request for Hearing--Part B Medicare Claim). (See § 3795.) An SSA-1965 will always be completed when a claimant personally requests a hearing in the intermediary's office or in a social security office. If a writing is received from the claimant that does not clearly indicate a request for a hearing, the intermediary may request the claimant to complete an SSA-1965. Such a request for a hearing must be filed with the intermediary or a social security office. A period of 6 months after the date of the notice of the review determination is to be allowed within which a party to the review determination may request a hearing. The hearing officer, at his discretion, may upon request by the party affected, extend the period for filing the request for hearing.

D. Examples Determining Amount in Controversy.—Since determining the amount in controversy can be complex when more than one claim is involved, the following examples are provided. Hearing officers will use the following formula in determining the amount in controversy:

Step 1. Total amount charged for claims in dispute
- Total amount allowed for claims in dispute
Difference

Step 2. Difference of amount charged and allowed
- Unmet deductible
Balance remaining X 80% = amount in controversy

NOTE: Any amounts subject to 100% reimbursement (physician radiology and pathology services) should not be reduced for deductible and coinsurance.

EXAMPLE 1: The beneficiary has met $20 of the deductible in January. A claim for $65 is denied in March. The denial is reaffirmed on review and a hearing is requested in April. The hearing officer ascertains from the intermediary that only $20 of the deductible has been met. The following determination is made:

Step 1. $65 charged
- 0 allowed
$65 difference

Step 2. $65 difference
- 40 unmet deductible
$25 X 80% = $20 in controversy

No hearing may be held since the $100 limitation is not met.

EXAMPLE 2: The beneficiary met $20 of the deductible in January. The beneficiary's second claim that year is for $65. The claim is totally denied on review in March. The beneficiary's third claim that year is for $80. The claim is totally denied on review in April. The beneficiary requests a hearing on both denied claims in May. The hearing officer ascertains from the intermediary that only $20 of the deductible is met. The following determination is made:

Step 1: $145 charged ($65 + $80)
- 0 allowed
$145 difference

Step 2: $145 difference
- 40 unmet deductible
$105 X 80% = $84 amount in controversy

No hearing may be held since the $100 limitation is not met.

EXAMPLE 3: If all the facts in Example 2 were the same except that the hearing officer ascertains from the intermediary that the beneficiary had another claim for services in April that was allowed by another intermediary or carrier which satisfied the deductible, the following determination is made:

Step 1: $145 charged ($65 + $80)
- 0 allowed
$145 difference

Step 2: $145 difference
- 0 unmet deductible
$145 X 80% = $116 amount in controversy

A hearing would be held on the denied claims for $65 and $80.

EXAMPLE 4: The beneficiary met the $60 deductible in January. The beneficiary's second claim that year for $80 is denied in February. A review determination reaffirming the denial is made in March. The beneficiary's third claim that year for $90 is denied in September. A review determination is made in October. The beneficiary requests a hearing on both claims in November. The hearing officer would determine that the 6-month time limitation for requesting a hearing had expired for the $80 claim, in the absence of good cause for late filing. The $100 limitation is not met by the claim for $90. No hearing may be held.

EXAMPLE 5: The beneficiary met $20 of the deductible in March. The beneficiary's second claim that year for $80 is submitted in July and denied. The review determination which affirms the denial is made in November. The beneficiary had no other claims that year.

The beneficiary's first claim for the following year is for $95 and is totally denied in January. The review determination is made in February and affirms the denial.

The beneficiary requests a hearing on both claims in March. The following determination is made after the hearing officer ascertains that the deductible status for the first year is $30 unmet and for the second year is 0 met.

	First year	Second year
Step 1:	$80 charged - 0 allowed $80 difference	$95 charged - 0 allowed $95 difference
Step 2:	$80 difference - 30 unmet deductible $50	$95 difference - 60 unmet deductible $35

Amount in controversy: $50 + $35 = $85 X 80% = $68. No hearing may be held. In this case it was necessary to calculate the unmet deductible in two different years.

3794.2 Notice of Time and Place of Hearing.-- A claimant who requests a fair hearing is to be given adequate written notice of the time and place set for the hearing, information as to the specific issues to be determined, and the matters on which findings will be made and conclusions will be reached. Give the notice as promptly as possible after receipt of the request for a hearing. Where the hearing was requested by a person on behalf of the claimant, give notice also to that person. Give notice to any other person whose rights with respect to supplementary medical insurance benefits may be prejudiced or affected by the decision.

Schedule the hearing for a time and a place convenient to the claimant and/or his representative. Give the notice of the hearing sufficiently in advance of the date set and include sufficient information about the hearing procedure (including the claimant's right to representation) for effective preparation for the hearing. See § 3794.9 for cases where the claimant has moved out of your service area.

A request for a hearing may be withdrawn only by written notice by the claimant or his authorized representative. A request for a hearing may be considered abandoned if neither the claimant nor his representative appears at the time and place set for the hearing and no reply is received within a reasonable time (10 days) to a notice of inquiry mailed to the claimant and/or his representative.

The hearing officer may, for a good and sufficient reason, fix a new time and/or place for the hearing or adjourn the hearing on his own motion upon reasonable notification to the parties.

3794.3 Hearing Officer.-- The hearing is to be conducted by a competent, qualified and impartial individual designated by the appropriate official of the intermediary or carrier. The hearing officer is to be an individual who has not been involved in any way with the determination in question and has neither advised nor given consultation on the claimant's request for payment which is the basis for the hearing. The hearing officer should be an attorney or other qualified individual with ability to conduct formal hearings and with some understanding of medical matters and terminology, and a thorough knowledge of the program and the regulations issued together.

3794.4 Disqualification of Hearing Officer.-- A hearing officer is not to conduct a hearing in any case in which he is prejudiced or partial with respect to any party, or if he has any interest in the matter before him. He is to consider any objection and shall, at his discretion, withdraw. If he does withdraw, designate another hearing officer to conduct the hearing. If he does not withdraw, the objecting party may present his objections to you for your consideration at any time prior to the issuance of a decision, review the request and take appropriate action. The fact that a hearing officer is an employee of the intermediary does not create prima facie cause for disqualification.

3794.5 Hearing Procedures.-- The hearing procedure is to provide an opportunity for the claimant to appear in person and, if he desires, to be represented by legal counsel or by any other qualified individual. (See § 3797.) However, the claimant may forego the opportunity to appear personally or through a representative. A claimant and/or his representative is to have the opportunity to offer oral and written evidence, to examine and reply to evidence relied upon as the basis of your action, and to present and examine witnesses. The rules of evidence established for the hearing procedure must offer sufficient latitude so that all relevant and material evidence can be accepted and considered without regard to whether it would be admissible under the rules of evidence applicable to court procedures.

If all interested parties waive their right to appear before the hearing officer, it shall not be necessary for him to give notice of or conduct a formal hearing. However, the hearing officer will make a decision in accordance with the evidence at hand in the usual manner. A waiver of the right to appear must be in writing and filed at any time prior to the mailing of notice of the decision. Even though all parties have filed a waiver, the hearing officer may, nevertheless, give notice and conduct a hearing if he believes that the personal appearance and testimony would assist him to ascertain the facts. However, failure of the parties to appear shall not be cause for a finding of abandonment and the hearing officer shall still make his decision on the basis of the evidence adduced.

Make a complete record of the proceedings at the hearing. Transcribe the testimony and copies of the transcription and other documentary evidence are to be reproduced when directed by the hearing officer, the intermediary, or the Administration. Furnish a copy of the transcribed testimony to the beneficiary or his representative upon request, provided he bears the cost. However, the charge to the claimant or his representative may be waived if the cost of providing a copy of the transcribed testimony is $5 or less and you feel that a charge is not warranted in view of billing and bookkeeping expenses.

With the approval or upon action of the hearing officer, a request for a hearing may be withdrawn or dismissed at any time prior to the mailing of the notice of the decision; (1) upon the claimant's written application to you or the hearing officer; (2) by the claimant's oral request at the hearing; (3) upon failure of the claimant or his representative to appear at the hearing without giving proper notice within 10 days after the mailing of the notice of the time and place of the hearing to show good cause why he cannot appear; (4) where the claimant is not a proper party or is otherwise not entitled to a hearing; or (5) where the claimant dies and there is no information before the hearing officer showing that anyone may be prejudiced by your determination.

A hearing office may, on request of a party and for good and sufficient cause shown, vacate any dismissal of a request for a hearing at any time within 6 months from the date of the mailing of the notice of the dismissal to the party requesting the hearing at his last known address.

3794.6 Issues for Determination at a Part B Hearing.-- The "hearing" procedures are utilized only to settle issues arising from certain determinations by you involving Part B benefits. These include issues as to the deductible, covered services, the number of home health visits used, the timely execution and filing of a request for payment, waiver of beneficiary or provider liability, whether a claimant is entitled to have payment made under Part A instead of Part B, whether a physician's certification has been properly obtained and the medical necessity of the services. The hearing officer may not make determinations with respect to any issue or factor for which SSA has sole responsibility (for example, whether or not an individual is entitled to coverage under the supplementary medical insurance plan; whether an institution furnishing services meets the conditions for participation or coverage of services; or whether an overpayment should be waived) or which relates to hospital insurance benefits under Part A or non-provider services under Part B. In the latter case the carrier's hearing officer has jurisdiction for the hearing.

Institute procedures to assure that appropriate disposition is made of all protests and complaints. If you receive a protest from a claimant concerning an issue which is outside your area of responsibility, forward it to HCFA without delay and advise the claimant of the referral. If the case pertains to non-provider services under Part B, forward the hearing request to the appropriate carrier. Where a complaint is received which encompasses more than one issue, some of which are outside your area of responsibility, refer the complaint to HCFA for consideration of those aspects of the protest over which you have no jurisdiction. However, proceed with the review of that portion of the protest which falls within the confines of your adjudicative duties, provided that a decision on such portion of the complaint is not dependent on HCFA's determination on the other issues. Where such dependency exists, defer review pending HCFA's decision.

3794.7 Hearing Decision.-- As soon as practicable after the close of a hearing, the hearing officer is to make a decision in the case based upon the documents, requests, papers, or other written evidence included in the hearing record. The decision is in writing and contains a statement of the issues, a statement of the evidence with reference to exhibits where appropriate, a statement of the applicable law with appropriate citations, a statement of rationale, specific findings of fact, and a conclusion. The hearing officer's decision must comply with the provisions of title XVIII of the act and related regulations as well as with general instructions (e.g., policy statements, instructions and other guides). The hearing officer's authority is definitively restricted by these parameters. Mail a copy of the decision to each party to the hearing at his last known address. The hearing officer's decision is final and binding upon all parties to the hearing unless it is revised in accordance with § 3799. The law does not provide for an appeal from the hearing officer's decision or for judicial review by State or Federal courts.

3794.8 HCFA Regional Office Examination of Hearing Records.—To help assure uniform application of due process principles in the hearing process and to assist in identifying areas in which the expansion or revision of guidelines is necessary, HCFA's ROs examine records of hearings conducted by hearing officers. The following instructions set forth the procedures the ROs utilize in their review of hearing files.

A. The RO contacts the carriers in its region and works out arrangements for review of Part B hearing files.

B. Over the course of a fiscal or calendar year, the RO reviews a sample of hearing officers' decisions. The sample is based on the last digit of a claimant's Social Security number, which the RO selects at random.

C. The RO reviews 16 hearing files for each hearing officer who has decided, dismissed or accepted withdrawal of a hearing request in the year under review. If a hearing officer handled fewer than 16 hearings during the year, the RO reviews all hearing records.

D. Where the claimant receives an in-person or telephone hearing, the RO has the option of reviewing either a typed transcript of the hearing record or a taped recording.

E. The RO examines the following items in its due process review:

1. Is an EOMB in file?
2. Is a review request signed by proper party (§3792.1)?
3. Is a review determination in file?
*4. Does the review determination explain why, in specific terms, the decision was not fully favorable (§3792.2F)?
5. Was a review request timely (§3792.1A)?
6. If not timely, was a good cause determination made (§3792.1A)?
*7. Is an appeal paragraph included (§3792.2F)?
*8. Is waiver of liability (§§3400ff.) applicable, and, if so, considered?

9. Is hearing request signed by proper party (S3794.1C)?
10. Is hearing request timely (S3794.1C)?
11. If not, was good cause determination made (S3794.1C)?
12. Was request acknowledged timely (S3794.2)?
*13. Is amount in controversy computed correctly? (See S3794.1D for proper formula.)
*14. If amount is less than $100, or withdrawal is accepted, was dismissal sent as described in S3794.1B?
*15. Was hearing notice properly sent? (See S3794.2.)
*16. Was second review conducted?
17. Did Hearing Officer review before hearing?
18. Was opening statement given?
*19. Was claimant apprised of his rights?
*20. Did Hearing Officer facilitate claimant/witness testimony?
*21. Was hearing officer's decision more adverse to the claimant than the review determination?
*22. Was S3794.7 met?
*23. Was complete record kept/transcript available per S3794.5?
24. Was hearing decision rendered within 120 days after the hearing request was received?
25. Are files complete? Is all evidence on which review and hearing decision based in file?

*Due process is not met when the items marked by an asterisk are not followed.

3794.9 Request for Hearing--Impractical for Servicing Intermediary's Hearing Officer to Hold Hearing.-- A Part B hearing is usually held by the servicing intermediary at a time and place convenient to the claimant. However, instances may arise when it will be impractical for the servicing intermediary to conduct a hearing with its own hearing officer because of the distance, time, and expense involved in holding the hearing at a location which would be convenient for the claimant (usually near his residence).

Normally, the most economical and expeditious alternative available for handling this type of situation is to have an intermediary or carrier located nearer the claimant's residence provide the servicing intermediary with a hearing officer. Whether or not this procedure should be followed depends upon the facts in each individual case. A servicing intermediary should conduct a hearing with its own hearing officer where there would be no savings in time or travel by utilizing the hearing officer supplied by an intermediary or carrier nearer the claimant's residence or where there are factors present which make this the more appropriate course of action to assure a fair and just decision at the hearing.

Intermediaries should feel free to discuss with the HCFA regional office the best method for providing a hearing where it appears impractical for the hearing to be held by the servicing intermediary. If it is decided that the best course of action is to have another intermediary or carrier nearer the claimant's residence furnish a hearing officer, the regional office will make the necessary arrangements, including coordination with another regional office if the claimant does not reside in the region.

EXAMPLE: A beneficiary from New York, while on vacation in Florida, incurred expenses for medical services. His claim was denied on the basis that the services were not covered under Medicare. The beneficiary, some time after the review determination affirmed the initial denial, returned to New York City, and requested a hearing on his claim. Since he was not returning to Florida and wanted an opportunity to appear personally before a hearing officer, he asked that the hearing be held in New York. The servicing intermediary, after consulting with the Atlanta RO, felt that the proper disposition of the hearing did not require that its hearing officer hold the hearing. The request for hearing, along with copies of all the pertinent information and documents, was forwarded to the RO in Atlanta, Georgia. The Atlanta RO contacted the New York RO for assistance in obtaining a hearing officer and forwarded the request and materials to the HIRO in New York. The New York RO then made arrangements with an intermediary or carrier in New York for the selection of a hearing officer.

The hearing officer selected to hold a hearing for another intermediary under this procedure acts as that intermediary's hearing officer and all communications with the claimant, including the decision, will reflect this.

Where the hearing officer supplied by an intermediary or carrier nearer the claimant's residence requires any additional development, information or documents for handling the case, the request should be forwarded to the HI regional representative in accord with his intermediary's usual practices. The HIRO will then forward the request to the servicing intermediary, or if it is an out-of-region intermediary or carrier, to the appropriate HIRO for transmittal to the servicing intermediary.

The servicing intermediary is bound by the decision of the hearing officer selected to hold the hearing, but only relative to that particular case. In accordance with the general rule, the decision of the hearing officer does not create a precedent which the intermediary is bound to follow in subsequent cases.

Only the servicing intermediary should record a transferred hearing case in its statistical reports. When the hearing file containing the transcript of the hearing and the final decision of the selected hearing officer is returned via the BHIRO to the servicing intermediary, the case should then be cleared from its pending hearings record. The servicing intermediary (not the hearing officer) should forward a copy of the hearing file to BHI in accordance with § 3794.8.

Any problems encountered in implementing these procedures should be brought to the attention of the HI regional office immediately.

3795. FILING PART B APPEAL REQUESTS ON SSA-1964 AND SSA-1965

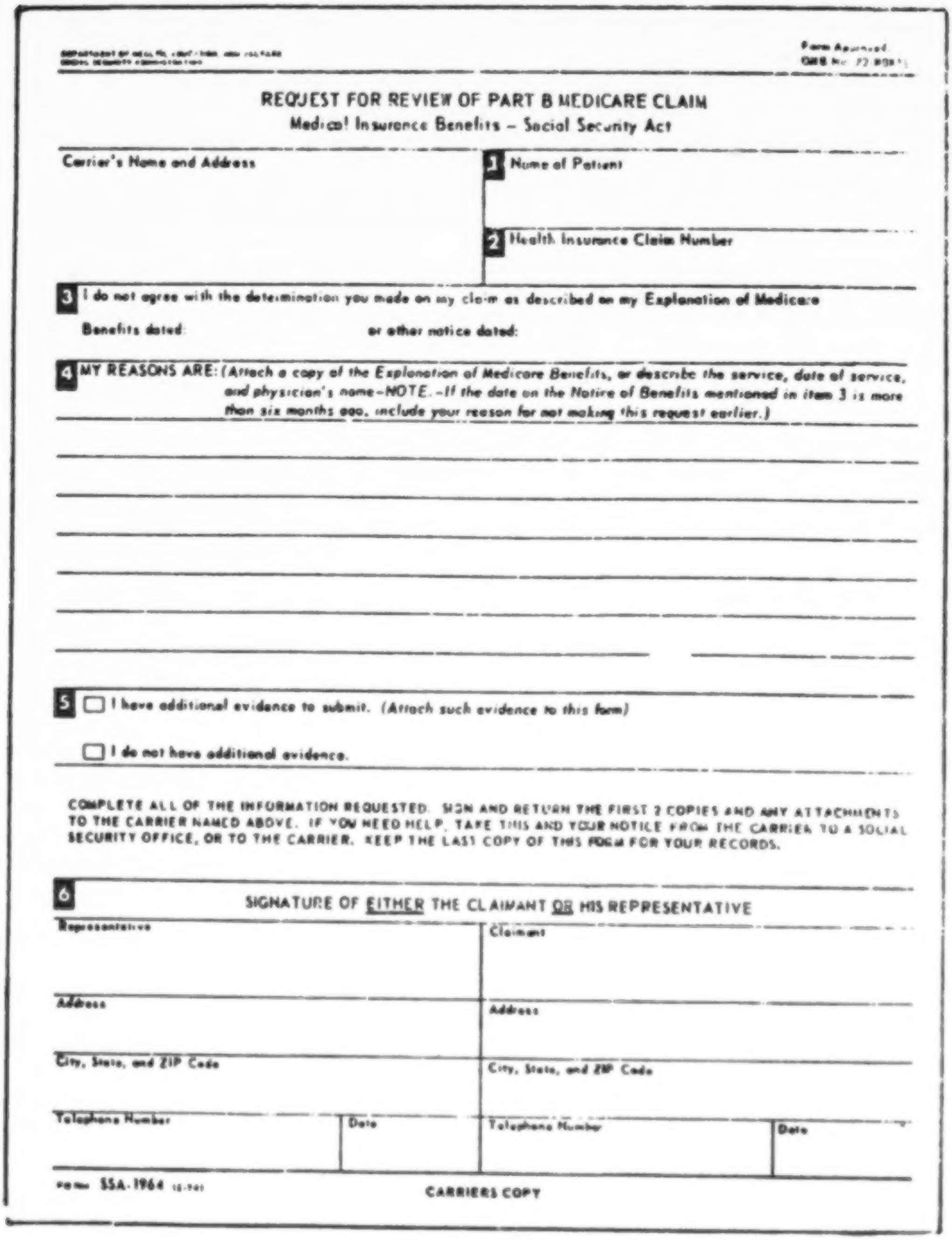
When a claimant wishes to appeal the initial determination or the intermediary's review determination of his claim and he has not submitted a written statement of his intent, he will file a form SSA-1964 (Request for Review of Part B Medicare Claim) or an SSA-1965 (Request for Hearing--Part B Medicare Claim).

The claimant may also appoint any qualified individual to act as his representative in prosecuting his request for a review or hearing. If the individual appointed is not an attorney or a member of Congress, the claimant must execute an SSA-1696 (Appointment of Representative), in addition to the SSA-1964 or SSA-1965. The SSA-1696 must also contain the signed acceptance of the person appointed. Where the individual is an attorney or a member of Congress, completion of the SSA-1696 is not necessary. A request for an appeal by a representative on behalf of a beneficiary shall be treated as a request by the beneficiary himself. (See § 3789, Exhibit 1.)

The intermediary may mail the forms directly to the claimant for completion or may request the social security office to obtain an appropriate form when the claimant appears to need assistance. These cases must be controlled in the intermediary's office in the same way as when other claims forms or information is requested.

When the forms (SSA-1964, SSA-1965, SSA-1696) are filed through the social security office, that office distributes each copy to the appropriate parties. Prior to distribution, each copy of the SSA-1964 is date stamped. In the case of the SSA-1965, the social security office completes the acknowledgment portion. The file copy of the SSA-1696 is forwarded with the intermediary's copy of the appeal form to the intermediary for inclusion in the claims file.

When the form SSA-1964 is filed with the intermediary, destroy the SSA copy, if any. In hearing cases, upon return of the claimant copy of form SSA-1965 to the claimant, the SSA copy of the form (if any) should be destroyed.



REQUEST FOR REVIEW OF PART B MEDICARE CLAIM

Medical Insurance Benefits – Social Security Act

Carrier's Name and Address

1 Name of Patient

2 Health Insurance Claim Number

3 I do not agree with the determination you made on my claim as described on my Explanation of Medicare Benefits dated: or other notice dated:

4 MY REASONS ARE: *(Attach a copy of the Explanation of Medicare Benefits, or describe the service, date of service, and physician's name–NOTE.–If the date on the Notice of Benefits mentioned in item 3 is more than six months ago, include your reason for not making this request earlier.)*

5 ☐ I have additional evidence to submit. *(Attach such evidence to this form)*

☐ I do not have additional evidence.

COMPLETE ALL OF THE INFORMATION REQUESTED. SIGN AND RETURN THE FIRST 2 COPIES AND ANY ATTACHMENTS TO THE CARRIER NAMED ABOVE. IF YOU NEED HELP, TAKE THIS AND YOUR NOTICE FROM THE CARRIER TO A SOCIAL SECURITY OFFICE, OR TO THE CARRIER. KEEP THE LAST COPY OF THIS FORM FOR YOUR RECORDS.

6 SIGNATURE OF EITHER THE CLAIMANT OR HIS REPRESENTATIVE

Representative		Claimant	
Address		Address	
City, State, and ZIP Code		City, State, and ZIP Code	
Telephone Number	Date	Telephone Number	Date

FORM SSA-1964 (2-74)

CARRIERS COPY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved.
OMB No. 72-R0839

REQUEST FOR HEARING - PART B MEDICARE CLAIM
Medical Insurance Benefits - Social Security Act

Carrier's Name and Address

1 Name of patient

2 Health insurance claim number

3 I disagree with the review determination on my claim, and request a hearing before a hearing officer of the insurance carrier named above.

MY REASONS ARE: *(Attach a copy of the Review Notice. NOTE.—If the review decision was made more than 6 months ago include your reason for not making this request earlier)*

4 ☐ I have additional evidence to submit. (attach such evidence to this form or forward it to the carrier within 10 days.)
☐ I do not have additional evidence.

5 EITHER THE CLAIMANT OR HIS REPRESENTATIVE SHOULD SIGN IN THE APPROPRIATE SPACE BELOW:

Signature or Name of Claimant's Representative		Claimant's Signature	
Address		Address	
City, State, and Zip Code		City, State, and Zip Code	
Telephone Number	Date	Telephone Number	Date

(Claimant should not write below this line)

ACKNOWLEDGMENT OF REQUEST FOR HEARING

Your request for a hearing was received on ______________. You will be notified of the time and place of the hearing at least 10 days before the date of the hearing.

Signed	Date

FORM SSA-1965 (10-72)

CARRIERS COPY

3797. AUTHORIZED REPRESENTATIVE-PART B.

A party to an initial determination, review, or hearing may appoint any individual as his representative unless that person is disqualified or suspended from acting as a representative in proceedings before the Social Security Administration or unless otherwise prohibited by law. The file may also reflect that a party's mental or physical ability is so impaired that there is a prima facie showing of mental incompetency, or physical inability to pursue his rights. In these cases, the request for review or hearing on behalf of such individual should be considered valid if it is signed by an individual who would qualify to execute a request for payment on behalf of the claimant. (See § 3303.) Where the representative is an attorney or a Member of Congress, in the absence of information to the contrary, his representation that he has such authority shall be accepted.

A representative may make or give, on behalf of the party he represents, any request or notice relative to any proceeding before the intermediary including review and hearing. A representative shall be entitled to present evidence and allegations as to facts and law in any proceeding affecting the party he represents and to obtain information with respect to the claim of the party to the same extent as the party. Notice to any party of any action, determination, or decision, or request to any party for the production of evidence, is to be sent to the representative of such party.

Hospital Appeals Under the Medicare Prospective Payment System (PPS)

3798 APPEALS BY HOSPITALS OF DIAGNOSIS-RELATED GROUP (DRG) ASSIGNMENTS UNDER PPS

A. Intermediary Review of Initial DRG Assignments.—Under PPS, the amount of payment to hospitals for inpatient hospital services is determined prospectively on a per-case basis. A single payment amount is paid for each type of case identified by the DRG into which each is classified. In accordance with §3637.12, a DRG is assigned to each hospital discharge by use of a computer software program, the DRG grouper, from data elements reported by the hospital.

The hospital has 60 days after the date of the initial DRG assignment to request review.

If the hospital disagrees with the DRG assigned to a case, it may resubmit additional billing data for that case. (See §3637.13.) Review the resubmitted data and adjust the DRG, if necessary.

The beneficiary is not entitled to a review of the initial DRG assignment since the DRG assignment does not constitute a denial of benefits. Beneficiary liability is limited to deductibles and/or coinsurance and payment for services not covered by Medicare. Of course, the beneficiary retains the full range of appeal rights specified in §3781.1 for cases involving denial of benefits.

B. Intermediary's Role as Medical Review Entity—Review of Revised DRG Assignments.—Hospitals receiving payment under PPS are required to enter into contracts with Peer Review Organizations (PROs) by September 30, 1984. Until a PRO contract is awarded in the area, the medical review function will be performed by Professional Standards Review Organizations (PSROs) or fiscal intermediaries (absent a federally funded PSRO in the area).

If the intermediary performs the medical review in the absence of a PRO or PSRO, one of its functions is to ascertain that the diagnostic and procedural information supplied by the hospital that led to the DRG assignment is substantiated by the medical records. (See §3690.4.) If it is determined that an error has occurred in the coding and/or sequencing of the diagnostic and/or procedural information in the medical record or on the bill, assign a revised DRG, notify the hospital and adjust its reimbursement accordingly.

If the hospital disagrees with the revised DRG, it may request the intermediary to review the determination within 60 days after the date of notice of the revised DRG assignment.

As in the case when the initial DRG is assigned, the beneficiary is not entitled to a review of the revised DRG assignment since he/she is not denied any benefits and thus is not adversely affected.

Reopenings and Revisions

3799. REOPENING AND REVISION OF DETERMINATIONS AND DECISIONS ON CLAIMS--GENERAL.

When a determination on a bill for services furnished a beneficiary is made, he (and the provider) should be able to rely on the determination with respect to the coverage of the services and the amount of payment. There are, however, instances in which strong equities exist for the parties to the determination and for the Government, in favor of reopening a potentially incorrect initial, revised, reviewed, or reconsidered determination, or hearing officer's, ALJ's or AC's decision.

The regulations do not permit unrestricted reopening of determinations and decisions. They do set specific circumstances under which determinations may be reopened. The following sections outline these policies and procedures. (See §§2633ff. for guidelines regarding reopening determinations or decisions on provider's costs and the amount of reimbursement.)

The authority to reopen decisions of an ALJ or the Appeals Council rests solely with the ALJ or AC. These instructions are not applicable to such reopenings, even though the basic rules applied by ALJ and the AC are the same. Therefore, references to "decisions" in the following sections are to those of a hearing officer.

3799.1 How Issues May Arise.--A party whose right to reconsideration, review, or hearing has expired (§§3781.2, 3792, and 3794.1) may express dissatisfaction with a denial or the amount of the payment, or supply additional information pertinent to a determination. If dissatisfaction is expressed after the right to reconsideration, review, or hearing has expired and no extension of time (see §§3781.3, 3792, and 3794.1C) has been granted, or if HCFA, you, or a hearing officer determines that a determination or decision may be erroneous and should be reopened, apply the rules in §§3799.2-3799.16. (If a decision is reopened as a result of a beneficiary's request and a less favorable determination is suggested, follow §3783.2.)

3799.2 Summary of Conditions under Which a Determination or Decision May be Reopened.--Your initial, revised, reconsidered, or reviewed determination or a decision by a hearing officer may be reopened under the following conditions: (See §3799.5 for actions necessary to permit reopening.)

- Within 12 months after the date of the determination or decision, it may be reopened for any reason other than to add diagnosis or procedures to the DRG. (See §3799.11 for an exception.);

- After such 12-month period, but within 4 years after the date of the initial determination, it may be reopened for good cause. (See §3799.6.);

- At any time, if the determination or decision is unfavorable to the party or parties, in whole or part, but only for the purpose of correcting a clerical error or error on the face of the evidence; or the determination or decision was procured by fraud or similar fault of the party or parties. (See §3799.12.)

A revised determination or decision need not be made within the above time limits. However, make it as expeditiously as possible. Where the grounds for reopening involve clerical error, or error on the face of the evidence, the revised determination or decision is generally made at the same time the reopening occurs. Hospital omission of diagnoses or procedures is not considered an error that permits reopening. Where it is necessary to develop additional evidence, notify the party or parties to the determination of the reopening. Develop as expeditiously as possible.

3799.3 Date of Initial, Revised, Reconsidered, or Reviewed Determination, or Hearing Officer's Decision.--To establish the date of the initial, revised, reconsidered, or reviewed determination, or a hearing officer's decision, for purposes of §3799.2, the following rules will apply:

A. Date of Initial Determination.—The date of an initial determination is the date you mailed the denial notice or the date you paid an amount being questioned.

B. Date of Revised or Reviewed Determination or Hearing Officer's Decision.--The date of the notice of the revised, reconsidered, or reviewed determination, or the hearing officer's decision is the date of such determination or decision.

3799.4 Who May Reopen an Initial, Revised, Reconsidered, or Reviewed Determination, or Hearing Officer's Decision.--

A. Part A Claims.--HCFA or you may reopen a Part A initial, revised, or reconsidered determination. However, you may reopen only if you took the last action on the determination (i.e., a determination has not been made by an AJL, AC or a court).

B. Part B Claims.--Only you may reopen a Part B initial, revised, or reviewed determination. A decision by a hearing officer may be reopened only by the hearing officer. If he is unavailable for reasons of death, termination of employment, or leave of absence it may be reopened by another hearing officer you select.

3799.5 Actions Necessary to Permit Reopening Within the 1 or 4-Year Period.--To reopen a determination or decision under either the 1 or 4-year rule, it is necessary that:

- A written request be filed by a party to the determination or decision, within the applicable time limit; or

- HCFA, you, or (for Part B claims) a hearing officer takes some action documented within the applicable time limit questioning the correctness of the determination or decision.

The decision to conduct a sample study of a provider's claims constitutes a reopening of all determinations but only when such a decision is documented and is clearly intended to question their correctness. Send a notice to the provider as soon as possible explaining: the reason for the study (e.g., possible overutilization of services); the period to which the results will apply; the sampling procedure, including the method used to select the sample and a statement that the sample findings will be projected to the entire population of claims. However, do not send a notice if the study is performed because fraud is suspected.

3799.6 Good Cause for Reopening.—"Good cause for reopening" exists where:

- New and material evidence is furnished. (See §3799.7.);
- You made a clerical error in the statement of the initial determination. (See §3799.8.);
- There is an error on the face of the evidence; i.e., on the basis of all the evidence on file at the time the decision was made, it is clear that the decision was incorrect. (See §3799.9.)

An omission in the hospitals' coding of diagnosis or procedure is not a "good cause."

3799.7 "New and Material Evidence".—Good cause exists for reopening a determination or decision within the 4-year period on the basis of new and material evidence even though the determination or decision, when made, was reasonable based upon the evidence then in file. It includes any evidence which was not considered when the determination or decision was made and which shows facts that may result in a different conclusion.

It is possible that the evidence may justify or require that further development be undertaken before a revised determination or decision is made.

3799.8 "Clerical Error".—"Clerical error," for purposes of reopening a determination or decision within the appropriate periods includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding, card punching, and computer errors.

3799.9 "Error on the Face of the Evidence".—An "error on the face of the evidence" exists where it is clear that the determination or decision was incorrect based on evidence:

- In the file used to make the determination or decision, or
- Of record anywhere in your files or those of HCFA at the time the determination or decision was made.

A. Reopening Within 4-Years Only.--

- Payment of a bill without reducing the amount payable on account of a deductible or coinsurance requirement;
- A duplicate payment for the same item;
- Payment to a person who did not bill for, and was not entitled to, the benefit;
- Payment for a service which the evidence in file clearly shows is not covered (e.g., payment for services paid for by a governmental entity, or payment for items shown in the file to be covered by WC).

B. Reopening at Any Time.--Claims can be reopended if there is an excessive application of a deductible or coinsurance amount or failure to pay for a service or item which the evidence shows to be covered.

3799.10 "Unfavorable Determination".—A determination or decision is considered "unfavorable" where a request for payment is denied or where payment is made for less than the requested amount.

3799.11 "Change of Position".—A determination or decision may be reopened and revised on the basis of a change in position within 1 year. A "change of position" occurs when there is a shift in the weighting of the evidence, or a different inference is drawn from the evidence. A policy, legal interpretation, or administrative ruling which was previously followed in deciding claims is changed, is also considered a change of position, except that a determination or decision favorable to the beneficiary will not be reopened and revised on this basis.

3799.12 Unrestricted Reopening - Fraud or Similar Fault.—A determination or decision may be reopened at any time if it was procured by beneficiary, provider, physician, or any other person.

"Fraud or Similar Fault" means:

- Intentional deception by a person who knows that the deception may result in an unauthorized benefit to some one.
- An act which approximates fraud, i.e., the furnishing of information which the individual knew was incorrect or incomplete, or the deliberate concealment of information, without a judicial finding of fraud;

- A pattern of program abuse resulting from practices that are inconsistent with accepted sound fiscal, business, or medical practice, such as:

- The furnishing of services in excess of the individual's needs or of a quality that does not meet professionally recognized standards of health care; or

The submittal of incorrect, incomplete or misleading information that results in payment for:

- Services that were not furnished;

- Services more expensive than those furnished;

- Services that were not furnished under the conditions indicated on the bill.

- The submittal of, or causing the submittal of bills, or requests for payment containing charges in excess of the amounts the provider customarily charges.

- An act or pattern of program abuse involving collusion between the provider or supplier and the recipient that results in higher costs or charges to the program;

- Any act that constitutes fraud under Federal or State law.

A determination that "fraud or similar fault" is present depends upon the facts. For example, where the evidence establishes a pattern of billing by a provider for inpatient hospital services which, under established standards of good medical practice could adequately have been supplied in an ICF, a finding of "fraud or similar fault" should be made and the claims reopened more than 4 years after the payment was approved.

3799.13 Elements Where Initial Determinations are Reopened.—Where an initial determination is reopened at the request of a party, reexamine the case in accordance with the instructions applicable to a reconsideration. (See SS3784ff.) In addition, consider waiver of liability. (See SS3430ff.)

3799.14 Results of Reopening.--When a determination or decision is reopened and revised, mail a notice of the revision, including an explanation of the reasons for the revision and an explanation of the individual's appeal rights, except as in S3799.15. However, if a determination or decision is reopened, but not revised (see S3799.17 for definition of revised determination or decision), do not include an appeal paragraph. Send it only if the reopening was at the request of a party or a notice of reopening had been previously sent.

When a determination is reopened and revised at the request of a party, include in the notice:

> "If you believe this determination is not correct, you may request a hearing within 60 days of the date you receive this notice ("6 months from the date of this notice" for Part B claims) if the amount of benefits in question is $100 or more. You may make the request by writing to us or through any social security office. The people there will be glad to assist you or answer any questions you may have about this determination. If you go in person, please take this notice with you."

When a determination is reopened and revised on the motion of HCFA or you, include in notice one of the following paragraphs:

A. Initial Determination.—"If you believe this determination is not correct, you may request a reconsideration ("review," if Part B items or services are involved) if the amount of benefits in question is less than $100, or a hearing if the amount is $100 or more. If you wish to file an appeal, request it within 60 days of the date you receive this notice (minimal "6 months from the date of this notice" for Part B claims). You may make the request by writing to us or through any social security office. The people there will be glad to assist you. If you go in person, please take this notice with you."

B. Reconsidered or Reviewed Determination.—"If you believe this determination is not correct, you may request a hearing if the amount in question is $100 or more. If you wish to file such an appeal, you must request it within 60 days of the date you receive this notice (minimal "6 months from the date of the notice" for Part B claims). You may make the request by writing to us or through any social security office. The people there will be glad to assist you or answer any questions you may have about this determination. If you go in person, please take this notice with you."

3799.15 Exception to Sending Notice of Revision to Parties--Cases Involving Limitation on Recovery from Beneficiary.—Waive recovery of overpayments from a beneficiary who was without fault where the determination or decision that the services were noncovered was made in the fourth calendar year after the year in which you approved payment. Where a revised determination or decision results in an overpayment for which the beneficiary would be liable (per §3708.4), but it appears that the conditions for automatic consideration of waiver are met, do not send a notice of the revision to any party. Instead, refer the overpayment to HCFA for consideration of the waiver issue. In referring such cases, follow §3709.2D.

3799.16 Refusal to Reopen Is not an "Initial Determination.—A finding that a prior determination or decision may not be reopened is not an "initial determination or decision." No right of appeal from such a finding exists. Accordingly, do not include a statement concerning the right to an appeal.

3799.17 Revised Determination or Decision.—A revised determination or decision is one in which: The end result is changed (for example, a service found to be covered is now found not to be covered or the amount of reimbursement allowed is determined to be incorrect). The end result is not changed, but a party might be disadvantaged by the revision (e.g., a disallowed claim because the services were custodial in nature, and therefore subject to the waiver of liability provisions, is disallowed on a basis that precludes consideration of waiver of liability).

CHAPTER VIII

PAYMENT PROCEDURES

TABLE OF CONTENTS
FOR INTERIM MANUAL INSTRUCTIONS

SECTION

Documenting Part A Reconsideration Requests............... IM3783

Documentation Sources.................................... IM3783.1

Assembling the Reconsideration File....................... IM3783.2

Development of Reconsiderations........................... IM3783.3

Elements of Review.. IM3792.2

Hearing... IM3794

Reopening and Revision of Determinations and Decisions on Claims.................................. IM3799

Budgetary Allocation and Workload Reporting............... IM3799.1

Documentation

IM3783. DOCUMENTING PART A RECONSIDERATION REQUESTS

Following denial of a Part A claim, the claimant is entitled to a reconsideration if a request is made in writing within 60 days following the receipt of the initial determination. Section 4032 of the Omnibus Budget Reconciliation Act of 1987 requires, effective October 1, 1988, that you complete 66 percent of the reconsiderations within 60 days. Effective October 1, 1989, the percentage to be complete within 60 days increases to 75.

The reconsideration is based upon information in your possession when the initial determination was made; statements or information submitted by the party or parties; and the medical and other records acquired during the reconsideration. If the evidence is not clear and convincing, obtain a statement discussing the issues from the provider.

IM3783.1 Documentation Sources.—Contact the provider to obtain any clarifying information needed if the beneficiary's allegation raises an issue which has not been fully documented.

A reconsideration constitutes your final review of your earlier determination. It is in the interests of all that all relevant information be available to you. Urge the provider to submit documentation timely.

Contact with the provider and/or the beneficiary may be necessary to obtain information. In most cases, these contacts can be by letter. You may use your own representative to secure information. The Social Security Office (SSO) may be utilized to obtain additional information. Since the provider prepares and submits the claim, it generally submits the medical documentation.

Charge all activities directly related to reconsiderations, including the written request, to appeals (Line 2) on the Administrative Budget and Cost Report; i.e., medical development, whether or not the actions result in an adjustment.

However, do not charge to appeals any oral requests for reconsideration or for further information. Charge them to initial claims processing (Line 1).

IM3783.2 Assembling the Reconsideration File.—Place all reconsideration requests (formal or informal) in manila folders as soon as possible. Enter the beneficiary's HICN on the top line of the folder tab in the upper right-hand corner. Enter the beneficiary's last name, first name, and middle initial, if any, beneath the number. Example:

HICN 300-00-7777A
Doe, Mary A.

IM3783.3 Development of Reconsiderations.--The provider is responsible for providing the information needed to support the reconsideration request. Develop information which is in your, HCFA's, or SSA's files. If the claimant is the beneficiary, develop the supporting documentation.

Inform providers of the statutory processing time limits which go into effect on October 1, 1988 and why it benefits all concerned parties if supporting documentation is submitted timely. If the claimant is unsuccessful in securing the information from another provider, assist the claimant. If necessary, remind the uncooperative provider of its responsibilities under the Provider Agreement, as enunciated in 1866 of the Act and Federal regulations at 42 CFR Part 489.

If providers request assistance, help them. However, do not assume responsibility for gathering the information. Your primary role is to assist providers in gathering information from other providers.

Include Attachment A with your denial notices or with your appeal request acknowledgements, whichever is easier in your specific system. It contains a listing of information sources for you to modify as your experience dictates.

Prong-file in chronological order, by type of evidence, all material pertaining to the services in question, including the envelope in which the request for reconsideration was received if the postmark is germane. Include only original documents whenever possible. Do not include duplicates.

Stamp the date of receipt on each document or category of documents received at the reconsideration level. Unless the format of a particular document or your claim processing system dictates otherwise, stamp the receipt date in the upper right-hand corner.

Build the file by placing the oldest of a particular category on the bottom and the most recent on the top.

The eight major categories, listed in order (category 1 appears on the bottom of all other documents), are:

1. All billing forms or summaries (see § 3783.9)
2. Report of Eligibility
3. Doctor's orders
4. Progress notes

5. Nurses' notes
6. Medication charts
7. Laboratory reports and other studies
8. Therapy treatment plan and treatment record

IM 3792.2. Elements of Review.—To implement §9341 of OBRA, a claimant dissatisfied with a Part B review determination is entitled to (1) a contractor fair hearing if the amount in dispute is at least $100 and (2) an Administrative Law Judge (ALJ) hearing following the contractor fair hearing if at least $500 is in dispute. This provision is effective for items and services furnished on or after January 1, 1987. (The new hearing provisions are discussed in §IM 3794.)

Apply the rules in §3794.1B to determine the amount in controversy remaining following the review determination. Insert in the review determination letter (§3792.2D.3) one of the following appeals paragraphs, depending on the amount in controversy:

A. Amount in Controversy Less Than $100.—"On the basis of this claim, we have determined that there is only $________ in question. The amount of benefits in question must be at least $100 in order to have a hearing. Therefore, you do not have a right to appeal this decision.

"You may be able to meet the $100 level for a hearing by combining claims as follows: Combine the amounts for any claims on which Medicare made a determination within the past 6 months based on (1) a request for review or (2) a reopening of an initial or review determination.

"If, as described above, you are able to combine claims to meet the $100 level, write to us or contact any Social Security Office if you want a hearing."

B. Amount in Controversy At Least $100.—"On the basis of this claim, we have determined that there is $_______ in question. Therefore, you may request a hearing if you do not agree with this decision. You must request the hearing within 6 months of the date of this letter. One of our hearing officers will conduct the hearing.

"Write to us or contact any social security office if you want a hearing. You may attend the hearing in person. You may also take or send someone to represent you. This person may be a lawyer or anyone you choose. Please note on your request who will attend the hearing. You do not have to appear in person. You may ask that a decision be made based on the facts in the file. A copy of the decision will be sent to you."

C. Amount in Controversy At Least $500.—"On the basis of this claim, we have determined that there is $_______ in question. Therefore, you may request a hearing if you do not agree with this decision. You must request the hearing within 6 months of the date of this letter. One of our hearing officers will conduct the hearing. Since your claim involves at least $500, you have a right to a hearing by an Administrative Law Judge in the event that you are dissatisfied with our hearing officer's decision, and at least $500 remains in dispute.

"Write to us or contact any social security office if you want a hearing. You may attend the hearing in person. You may also take or send someone to represent you. This person may be a lawyer or anyone you choose. Please note on your request who will attend the hearing. You do not have to appear in person. You may ask that a decision be made based on the facts in the file. A copy of the decision will be sent to you."

IM 3794. HEARING

A. General.—Section 9341 of the Omnibus Budget Reconciliation Act of 1986 (OBRA) (Public Law 99-509) provides for Administrative Law Judge (ALJ) hearings and judicial review for Part B claims denials, subject to minimum amounts in controversy. Section 9313(b) reaffirms the right of beneficiaries to appeal both Part A and Part B technical denials of home health benefits, e.g., denials for failure to meet the homebound or intermittent nursing care requirements.

B. Contractor Fair Hearing.—The contractor fair hearing is a prerequisite for an ALJ hearing. If less than $500 is in controversy following the contractor hearing officer's decision, no further appeals are available.

C. ALJ Hearings and Judicial Review for Part B Denials.—A person (including a provider or physician entitled to a hearing under §1879 of the Act) who is dissatisfied with the contractor hearing officer's decision on a Part B claim in which the amount remaining in controversy is at least $500, is entitled to a hearing before an ALJ. If at least $1,000 remains in controversy following the ALJ's decision, the claimant is entitled to judicial review before a Federal district court judge. This provision applies to items and services furnished on or after January 1, 1987.

D. Determining Amount in Controversy.—Section 9341 provides that in determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if they involve:

1. The delivery of similar or related services to the same individual, or

2. Common issues of law and fact arising from services furnished to two or more individuals.

Until new regulations are promulgated, follow the current rules for aggregating Part A and Part B claims. These rules are found in the regulations, for Part A, at 42 CFR §405.740 (see §3794.1B.) and, for Part B, at 42 CFR §405.820(b). The interim application of the pre-existing rules will not prejudice the rights of any claimant since the pre-existing rules respecting aggregation are less restrictive than the aggregation requirements of §9341.

E. Time Periods for Filing for Hearings.—Where Part B benefits are denied, the claimant has the right to a contractor hearing if at least $100 is in controversy and following that, an ALJ hearing, if at least $500 remains in controversy. (See B. and C. above.)

A contractor fair hearing (amount in dispute at least $100) must by regulation be requested within 6 months of the date of the review determination. An ALJ hearing (amount remaining in dispute after the contractor hearing at least $500) must by law be requested within 60 days of the date of receipt of the contractor hearing officer's decision.

F. Methods of Requesting Hearing.—The request for contractor fair hearing must be in writing and filed with the intermediary or a SSO. It may be any written expression of dissatisfaction with the intermediary review determination or a filing of Form HCFA-1965 — "Request for Hearing — Part B Medicare Claim." The SSO forwards the request for hearing to the appropriate intermediary.

G. Action by Intermediary Upon Receipt of Request for Hearing.—When a request for contractor hearing is filed, notify the claimant or representative that the contractor hearing officer will be contacting him about the request. Then forward the case file to a hearing officer who will take one of two actions:

1. Dismiss the hearing request if the hearing officer believes there is under $100 in controversy; or

2. Process the hearing request in accordance with §3794ff. if the hearing officer believes that the amount in controversy is at least $100.

H. Hearing Decision.—The hearing officer's decision should contain the following appeals right language depending on the amount of benefits in controversy:

1. Amount Remaining in Controversy Is At Least $500.—"On the basis of this decision, I have determined that there is $_______ in question. Therefore, you may request a hearing by an Administrative Law Judge (ALJ) if you do not agree with this decision. You must request the hearing within 60 days of the date of receipt of this letter.

"Write to me or contact any social security office if you want a hearing. Your request will be sent to the ALJ. The ALJ will then advise you what you have to do to prepare for the hearing."

2. Amount in Controversy Below $500.—"On the basis of this decision, I have determined that there is $_____ in question. Therefore, there are no other levels of appeal available to you. However, if you think I have made a mistake you may ask me to open the case again. To do this you must write me as soon as possible. Include with your letter any additional information you may have which you feel may result in a more favorable decision."

I. Hearing Officer Action Upon Receipt of Request for ALJ Hearing.—When the contractor hearing officer, following his decision, receives a request for an ALJ hearing in which the amount remaining in controversy is at least $500, the hearing officer will take the following action:

1. New Evidence.—If any new evidence is submitted with the hearing request, review the case file to determine if the claim(s) may be reversed fully in favor of the claimant. If a full reversal is in order, prepare a decision containing the following elements:

- A clear statement of the issues,

- An explanation describing the reasons why a fully favorable decision is possible, with reference to the facts and evidence in the case,

- A statement of the statutory or regulatory basis for the decision,

- The decision, i.e., what the claimant can expect, and

- Signature of the HO.

Forward the full reversal decision to the claimant; then, forward the case file to the intermediary for effectuation of the decision. (A full reversal decision is actually a reopening and revision of the hearing officer's decision.)

2. Case File to ALJ.—Unless the claim(s) warrants a full reversal, forward the file to the ALJ. Prior to forwarding the file, review carefully to ensure that all available evidence is included. Also, review to ensure that the decision contains all of the items described in §3794.7. If any element in §3794.7 is not included in the hearing decision, prepare for the ALJ, as an attachment to the decision, a brief written description of the omitted element. If a partial reversal appears possible, based on any new evidence submitted, include that in an explanation to the ALJ.

J. Limitation on Authority of ALJs and Courts.—Section 9341 of OBRA stipulates the following limitations on the authority of ALJs and the Courts to rule on appealed Medicare claims:

1. ALJs have no authority to overturn national coverage determinations made by HCFA under §1862(a)(1) of the Act, i.e., determinations that a particular category of items or services is not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. However, the ALJ will determine whether the "limitation of liability" rules in 42 CFR 405.332 (§§3430ff.) were applied correctly, i.e., whether the beneficiary or provider (or both) knew or could reasonably have been expected to know that the items or services were not covered. Although the substantive national coverage determination may not be overturned by an ALJ, it is subject to judicial review, as limited as provided in paragraph 2.

2. In judicial review of the ALJs' decisions, Courts have no authority to overturn a national coverage determination made under §1862(a)(1) of the Act solely on the grounds that the coverage rule relied upon in making the determination was not issued in accordance with the notice and comment procedures of the Administrative Procedure Act. In any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of the determination, it must remand the matter to the Secretary for additional proceedings to supplement the record. The court may not determine that an item or service is covered except upon review of the supplemented record.

3. Regulations and policy instructions initially issued prior to January 1, 1981 which concern a method for determining the amount of payment under Part B are not subject to judicial review.

Reopenings and Revisions

IM3799. REOPENING AND REVISION OF DETERMINATIONS AND DECISIONS ON CLAIMS

When a determination is made for services furnished, the beneficiary (and the provider) should be able to rely on an accurate determination with respect to the coverage of the services and the amount of payment. However, there are instances in which strong equities exist for claimants and the Government in favor of reopening an incorrect initial or reconsidered determination, or an Administrative Law Judge's (ALJ), or Appeals Council's (AC) decision.

Regulations do not permit unrestricted reopenings. They set specific circumstances under which determinations may be reopened. The following sections outline these policies and procedures. (See Part 2, §§2633ff. for guidelines regarding reopening determinations or decisions on provider's costs and the amount of reimbursement.) The authority to reopen an ALJ's or an AC's decision rests solely with the ALJ or AC.

In legal terms, a case is open until the last determination becomes final by the losing party's failure to appeal or the exhaustion of appeal rights. Only if the case is closed and the new material is significant or discloses errors on the face of the materials, or fraud is involved, can the case be reopened. However, neither the statute nor the regulations entitle claimants to a reopening.

A reopening, as contained in Federal regulations, is not an appeal right. It is a discretionary action you take with or without a request of the claimant, where good cause exists. Claimants have no appeal right regarding your decision to refuse a reopening. A reopening is an action which you may take on your own volition when refusal to reopen would either inflate costs to the Government without a commensurate benefit to the claimant or deprive the claimant of rightful payment.

Do not conduct reopenings routinely. Do not grant them in the absence of additional, relevant, and significant information, or discovery of an error. Do not grant a reopening based on an oral request. Consider granting a reopening in response to a written request if the criteria in §§12100 ff. are met. Charge reopenings to line 1 of the Administrative Budget and Cost Report.

Some intermediaries have developed informal procedures under the general heading of "reopenings". Providers have come to view these actions as appeal rights. These non-technical reopenings are not part of the appeals process. They are not a claimant's right. They are not additional levels of appeal, nor are they intended to provide an appeal for a determination for which a formal appeal is not available; e.g., for providers paid under waiver of liability.

We want this practice ended, but we do not want you to immediately terminate it if you have been granting such informal reopenings. Rather, when the provider makes such a request, discuss the appropriate appeals route. Act on the reopening request, but indicate that future requests must be within the process provided by Medicare, i.e., the reconsideration, and, if necessary and the case involves at least $100.00 in controversy, the hearing.

A special notice, explaining the policy on reopenings and appeal rights, and the policy that appellant providers are responsible for providing the information needed to support the appeal, is attached (Attachment C). Also attached (Attachment D), is a HCFA policy statement on reopenings to help you respond to requests for reopening prior to the expiration of appeal rights.

A reopening of an initial denial can take place only after the time for appeal has expired. Do not reopen, for example, a denial if the provider has been paid under the waiver of liability. By regulation 42 CFR 405.704 (c) such determinations are not subject to appeal. Although a technical reopening in this situation is theoretically possible; e.g., fraud investigations and court orders, it is extremely rare. In any event, do not conduct reopenings routinely at the request of providers. In waiver cases, if the provider is paid, its only access to reconsideration is as the beneficiary's representative.

Once a case has been forwarded to the reconsideration intermediary and the "medical review" staff is involved, do not consider a non-technical reopening. Treat the reopening request as a request for reconsideration and acknowledge the appeal. Explain to the claimant that there is no entitlement to a reopening and that you are treating the request as a request for reconsideration (Model paragraphs are attached (Attachment B)). Furnish the claimant the documentation listing if you have not already done so.

Charge reconsiderations and all directly related activities to line 2 of the Administrative Budget and Cost Report. If you elect to do a non-technical reopening, it does not affect the filing deadline for reconsideration. Charge a non-technical reopening, before reconsideration, to line 1.

Following reconsideration, and pending a requested ALJ review, you may receive additional information that might affect payment. Review it. Whether or not it enables you to fully reverse the reconsideration decision, count and charge the activity as ALJ case preparation on line 2 of the Administrative Budget and Cost Report.

Forward the information for incorporation into the hearing file, but first review your copy to ensure that the file sent to the ALJ is complete. A test is whether or not someone not involved in the reconsideration process can understand what you did, why you did it, and the basis for your decision. Although ALJs are not required to defer to your rationale, they may if they understand why you decided what you did. Be mindful that after the request for an ALJ hearing is filed, the ALJ has jurisdiction.

3799.1 Budgetary Allocation and Workload Reporting—Charge activities as follows:

Administrative Budget and Cost Report	Line
(Initial Claims Processing)	1
o Adjustments following inquiry	1
o Corrections of processing errors	1
o Technical and non-technical reopenings	1
o Medical Review	4
o Oral request for reconsideration	1
o Written request for reconsideration	2
(Reconsideration)	2
o Technical reopening (appeals exhausted)	1
o Non-technical reopening	2
o Medical Review	2
o Case preparation (ALJ)	2
o Other activities directly related to reconsideration	2

For workload reporting purposes, count technical and non-technical reopenings as reopenings.

ATTACHMENT A

MODEL NOTICE TO PROVIDER

If you decide to appeal this decision, please make sure that you submit all documentation necessary to support the appeal. Forwarding this information with your request for appeal will facilitate processing and payment, if appropriate.

Only you can decide on the documentation that best supports your claim. Nevertheless, you may want to consider the following, depending on the nature of the claim:

- Discharge summary or cause of death, if applicable
- Special studies and reports (blood, pathology, etc.)
- Consultation reports
- Operative and anesthetic report
- Social service notes
- Therapy treatment plan and treatment record
- Referrals, transfer forms
- Billing forms
- Copies of communications between you and beneficiary.

If you have a problem in obtaining certain information, let us know. We will assist to the extent we can.

ATTACHMENT B

RECOMMENDED RESPONSES TO REQUESTS FOR REOPENINGS

MODEL PARAGRAPHS

Waiver of Liability (Provider only)

Because you were paid under Waiver of Liability, there is no appeal available. You may request a reopening if you can show an error on the record or you can furnish new and significant information showing that the determination of record is erroneous.

Additional Information - Non-Technical Reopening

Because the additional information you submitted enables payment, we have decided to informally reopen the claim. Generally, we can make better decisions on claims if you submit all relevant information at the time the claim is filed. Please bear that in mind when you file claims.

Additional Information - Refusal to Reopen - Appeals Process Available

We are not granting your request for a reopening since there are administrative appeals available to you. We are considering your letter a request for (reconsideration, hearing).

Additional Information - Refusal to Reopen

We understand that you are still dissatisfied with the final decision in your case and that you have exhausted your appeal rights. Medicare policy, however, is to reopen final decisions only to correct clear errors in those decisions. These include:

- Factual errors which are found when new and material evidence, which was not available when the final decision was made, is presented.
- Clerical or computational errors.
- Errors on the face of the evidence.
- Errors caused by fraud or similar fault.

Since your request for reopening does not include evidence to indicate that any of these errors were made, we are not reopening the case. However, if you have such evidence, please submit it to us, and we will again consider your request for reopening.

ATTACHMENT C

SPECIAL NOTICE TO PART A PROVIDERS AND PART B SUPPLIERS AND OTHER INDEPENDENT PRACTITIONERS

The purpose of this notice is to inform you of certain procedural revisions recently received from the Health Care Financing Administration, and to remind you of your appeal rights under Part A and Part B of the Medicare Program.

Appeals

Law and regulations provide specific redress for claimants who are dissatisfied with Medicare determinations. Through these appeals, the Government seeks to ensure that the correct payment is made, or a clear and adequate explanation is given as to why payment is not made.

Part A Intermediary Appeals

Part A providers may appeal claim decisions on individual claims under the following circumstances:

- o On its own behalf if the claim is denied under the limitation of liability provisions and the beneficiary is not going to appeal (in which case, you may appeal both the denial of waiver of liability, and the underlying denial of coverage for the specific services); or
- o On the beneficiary's behalf if the provider is the duly authorized representative of the beneficiary.

If you are dissatisfied with the initial determination, the determination is subject to appeal, and one of the above conditions is met, you may request a reconsideration. The request must be filed, in writing, within 60 days of the receipt of the notice.

If you are still dissatisfied following reconsideration and the amount in controversy is at least $100, you have a right to a hearing before an administrative law judge (ALJ) of the Social Security Administration (SSA). The request for this hearing must be in writing, and filed within 60 days following the date you receive the reconsideration notice.

If you are still dissatisfied, you may appeal to the Appeals Council. The request must be in writing and filed within 60 days after the date of the hearing decision notice. If you are still dissatisfied and the amount in controversy is at least $1000, you are entitled to judicial review.

Part B Carrier Appeals

As a physician or supplier providing items and services to Medicare beneficiaries payable under Part B, you may appeal an initial determination if you:

- o Accepted assignment;
- o Did not accept assignment and we denied the claim as not reasonable and necessary, and the beneficiary did not know and could not have been expected to know that the service would not be covered, requiring you to return any money you had collected for these services; or
- o You are the duly authorized representative of the beneficiary.

If you are dissatisfied with the carrier's initial determination and the determination is subject to appeal, you may request a review. The request must be in writing, signed, and filed within 6 months after the date of the initial determination.

If you remain dissatisfied after the review determination, and the amount in controversy is at least $100, you may request a fair hearing. Requests for fair hearings must be filed, in writing, within 6 months following the date of the review determination. You may request a hearing in-person, by telephone, or on-the-record. If you request an in-person or telephone hearing, it will be scheduled, but in the interim an on-the-record hearing will be conducted based on the information in file and any additional information you submit.

If you are still dissatisfied following the on-the-record hearing, you will receive the hearing previously scheduled. Moreover, a different hearing officer will be assigned to preclude any possibility of prejudice.

If you are still dissatisfied with the determination made by the hearing officer, and the amount in controversy is at least $500, you may request a hearing before an Administrative Law Judge of the Social Security Administration. The request must be in writing and filed within 60 days of the date of the fair hearing decision of record. If you are still dissatisfied, you may appeal to the Appeals Council. Finally, if you are still dissatisfied, and the amount in controversy is at least $1000 you may seek judicial review.

Development of Appeals

For individual claims submitted by providers, physicians, and others who furnish items and services to Medicare beneficiaries, the responsibility for gathering and submitting documentation that supports claims and appeals rests with the provider. We will offer guidance and assistance as necessary, but the responsibility for identifying what is needed and where it is located is your responsibility. If you have tried to secure essential documentation, but have been unsuccessful, we will try to assist you. Attached is a list of documentation sources which have proven useful. If you have any questions on other kinds of information which may be necessary, let us know.

Reopenings

Reopenings are not, in a legal sense, appeals. They are actions taken after a claim is closed to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the claim was initially processed. Reopenings should be done rarely, on individual cases, or on a group of cases adversely affected by a systems error.

Unfortunately, among some providers, reopenings have become equated with appeals. A reopening is requested when a review (Part B) is appropriate, or a hearing (Part A) is the correct choice.

Some intermediaries and carriers have developed a variety of informal procedures under the general heading of "reopenings". These informal actions can extend the appeals process by subjecting claims to unnecessary and superfluous levels of review which delay access to the formal levels of appeal, with their respective procedural safeguards.

Usually, these reopenings occur because claimants fail to timely submit supporting documentation. The timely submittal of documentation not only negates the perceived need for "reopenings", but helps to ensure timely payment.

You will not be affected by our decision to eliminate informal reopenings, as you may appeal using the regular appeals process. Reopenings are not appeals. They are discretionary actions that we may initiate after appeal rights are exhausted.

REOPENINGS POLICY: PART A AND PART B

This paper outlines the legal and policy bases for our position on reopenings, and for the restriction on quasi-appeals of claims submitted by providers who have been paid under waiver.

The regulations grant providers the right to appeal decisions concerning individual payments only in specific, and limited, circumstances. These restrictions are consistent with the structure of the Medicare program, in which payments are made to, or on behalf of, beneficiaries, and the right to appeal disputes over payments is granted to beneficiaries, but not to institutional providers under Part A or physicians or others who furnish items and services under Part B. See, for example, § 1869 of the Social Security Act (the Act) which grants appeal rights to beneficiaries (or physicians or suppliers on a beneficiary's behalf if the physician or supplier accepts assignment on certain types of payments) and to physicians that did not accept assignment and we denied the claim as not reasonable and necessary, and the beneficiary did not know and could not have been expected to know that the services would not be covered, requiring the physician to return any money collected for the services, and § 1879 granting appeal rights to providers on the beneficiary's behalf on the issue of waiver of liability, but on narrowly prescribed grounds discussed in more detail below.

A provider obtains the right to appeal if the claim is denied under waiver and the beneficiary is not going to appeal. There is no right to appeal if the waiver is granted. See 42 CFR 405.704(b) and (c), outlining, respectively, the types of determinations which constitute "initial determinations" for beneficiaries and providers under Part A. Under § 405.710, a party may appeal only initial determinations.

The only other circumstances in which a provider may appeal is as the beneficiary's fully-authorized representative. This is contemplated in § 1869(b) of the Act, which provides the following safeguards against abuse of beneficiaries and frivolous appeals:

> "Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in § 1879(a)(2) (waiver of beneficiary liability) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation."

However, although the provider has the right to request a reopening, the case law makes it clear that a reopening is not a matter of right, but is a decision left to the discretion of the Secretary. The Supreme Court has held that the Secretary's decision not to reopen a case is entirely a matter of the Secretary's discretion, and is not an appealable determination. Califano v. Sanders, 430 U.S. 99, 97 S. Ct. 980 (1977); Lopez v. Heckler, 469 U.S. 1082, 105 S. Ct. 583 (1984). (Although the regulations specifically authorize the Secretary to reopen decisions within one year for any reason, the Supreme Court has held that the Secretary's decision not to reopen a case, unless challenged on constitutional grounds, is entirely a matter of the Secretary's discretion, not reviewable by the courts.) Califano v. Sanders, supra.

Thus the Secretary can be held only to his own criteria for reopening, as set forth at 42 CFR 405.750(b) and 42 CFR 405.841, and the good cause provision in 20 CFR 404.989.

42 CFR 405.750(b) and 42 CFR 841 provide that a determination may be reopened if it is final under 20 CFR 404.955 or 404.981, and 42 CFR 405.708, 405.717, 405.832, or 405.835. In other words, a provider may request reopening only after a final determination has been made, i.e., at the close of the appeals process by the beneficiary.

A reopening is conducted at the discretion of the Secretary or the Secretary's agents (Intermediaries, Carriers, Hearing Officers, Administrative Law Judges, and the Appeals Council).

42 CFR 405.750(b) permits the intermediary to reopen:

1 Within 12 months of the date of the initial or reconsidered determination for any reason acceptable to it.

2 After 12 months, but before 4 years of the date of notice of the initial determination, for good cause, which is defined at 20 CFR 404.989 as:

   a. New and material evidence;

   b. Clerical or computational error; or

   c. The evidence that was considered clearly shows on its face that an error was made.

3 At any time when:

   a. When a decision is unfavorable, to correct a clerical error or error on the face of the evidence;

   b. For fraud or similar fault; or

   c. In response to a court order.

CHAPTER IX

PROCESSING - REPORTS - RECORDS

Section Page

Transmittal to HCFA

Reporting Bills to HCFA.................................. 3801 9-5
Batching Bills... 3803 9-5
Control of Rejected Bills................................ 3804 9-6
  Resubmitting Rejected Bills.......................... 3804.1 9-7
  Batching Resubmitted Bills........................... 3804.2 9-8
  Followup/Control Notices for Rejected Bills.......... 3804.3 9-10
  Bill Received and Returned Report.................... 3804.4 9-20
Timeliness of Billing Data Submitted to HCFA............ 3805 9-23.2
Packing and Mailing of Magnetic Tape Reels.............. 3808 9-23.2
  Notification of Intermediary Address and/or Corporate Name Change.......................... 3808.1 9-23.2
Adjustment bills... 3816 9-25
  Tolerance Guides for Submitting Adjustment Billing Forms...................... 3816.1 9-29
  HCFA Form-L1001, Notification of Internal Adjustment Action(s) taken by HCFA............ 3816.2 9-33

HCFA Bill Processing

Submittal of Bills...................................... 3820 9-39
Consistency Editing...................................... 3824 9-39
Explanation of Consistency Error Codes................... 3825 9-39
Monitoring the Use of Medicare Code Editor (MCE)........ 3826 9-39
Utilization Editing...................................... 3827 9-74.5
  Bills Which Failed the Consistency Edits.............. 3827.1 9-74.5
  Bills Which Have Passed the Consistency Edits......... 3827.2 9-74.5
Explanation of the Utilization Edit--General............ 3828 9-74.5
  Utilization Edit Error Codes.......................... 3828.1 9-74.6
  Adjustment Bills - Utilization Bills.................. 3828.2 9-79
  Automatically Corrected Bills......................... 3828.3 9-79
  Purged Bill Utilization Edit Error Code............... 3828.4 9-79.2

Rejected Bill Processing

Non-Pilot Intermediary Process Code and Bill Reply Record...................................... 3829 9-79.2
Batch Clearance Record................................... 3830 9-79.2A
  Description of Batch Clearance and Exception Files............................... 3830.1 9-80
RTI Utilization Reject................................... 3831 9-92
  Explanation fo Items Appearing on the RTI Utilization Reject File........................ 3831.1 9-96
RTI Consistency Reject................................... 3832 9-112

PROCESSING - REPORTS - RECORDS

	Section	Page
Intermediary Action on Returned Bills and/or Bills Automatically Corrected and Reinstated by HCFA.......	3833	9-129

Bill Processing Criteria

	Section	Page
Inpatient Bill Processing Techniques......................	3835	9-132.1
Requests for Deletion of Selected Orbiting Bills and Open Items (G and Erroneous R Trailers)..........	3838	9-139
Elimination of Blocking Open Items from Saturated Records.................................	3838.7	9-139.2
Health Insurance Printout - Purpose and Scope........	3838.8	9-139.2
Intermediary Prepared Discharge Bills - Dummy Bills........	3839	9-140

Bill History

	Section	Page
HI Bill Retrieval Record (Bill History) General............	3840	9-140.1
Explanation of Items Appearing on the HI Bill Retrieval..................................	3840.1	9-143
Intermeiary Requests for HI Bill Retrieval Listing (Bill History)............................	3840.2	9-151

Batch Status Report

	Section	Page
Monthly Batch Status Report................................	3842	9-153
Intermediary Action Upon Receipt of Monthly Batch Status Report.......................	3842.1	9-157
Description of Data Appearing on Hardcopy Batch Clearance Record Obtained Via "Letter A"............	3843	9-161

Missing Batch Report

	Section	Page
Quarterly Missing Batch Report............................	3844	9-167

Bill Error Report

	Section	Page
Bill Error Report...	3845	9-168
Description of Items on Page One of the Bill Error Report.................................	3845.1	9-170
Description of Items on Page Two of the Bill Error Report.................................	3845.2	9-171

Provider Specific Payment Data

	Section	Page
Provider Specific Payment Data............................	3850	9-173.2
Physcial File Specifications-Magnetic Tape..........	3850.1	9-173.2
Provider Specific Payment Data Record Layout and Description.....................	3850.2	9-173.3

PROCESSING - REPORTS - RECORDS

Section Page

Magnetic Tape Specifications

Magnetic Test Data File--Description.................. 3865 9-174

Preparation and Submission of Provider Bills Tapes

Test Procedures.. 3866 9-174
  Number of Test Bills................................. 3866.1 9-175
  Recording Characteristics............................ 3866.2 9-175
Operational Procedures................................. 3867 9-175
  Magnetic Tape Reel External
  Identification Label................................. 3867.1 9-176
  The Summary Totals Report............................ 3867.2 9-177
  File Retention....................................... 3867.3 9-177

Consistency Edits-Magnetic Tape File

Consistency Edits - All Bill Types..................... 3868 9-178
Consistency Edits - Adjustment Bills................... 3869 9-178

Data Elements, Coding Structures, and Service Code Cross References

Alphabetic Glossary of Data Elements................... 3870 9-179
Coding Structures...................................... 3871 9-187
UNIBILL Service Codes.................................. 3872 9-199
  Deductions and Coinsurance for
  Selected Revenue Center Codes........................ 3872.1 9-200.1
Service Code Cross Reference........................... 3873 9-201
  Type of Bill Code--Relationship of HCFA-1450
  Item 4 to HCFA-1483 Item 9........................... 3873.1 9-202
  Bill Type Codes and Allowable
  Provider Numbers..................................... 3873.2 9-202.1

The Bills Tape Data File

The Bills Tape Internal Label.......................... 3874 9-203
  The Reel Number...................................... 3874.1 9-203
  The Internal Label Record Description--
  Operational.. 3874.2 9-203
  The Internal Label Record Description--
  Test Tape.. 3874.3 9-204
The Bill Tape Batch Control Record..................... 3875 9-205
  Record Identification Code........................... 3875.1 9-205
  The Batch Number..................................... 3875.2 9-205
  The Batch-Type Code.................................. 3875.3 9-205

	Section	Page
The Batch Control Record Layout and Description	3875.4	9-206
The Action Code	3875.5	9-206
Inpatient Hospital/SNF Record Layout and Description	3876	9-207
Bill Type Codes Billed on the Inpatient Hospital/SNF Record	3876.1	9-210
Outpatient/Hospice/Home Health/CORF Record Layout and Description	3877	9-211
Bill Type Code Combinations Billed on the Outpatient Hospice/Home Health/CORF Record Layout and Description	3878	9-214
RTI Void Record Layout and Description	3879	9-217
The Batch Summary Record Description	3880	9-219
The Trailer Record Layout and Description	3881	9-220
UNIBILL Consistency Return Codes	3882	9-221
Identifying and Editing Final Nonpayment Bills	3882.1	9-233
Adjustment Bill Return Codes	3882.2	9-233
MCE Error Codes	3882.3	9-234

Special Billing Procedures

	Section	Page
Sample Bills	3883	9-281
Inpatient Hospital Bills Involving ESRD Services	3883.1	9-281
The Batching of Bills	3884	9-282
Adjustment Bills	3885	9-282.1
The Association Adjustment Code	3885.1	9-282.1
The Cancel Only Adjustment (Action Code 4)	3885.2	9-282.1
The Credit/Debit Adjustment Action (Action Codes 2 and 3)	3885.3	9-283
Code R and Code P Adjustment Bills	3885.4	9-283
RTI Adjustment Bills	3885.5	9-283
Adjustment Batch Balancing	3885.6	9-283
The Bills Tape RTI Action	3886	9-283
The RTI Control Number	3886.1	9-283
RTI Correction Action Bills	3886.2	9-284
RTI VOID Action Bills	3886.3	9-284
Tape Deletions--Batches, Items, Batch Numbers	3887	9-284
Exhibits	3890	9-284

Monthly Statistical Report on Status of Intermediary Workloads

	Section	Page
Monthly Intermediary Workload Report (Form HCFA-1566)--General	3892	9-289
Purpose and Scope	3892.1	9-289
Due Date	3892.2	9-289
Completing Page One of Monthly Intermediary Workload Report	3893	9-290
Heading	3893.1	9-290
Checking Reports	3893.2	9-290
Type of Bill	3893.3	9-291
Body of Report	3893.4	9-292
Completing Pages Two Through Eleven of Intermediary Workload Report	3894	9-298
Heading	3894.1	9-298
Checking Reports	3894.2	9-298
Body of Report	3894.3	9-298
Completing Page Twelve of Intermediary Workload Report	3894.4	9-298.4
Heading	3894.5	9-298.4
Checking Reports	3894.6	9-298.4
Body of Report	3894.7	9-298.4

Monthly Statistical Report on Status of Independent Rural Health Clinic Bill Workloads

	Section	Page
Monthly Intermediary Report on Independent Rural Health Clinic Bill Workloads--General	3895	9-299.4
Purpose and Scope	3895.1	9-299.4
Due Date	3895.2	9-299.4
Reporting Definitions	3895.3	9-299.5
Reporting Instructions	3895.4	9-299.5
Checking Reports	3895.5	9-299.5
Reporting Form	3895.6	9-299.6

Quarterly Statistical Report on Selected Intermediary Workload Activities

	Section	Page
Quarterly Supplement to Intermediary Workload Report General	3896	9-300
Purpose and Scope	3896.1	9-300
Due Date	3896.2	9-300
Completing Quarterly Supplement to Intermediary Workload Report - Pages 1 and 2	3898	9-300
Heading	3898.1	9-300
Checking Reports	3898.2	9-300
Type of Bill	3898.3	9-301
Body of Report	3898.4	9-302

Section Page

Quarterly Statistical Report on Selected Intermediary Workload Activities (Cont.)

Completing Quarterly Supplement to Intermediary Workload Report - Page 3.................................. 3898.5 9-302
Heading.. 3898.6 9-302
Checking Reports... 3898.7 9-302
Type of Bill... 3898.8 9-303
Body of Report... 3898.9 9-303
Quarterly Supplement to Intermediary Workload Report - Pages 1, 2, and 3................................ 3898.10 9-306

Monthly Statistical Report on Medicare Secondary Payer Savings

Monthly Intermediary Report on Medicare Secondary Payer Savings (Form HCFA-1563)................................ 3899 9-309
- General.. 3899.1 9-309
- Purpose and Scope.................................... 3899.2 9-309
- Due Date... 3899.3 9-309
- Form Heading... 3899.4 9-309
- Savings Calculations................................. 3899.5 9-309
- Recording Savings.................................... 3899.6 9-310
- Source of Savings.................................... 3899.7 9-310
- Type of Savings...................................... 3899.8 9-311
- Electronic Submission................................ 3899.9 9-316
- Exhibit - Monthly Intermediary Report on Medicare Secondary Payer Savings (Form HCFA-1563)............ 3899.10 9-318

Transmittal to HCFA

3801. REPORTING BILLS TO HCFA

Effective May 1, 1977, all bills should be reported to HCFA on magnetic tape. The format of the tape must be as specified in sections 3865 - 3890. The tape must meet all edit specifications contained in the above referenced document. All billing data must be submitted to HCFA on PAT-BILL tapes.

Effective October 1, 1978, hardcopy bills will not be accepted by HCFA. Any hardcopy bills received after that date will be returned to the intermediary for resubmission on magnetic tape.

3803. BATCHING BILLS

Your compliance with proper submission and batching procedures facilitates the submission and subsequent processing of bills. Below are listed the categories of bills to be batched. Bills should be separated by type of bill and service, except that all types of rejected bills which are to be voided may be batched together. No batch shall exceed 90 in the number. Different categories may be recorded on the same reel and they may be sequenced in any order (see 3884).

The categories of bills are as follows:

1. Inpatient Hospital and Extended Care Admission and Billing, Form HCFA-1453. Includes all types of services billed by a provider on this form and corrections and adjustments to this type of bill.

2. Provider Billing for Medical and Other Health Services, Form HCFA-1483. Includes all types of services billed by a provider on this form and corrections and adjustments to this type of bill.

3. Home Health Agency Report and Billing, Form HCFA-1487. Includes both Part A and B billing data as well as corrections and adjustments to this type of bill.

4. Inpatient Admission and Billing--Christian Science Sanatorium, Form HCFA-1486. Includes all services billed by providers on this form and corrections and adjustments to this type of bill.

5. Noncovered Bills.--This category includes bills for services for which no payments can be made because:

   a. benefits are exhausted;

   b. workers' compensation paid, or can be expected to pay, the entire bill;

c. a National Institutes of Health grant paid, or will pay, the entire bill;

d. services rendered are not covered by the health insurance program;

e. a utilization review finding precludes payment of the entire bill.

All types of bills falling in this category, e.g., HCFA-1453 and HCFA-1487 may be forwarded in the same batch. See § 3610 for completion of no payment bills.

Note: This category must never contain interim bills, unmet deductible bills, or bills for which there is no cost reimbursement even though the deductible is met. Such bills should be included in the batches provided for other bills of the same type for which payment is made. Also, individual bills for both covered and noncovered services should not be included in this batch.

6. Void Bills.--All types of voided bills may be included in a voided batch (see § 3804.2).

3804. CONTROL OF REJECTED BILLS

HCFAcontrols all bills which are returned to intermediaries for correction, except adjustment bills, void bills (4444), duplicate bills (error code 5600), and read errors (3333). Bills that fail the consistency or utilization edits are entered on a suspense file and controlled by a Returned to Intermediary (RTI) number. Part A bills that fail certain utilization edits and which are automatically corrected by HCFAare not controlled by this suspense file. However, establish internal controls to make certain all necessary refunds for overcollected Part A cash and blood deductibles and overcollected Part A coinsurance as well as recoupment for undercollected Part A blood deductibles and undercollected Part A coinsurance are made. HCFA assigns this 10-digit number which remains with the rejected bill until it is removed from this suspense file.

The RTI number consists of the original 4-digit batch number, the 3-digit Julian date batched preceded by the last digit of the year; e.g., January 10, 1975, is listed as 5010 (both taken from the batch control record), and a 2-digit sequence number assigned by HCFA to each bill in a batch (shown on the interim for final batch clearance detail record). The RTI number is shown on the exception record provided on the HCSSACL Tape.

The RTI Control Number is provided with the exception data for rejected adjustment bills for purpose of consistency; however, rejected adjustment bills are not controlled by HCFA and should not be returned in a void batch.

3804.1 Resubmitting Rejected Bills.--Resubmit all rejected bills (RTI bills) to HCFA, except adjustment bills and duplicate bills. Bills should be returned as either corrections or voids (see § 3833).

Resubmitted bills which are rejected again, except for rejected adjustment bills, are controlled under the original RTI Control Number. This number will not change. The most recent batch number is shown on the interim and final batch clearance record. However, the first four digits of the RTI Control Number represent the initial batch number. For example, a bill is originally rejected for a consistency edit and is assigned RTI Control Number 1234936501. The bill is resubmitted but is rejected again. The RTI number remains 1234936501.

EXCEPTION: If a controlled rejected bill is resubmitted to HCFA without an RTI number and that bill is rejected again, a new RTI number will be assigned by HCFA. The new number consists of the most recent batch number-date and sequence number. In this situation, the original item can be removed from the RTI Control only by referring the problem to:

Health Care Financing Administration
Records Requirements and Analysis Section,
Room 596, East Building
Baltimore, Maryland 21235

The minimum information required when corresponding about such a problem is the original RTI control number, the most recent RTI control number, the beneficiary's claim number, and the last batch number used to resubmit the billing data.

If a resubmitted bill contains an incorrect RTI number and is again rejected, the new control will be under the incorrect RTI number. In this situation, the original item should be removed from the RTI control file as a result of HCFA reinstatement action. In all cases, when the re-rejected bill is resubmitted, it should contain the RTI number shown on the latest reject listing. Since the RTI control number electronically shown on a HCFA reject listing is the one used for control purposes, never change it.

3804.2 Batching Resubmitted Bills.--Corrected bills must be batched separately from voided bills (i.e., rejected bills which should be voided). Except for this distinction, returned bills will be placed in the same batches as initial bills by category, that is, they must be of the same type as the initial bill. Batch numbers should be assigned in the same manner as initial batch numbers. Corrected bills (bills which have been returned to the intermediary for consistency or utilization errors) must be batched within type, e.g., all corrected hospital and SNF billings. (PIP correction bills must be itemized in the manner indicated in §§ 3620 and 3651 after October 1, 1974, before resubmitting, although the charges on the bills may not have been itemized initially.) All types of voided bills may be submitted in the same batch up to a maximum of 90 items per batch.

Corrected and voided bills should be batched and submitted daily if warranted. However, if the volume is relatively low, the bills may be accumulated and returned weekly. It is preferable to submit small batches of returned bills often rather than accumulate bills for a long period of time. See §§ 3801ff. for complete batching instructions.

Resubmitted corrected bills must have the RTI control number entered in the proper locations on the appropriate bill-type data record (see § 3880) and must be batched according to bill type (see § 3803).

Voided bills of all types should be submitted in the batch category reserved for such bills (90 bill maximum per batch). The RTI control number must be entered in the appropriate field of the format for resubmitting RTI bills for VOID processing. See § 3880.7.

```
                                              1.                 2.
                                 PENDING RETURNED BILL NOTICE XX/XX/XX
3.    4.          5.       6.       7.      8.     9.   10.       11.         12.    13. 14.   15.16. 17.
W   CLAIM        NAME     PROV     REIM    FROM   ERR  RTI        RTI         RTI    SE  MST   NO R   INT
P   NUMBER                          AMT    DATE   CODE DATE   CONTROL NO     BATCH   NO  BLK   PU I   NO
X XXXXXXXXXXX XXXXXXXX XXXXXX XXXXXXX XXXXXX XXXX XXXXXX XXXXXXXXXX XXXXXXXX XX XXXXX XX X XXXXX
```

3804.3 Followup/Control Notices for Rejected Bills.—To assure that each rejected bill is resubmitted and cleared from the RTI suspense file, a quarterly report titled "Pending Returned Bill Notice" is sent via a magnetic tape. All rejected bills which have not been cleared from the HCFA RTI suspense file as of the date of the report are identified. They are listed in sequence by the beneficiary's HICN. The type of bill can be identified by the "Type of Bill" indicator.

All re-rejected bills continue to appear on the report regardless of the number of times rejected. The pending age continues to accrete until the bill is accepted.

The data elements on the report are:

1. Title

   Pending Returned Bill Notice.

2. Date of Notice

   Six numeric positions which show the last date of the month covered by the report.

3. Source Code

   Identifies incoming bill format as: U = UNIBILL or P = PATBILL.

4. HICN

   The number as shown on HCFA's records. If the HICN on the report differs from that shown on your records, use the HICN on the report unless the bill was rejected because of an identification error. If rejected for an identification error, determine the correct HICN/name of the individual and resubmit the bill showing the proper HICN and/or name of the individual to clear the RTI.

5. Name

   Up to 6-positions of the beneficiary's surname and 2 initials.

6. Provider Number

   Up to 6 alpha-numeric positions as shown on your bill.

7. Reimbursement Amount

   Up to 8-numeric positions taken from your bill.

8. From Date

Up to 6-numeric positions as shown on your bill.

9. Error Code

A 4-position alpha-numeric code representing the reason for the bill rejection. (See §§3828.1 and T3882.)

10. RTI Date

A 6-position numeric date which shows when the bill was rejected.

11. RTI Control Number

A 10-position alpha-numeric control number HCFA assigns which remains with the rejected bill until it is removed from the suspense file. (See §3804.)

12. Batch Number

A 4-position alpha-numeric used for control of the bills. It represents the most recent batch number and 4-position Julian date you assigned. (See §§3875.2.)

13. Sequence

A 2-position alpha-numeric count assigned by HCFA to each bill in a batch.

NOTE: The batch number and sequence number are the same as the RTI control number, unless the bill rejects more than once. If the bill was returned, resubmitted, and rejected again, the batch number and sequence number is the most recent batch and sequence number, but the original RTI control number remains the same.

14. Master Block

A 5-position alpha-numeric control utilized by HCFA. The first digit represents the year the bill was received and the next three, the Julian day. The fifth digit identifies the type of bill.

L = Inpatient hospital or SNF
N = Christian Science
P = Outpatient
Q = Home health A or B
R = Final noncovered billing

15. Months Pending

A 2-position alpha-numeric assigned by HCFA to show the number of months pending. For example, a bill which has been pending 6 months as of the date of the report is numbered 06. A bill pending less than a month is shown as 00.

16. Resubmittal Code

An asterisk identifies resubmitted bills.

17. Intermediary Number

The 5-position numeric identifying number of the intermediary that submitted the billing.

If the bill on the report has not been corrected and returned, correct and return it. Enter the RTI number in the appropriate location for the bill-type data record. Assign priority to bills that have been pending 6 months or longer.

If:

- The bill should not have been submitted initially. Void the bill in accordance with §3833.
- The bill was sent within 30 days of the date on the report. Take no action, since HCFA may have received the bill in the interim.
- Your Batch Status Report shows that a batch clearance record was released and 60 days have elapsed since the report first showed its release. Request a special batch clearance record in accordance with §3842.1 to determine its status.

RTIs are removed automatically when a correction bill is properly submitted. Enter the RTI control number for each resubmitted bill. If you fail to enter an RTI control number or enter it incorrectly, HCFA may not be able to identify and remove the RTI.

RTIs that are not removed by the usual automatic means continue to appear on the Pending Returned Bill Notice. If you know that you corrected and resubmitted the bill, use a locally prepared copy of the RTI Removal Notice or the "VOID" bill procedure to remove the RTI. The "VOID" option is preferrable, since it does not require clerical intervention.

Description of Pending Returned Bill Notice Record Tape File

The tape characteristics are:

- 1600 BPI Recording Mode
- Standard label
- Record length is 110 characters

- Block size equals 2200 (110X20).
- HCRTIPEN is the acronym for the file name.
- The file is sequenced first by intermediary number and secondly, by HICN.

Blanks have been entered between the data fields to make it easier to use a straight print program to list the items. An example is included. The Source codes "U" and "P" may be used for electronic matching of bills on the tape with your internal records.

HCFA RECORD SPECIFICATION

FILE NAME	SPEC NUMBER	DATE

RECORD NAME

Intermediary Pending Returned Bill Notice

FIELD	REC. SIZE	USAGE		LOCATION	REMARKS
		TP	SI		
1. Record Source	1	X		1	U-UNIBILL P-PATBILL Blank-Heading line
2. Filler	1	X		2	
3. Claim Number	11	X		3-13	
4. Filler	1	X		14	
5. Name	18	X		15-22	Six position surname and two initials
6. Filler	1	X		23	
7. Provider	6	X		24-29	
8. Filler	1	X		30	
9. Reimbursement Amt	7	X		31-37	
10. Filler	1	X		38	
11. From Date	6	X		39-44	MMDDYY
12. Filler	1	X		45	
13. Error Code	4	X		46-49	
14. Filler	1	X		50	
15. RTI Date	6	X		51-56	MMDDYY
16. Filler	1	X		57	
17. RTI Control Number	10	X		58-67	

HCFA RECORD SPECIFICATION

FILE NAME

SPEC NUMBER

DATE

RECORD NAME

Intermediary Pending Returned Bill Notice

FIELD	REC SIZE	USAGE TP	USAGE ST	LOCATION	REMARKS
18. Filler	1	X		68	
19. MTI Batch Number	8	X		69-76	
20. Filler	1	X		77	
21. Sequence Number	2	X		78-79	
22. Filler	1	X		80	
23. Master Block	5	X		81-85	
24. Filler	1	X		86	
25. Months Pending	2	X		87-88	
26. Filler	1	X		89	
27. Resubmittal Code	1	X		90	An asterisk will appear if it is a resubmitted bill.
28. Filler	1	X		91	
29. Intermediary Number	5	X		92-96	
30. Filler	14	X		97-110	

RTI REMOVAL NOTICE
(Sample Only)

Health Care Financing Administration
Records and Telecommunications Branch
1-H-3 Meadows East Building
6325 Security Blvd
Baltimore, Maryland 21207

Date:______________

Individual Making Request:______________

The RTI'd bill(s) to be removed is listed below and identified on the enclosed batch record(s).

RTI CONTROL NUMBER* (As it appears on Pending Returned Bill Notice)	INTERMEDIARY NUMBER	BATCH/NUMBER/** JULIAN DATE (From most recent batch record)	MASTERBLOCK** NUMBER(From most recent batch record)	2-DIGIT** SEQUENCE NUMBER (From most recent batch record)		HI CLAIM*** NUMBER
HCFA's INTERNAL USE *Data above (requested) must always be shown. The data must be entered exactly as it appears on the Pending Returned Bill Notice.	**Data requested should always be shown. The data must be entered exactly as it appears on the most recent interim or final batch record.				HCFA's INTERNAL USE	***Data should always be shown by the intermediary. The data should be entered exactly as it appears on the Pending Returned Bill Notice and/or the most recent interim or final batch record.

3804.4 Bill Received and Returned Report.—This is a computer generated report sent monthly to each intermediary and HCFA Regional Office. The report represents the national, regional, and each intermediary's statistics broken down by inpatient hospital, SNF, hospice, home health, outpatient, Christian Science, and void bills. The report's primary purpose is to provide the RTI bill processing data for monitoring purposes.

Columns (A) through (I) on the report are described below.

A. NUMBER OF BILLS RECEIVED

This is the total number of bills excluding adjustment bills (counted before edits were performed) received during the reporting period. This figure includes all types of bills (corrected and initially submitted bills included).

B. NUMBER OF BILLS RETURNED

This is the number of bills processed (counted after all edits have been made, i.e., released from orbit and/or investigation status) during this reporting period that rejected. If the reject is a re-reject, it is also counted in column "E."

C. PERCENT OF BILLS ACCEPTED

This is the percent of bills submitted in column "A" accepted during this reporting period.

D. NUMBER OF RTI RECEIVED

This is the total number of RTI (including voids, but not initial submittals) received during this reporting period.

E. NUMBER OF RTI REJECTED

This is the number of RTI shown in column "D" re-rejected during this reporting period.

F. PERCENT OF RTI REJECTED

This is the percent of RTI shown in column "E" that re-rejected during this period.

G. RTI PENDING

This is the number of rejected bills which have not been resubmitted as of the date of the report.

H. NUMBER OF RTI PENDING 150 DAYS OR LESS

This is the number of RTI shown in column "G" that are 150 or less days old. The RTI aging factor is calculated by subtracting the RTI date from the date of the report.

I. PERCENT OF RTI PENDING 150 DAYS OR LESS

This is the percent of RTI shown in column "G" that are 150 or less days old.

Two versions of the report are prepared. One shows data for the "current" month (non-accumulative and without regard to fiscal or calendar year); the other shows data for the "last 12 months" (accumulative and without regard to fiscal or calendar year). The data under columns "G," "H," and "I" are always accumulative "TO DATE" figures for both versions.

```
          BILL RECEIVED AND RETURNED REPORT: FOR (1) (12) MONTHS ENDING: (MMDDYY) PAGE 1

                 (CURRENT MONTH) (LAST 12 MONTHS)
                  NUMBER   NUMBER   PERCENT  NO OF RTI  NO RTI     PERCENT     RTI      NUMBER OF      PERCENT OF
                  OF BILLS OF BILLS OF BILLS RECEIVED   REJECTED   OF RTI      PENDING  RTI  PENDING   RTI  PENDING
                  RECEIVED RETURNED ACCEPTED                       REJECTED             150 DAYS OR    150 DAYS OR
                                                                                        LESS           LESS

                     (A)        (B) (C=100%-B/A)  (D)        (E)    (F=E/D)    (G)         (H)         (I=H/G)
NATIONAL
  CONSISTENCY
                               XXX,XXX,XXX  XX.X
  UTILIZATION                                               X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
                               XXX,XXX,XXX  XX.X            X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
   TOTALS         XXX,XXX,XXX  XXX,XXX,XXX        X,XXX,XXX X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
REGION XX
  CONSISTENCY
                               XXX,XXX,XXX  XX.X
  UTILIZATION                                               X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
                               XXX,XXX,XXX  XX.X            X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
   TOTALS         XXX,XXX,XXX  XXX,XXX,XXX        X,XXX,XXX X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
INTERMEDIARY XXXXX
  CONSISTENCY
                               XXX,XXX,XXX  XX.X
  UTILIZATION                                               X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
                               XXX,XXX,XXX  XX.X            X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
   TOTALS         XXX,XXX,XXX  XXX,XXX,XXX        X,XXX,XXX X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
INPATIENT HOSPITAL
  CONSISTENCY
                               XXX,XXX,XXX  XX.X
  UTILIZATION                                               X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
                               XXX,XXX,XXX  XX.X            X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
   TOTALS         XXX,XXX,XXX  XXX,XXX,XXX        X,XXX,XXX X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
SKILLED NURSING FACILITY
  CONSISTENCY
                               XXX,XXX,XXX  XX.X
  UTILIZATION                                               X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
                               XXX,XXX,XXX  XX.X            X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
   TOTALS         XXX,XXX,XXX  XXX,XXX,XXX        X,XXX,XXX X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
HOSPICE
  CONSISTENCY
                               XXX,XXX,XXX  XX.X
  UTILIZATION                                               X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
                               XXX,XXX,XXX  XX.X            X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
   TOTALS         XXX,XXX,XXX  XXX,XXX,XXX        X,XXX,XXX X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
HOME HEALTH AGENCY
  CONSISTENCY
                               XXX,XXX,XXX  XX.X
  UTILIZATION                                               X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
                               XXX,XXX,XXX  XX.X            X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
   TOTALS         XXX,XXX,XXX  XXX,XXX,XXX        X,XXX,XXX X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
OUTPATIENT
  CONSISTENCY
                               XXX,XXX,XXX  XX.X
  UTILIZATION                                               X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
                               XXX,XXX,XXX  XX.X            X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
   TOTALS         XXX,XXX,XXX  XXX,XXX,XXX        X,XXX,XXX X,XXX,XXX  XX.X  X,XXX,XXX  X,XXX,XXX   XX.X
```

3805. TIMELINESS OF BILLING DATA SUBMITTED TO HCFA.

Send billing data submitted via magnetic tape at least once per week. In order to avoid using numerous tapes that are partially filled, send the data using the minimum number of tapes feasible. Use the full capacity of each tape to the extent practicable before starting another tape except as necessary to meet the once per week schedule.

Submitting the minimum number of tapes feasible does not mean that bills must be batched infrequently. If necessary, bills can be batched daily and then combined for the weekly submittal. Also, batching bills on the last work day of each month allows you to include all bills available for batching on the monthly workload report. Report the status of each batch of bills via the batch clearance tape file. (See § 3830.1).

3808. PACKING AND MAILING OF MAGNETIC TAPE REELS

Package magnetic tape reels securely enough to preclude damage and loss of contents. Ship magnetic tape reels (both test and operation) containing Part A billing data to Baltimore by priority mail. Ship the operational tape reels to:

Social Security Administration
Outside Agency Desk
271 NCC
Attn:UNIBILL Tape
6201 Security Blvd.
Baltimore, MD. 21235

Ship the test tape reels to the address in § 3866.

Do not use the following postal services: return receipt requested, insurance, or special handling. If a means of shipment other than priority mail is advisable, make arrangements on an individual basis. Tape reels accepted by HCFA will not be returned. Do not return batch clearance tape reels to HCFA.

3808.1 Notification of Intermediary Address and/or Corporate Name Changes.—To help ensure that all Medicare related materials (i.e., Pending Returned Bill Notice, SSACLEAR tape, and special batch notices) are forwarded to the correct address, promptly forward written notification of address changes to HCFA whenever any of the following changes occurs: corporate name, street address, post office box number, city and ZIP code. Forward address changes to:

Health Care Financing Administration
Part A Communications Branch
1-H-1 Meadows East Bldg.
Baltimore, MD. 21207

3816.2 Form HCFA-L1001, Notification of Internal Adjustment Action(s) Taken by HCFA.--HCFA identifies and internally adjusts specific provider bills that were accepted reflecting incorrect utilization of available benefits. You are notified of these adjustments via the form HCFA-L1001 or the batch clearance tape. The batch clearance tape is the usual medium. If the form HCFA-L1001 is used, the beneficiary and the adjusted bills for the benefit period are referred to on the reverse of the form. If the batch clearance tape is the medium, the adjusted bill data is shown only on the HI Bill Retrieval (bill history). (See 3840.1.) The Bill Retrieval is included in "The RTI Utilization Reject and HI Bill Retrieval File" (file "J") on the tape. (See 3830.1.)

If we post a Kron bill to a beneficiary's master record so that the thru date of the Kron bill is within 60 days of the next subsequent bill on the record, you may need to adjust the next bill if you submitted it as a nonpayment bill due to benefits exhausted. We alert you to this by sending you the appropriate bill history listing for the subsequent bills. We send this information in the "RTI Utilization Reject and H I Bill Retrieval File" (File "J") on the HCSSACL file (Batch Clearance Tape). This record is identified with a code of 7701.

Ensure that your in-house records comply with the adjustment action. Also notify your provider of such actions. Beyond that, no further action is necessary.

NOTE: When scrambled utilization is detected and HCFA can identify the appropriate beneficiary, HCFA initiates the necessary internal adjustment actions to remove utilization from the incorrect record. If a bill has not been posted for the correct record, submit one. HCFA cannot create the initial bill for the beneficiary's record.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing
Administration

Intermediary
No.

Gentlemen:

The reverse side of this letter identifies provider bills that were adjusted by HCFA because available benefits for the person specified were either overutilized or underutilized. A brief explanation of the internal action taken by HCFA is shown under the column heading, "Explanation." Please take the appropriate steps to insure that your in-house records comply with HCFA's internal adjustment(s).

If you have any questions about the adjustment(s) made by HCFA, please contact the address checked below:

☐ Health Care Financing Adm.
Bureau of Support Services
Transaction Processing Br.
Post Office Box 17078
Baltimore, Md. 21203

☐ Health Care Financing Adm.
Bureau of Support Services
Correspondence Services Br.
Post Office Box 11979
Baltimore, Md. 21207

Social Insurance Claims Examiner

Form HCFA-L1001 (11-80)

PATIENT'S LAST NAME | FIRST NAME | MI | HI CLAIM NUMBER

PAGE ____ OF ____ PAGES

ITEM	ADM. DATE	BILLING DATES		HOSPITAL DAYS			SNF DAYS		DEDUCTIBLES		A VISITS	B VISITS	INTER. NO.	PROVIDER NUMBER	BATCH NO.	OTHER
		FROM	THRU	FULL	COINS.	RES.	FULL	COINS.	INPAT.	BLD.						
1.																
2.																
3.																
4.																
5.																
6.																
7.																
8.																
9.																
10.																

UTILIZATION ERROR

HCFA INTERNAL ADJUSTMENT ACTION WAS TAKEN BECAUSE:

FULL DAYS 1. ☐ Overuse ☐ Underuse for one Benefit Period, item(s) ________

COINS. DAYS 2. ☐ Overuse ☐ Underuse for one Benefit Period, item(s) ________

INPATIENT DEDUCTIBLE 3. ☐ Overcharge ☐ Undercharge for one Benefit Period, item(s) ________

BENEFIT PERIOD 4. ☐ All items listed should be in the same Period.

5. ☐ Item(s) ________ should be in same Period as item(s) ________

6. ☐ Item(s) ________ should NOT be in the same Period as item(s) ________

EXPLANATION

HCFA Bill Processing

3820. SUBMITTAL OF BILLS

All bills must be submitted on magnetic tape as described in SS3867ff.

3824. CONSISTENCY EDITING

Each claim is first edited for consistency by an electronic edit program which identifies all invalid data and inconsistencies based on the data's face value. Invalid data are such things as a month indicated by a number greater than 12, more than 60 lifetime reserve days used, etc.

The consistency edits do not compare billing data to information in SSA records.

3825. EXPLANATION OF CONSISTENCY ERROR CODES

Except for a special group of codes used only on adjustment bills (those resulting from failure to properly apply the MCE, and a few others), all consistency error codes are in the following format:

- The first two positions identify the item number on the HCFA-1450. For example, "Date of this admission" on the keyed HCFA-1450 is 15, "Patient status" is 21.
- The third position is relevant if a specific item occurs more than once in UNIBILL (e.g., condition codes, value codes, occurrence codes, occurrence span codes, and revenue codes). In such cases, the third position identifies the occurrence of the code that caused the error.
- Item 94 of the UNIBILL is subdivider A thru G. For this item the third position of the code is the letter of the item or error.
- The fourth position is a simple numeric identification number. These range from 1 to 9 for a specific item.

3826. MONITORING THE USE OF MEDICARE CODE EDITOR (MCE)

Beginning with bills received December 19, 1986, HCFA monitors your performance in the use of MCE. This is done in the bill consistency edit system. You are notified of the errors, but the bill is accepted. The error is counted in the bill error report, and identified by one of the codes in the 7601-7608 range.

The following lists MCE exceptions and the corresponding error codes:

Exception Type	Code
Invalid diagnosis or procedure code	7601
Invalid fourth or fifth digit	7602
E-code as principal diagnosis	7603
Duplicate diagnosis of principal diagnosis	7604
Age conflict with diagnosis or procedure	7605
Sex conflict with diagnosis	7606
Manifestation code as principal diagnosis	7607
Unacceptable principal diagnosis	7608

Occurrence of such errors indicates that your MCE process is not working correctly. You are expected to identify and correct the errors in your system.

Since you already have corresponding Grouper edits for the following, they are excluded from HCFA's MCE monitoring process.

- o Invalid age;
- o Invalid sex; and
- o Invalid discharge status.

Also, the following are not included because development may not result in changes in hospital coding.

- o Nonspecific principal diagnosis;
- o Questionable admission;
- o Nonspecific operating room procedures;
- o Noncovered operating room procedures;
- o Bilateral procedures;
- o Open biopsy; and
- o MSP alerts.

3827. UTILIZATION EDITING

Once the consistency edits have been applied, the bills go through the utilization program. In this program, the bill data on the tape is compared to the data in HCFA's Master Health Insurance Record.

3827.1 Bills Which Failed the Consistency Edits.—The bills in the batch which failed the consistency edits are screened in the utilization program for only three items:

1. Name and claim number which match the master record,

2. Eligibility to Part A or Part B benefits during the billing period, and

3. A matching open item in the master record when the bill is a HCFA-1453 or HCFA-1486.

3827.2 Bills Which Have Passed the Consistency Edits.—Billing data which have passed the consistency edits are processed completely through the utilization program and is either posted or rejected.

3828. EXPLANATION OF THE UTILIZATION EDITS.

A. Patient's Name and Health Insurance Number.—These items are matched against the master record of the patient's name and correct health insurance number. Up to six positions of the patient's surname and the initial of his given name are matched electronically. If the bill record cannot be matched, it is rejected. HCFA then attempts to determine the correct name or health insurance number so that the bill can be reintroduced into the system. Once the bill record is matched with the master record, a check is made against the master record to see whether the patient is entitled to benefits for the period shown on the bill.

B. Date of Admission for Inpatient Hospital and SNF.—Once it is determined that the patient is entitled to benefits, HCFA attempts to match the date of admission to the open item on the record. In order to match, these admission dates must be within 1 day of each other and the provider number must match. Part A and Part B home health queries do not establish open items. Therefore, take extra precautions to make certain such queries are made to the appropriate record.

C. In Sequence Check.—After the open item has been matched to the bill, HCFA checks the master record to be sure that the bill is the next one in sequence. (See S 3835 for a complete discussion of in-sequence processing of provider bills.)

D. Spell of Illness.—After the bill has been determined to be in sequence, HCFA makes a spell of illness determination by checking its master records against the information shown on the billing form. If it is determined that a new spell of illness has begun, HCFA adjusts the beneficiary's utilization record accordingly.

E. Deductibles and Coinsurance.—The bills are now compared to the master record for the beneficiary's previous utilization history. If the data on the bills are consistent with HCFA's records the patient's utilization record is updated.

Certain types of erroneous data appearing on bills are automatically corrected by HCFA to conform with its records so that the bills can be posted. (See S 3830.1E, field 19 and S 3833.) HCFA also automatically overlays the through and discharge dates on home health and outpatient bills with the date of death on its master file when the bill meets specific criteria. (See S 3843.) In addition, when certain money amounts are less than $50 on the incoming bill or less than $50 of a deductible needs to be met, HCFA accepts the billing in some instances although errors may be present. (See S 3930.1E, field 18 and 19 and S 3843.)

3828.1 Utilization Edit Error Codes.—The error codes for the various types of bills are shown below.

Error Code	Explanation
5052	The name and/or claim number shown on the bill is incorrect. (This corresponds to query disposition code 52.) No master record data will be included on the printout in this situation.
5200	There is no record of the beneficiary's entitlement to the type of services shown on the bill.
5201	The name, social security number, and personal characteristics furnished in the bill match SSA's non-HI records, and HCFA determined that the individual is not eligible for HI benefits. This applies also to individuals receiving SSI benefits who are under age 65 and are not eligible for HI benefits. No master records data is included on the printout in this situation. Since most of the cases in this category are disallowed for failure to establish proof of age or residence requirements, the individual may become eligible at a later date. Ordinarily the intermediary would have been alerted to this situation when it queried and received a disposition code 51. (See S 3512.7.) However, if you previously received an approval of the query instead of a rejection, this code is an indication that subsequent to the query, HCFA discovered that the individual had been erroneously entitled and a retroactive disallowance was necessary. If the claim involves a disabled beneficiary, a type 7 code (automatic notification) was sent by SSA. For all other types of beneficiaries, no automatic notice is transmitted. Therefore, if the intermediary has not already taken the necessary disallowance action (See S 3719ff), it should do so upon receipt of this RTI.

Error Code	Explanation
5202	No record of hospice election.
5203	Hospice billing dates do not fall within the applicable hospice election and/or recertification period.
5210	Services are shown after benefits terminated.
5211	Services are shown after the patient died. Determine if the name and HICN for the beneficiary are correct. Follow the instructions for disposition code 38 and/or 43, §3512.7 to resolve error condition. Also see §3831.1,Item 1 and 2 for description of "DUMMY IDENT" record (RTI UTILIZATION REJECT) and format if a purged inactive HI master record is involved.
5220	Services are prior to the date of entitlement.
5232	Services on this bill overlap a period of HMO entitlement.
5233	HI master record shows HMO pays for services. Option code "C" is shown for inpatient hospital/SNF or an "A", "B", or "C" for home health/outpatient services. Bill shows you paid for services within the HMO enrollment and no hospice election is shown on HI master record, or the HMO paid for services and hospice election is shown on HI master record.
5310	No pre-entitlement reduction on psychiatric bills was shown.
5320	Both a Christian Science SNF and regular SNF utilization were reported for the same benefit period.
5340	A "benefits exhausted" bill is received, but benefits are not exhausted on HCFA's records.
5360	Age and/or sex is a factor in DRG determination and either age on HI master record is not within DRG code range or sex identified on HI master record is not compatible with type of DRG code.
	Deductible Discrepancies
5400	The Part A blood deductible was overapplied. (Automatically adjusted by HCFA to agree with its records if this is the only utilization error involved. See §3828.3, code 7400, and §3830.1E, Item 19.)
5401	The Part A blood deductible was underapplied. (Automatically adjusted by HCFA to agree with its records if this is the only utilization error involved. See §3830.1E, Item 19, and 3828.3, code 7401.)
5410	The Part A cash deductible was overapplied. (Automatically adjusted by HCFA to agree with its records if this is the only utilization error involved. See §3830.1E, Item 19, and 3828.3, code 7410.)

Error Code	Explanation
5411	The Part A cash deductible was underapplied. (See §3828.3, Code 7411.)
5420	A Part B deductible error is involved. The deductible for the year of services is not met or the deductible applied has not been queried.

Discrepancies in Days

Error Code	Explanation
5500	Full inpatient reimbursement days (applied to stays in hospitals or SNFs) have been overutilized . (Automatically adjusted by HCFA to agree with its records if this is the only utilization error involved. See §3828.3, code 7500, and 3830.1E, Item 19.
5501	An error in full coverage days (underutilization) is involved.
5510	An error in coinsurance days (overutilization) is involved.
5511	Inpatient coinsurance days (applied only to stays in hospitals) have been underutilized. (Automatically adjusted by HCFA to agree with its records if this is the only utilization error involved. See §3828.3, code 7511, and 3830.1E, Item 19.
5520	An error in lifetime reserve days (overutilization) is involved.
5530	An error in lifetime psychiatric days (overutilization) is involved.

Date Discrepancies

Error Code	Explanation
5600	A duplicate bill is involved.
5601	The bill overlaps a previously accounted bill.
5610	An unexplained gap in the bill dates.

If an incorrect entry in Item 15 and/or Item 20 of the HCFA-1450 caused the error, the unexplained billing gap can be eliminated by correcting the deleted bill and resubmitting it to HCFA.

If the gap is not due to an error on the bill, make certain that the bill for the missing period has been accepted by HCFA before resubmitting the deleted bill. Refer to the batch records for the batch in which the missing bill was submitted to determine status of the bill. If another intermediary is responsible for the missing bill, ask it to process the bill and verify that the bill has been submitted to HCFA.

5612 Bill through/discharge date overlaps a subsequent billing date(s). The overlapped bill(s) are also being returned, but as a Code 5613. The batch number of the orbiting bill(s) to be returned as a code 5613, can be determined by ascertaining which open item on the RTI Utilization Exception Listing is overlapped by the through/discharge date of the RTI'd bill. The batch record date of the subsequent bill(s) rejected by HCFA should be within 7 calendar days of the batch record date for this bill. Ordinarily two respective batch records will be sent in sequential date order.

Error Code	Explanation
	Other Discrepancies
5700	This bill is overlapping previously processed bills on the attached Bill Retrieval Listing. If the billing dates are correct, submit credit/debit or cancel only adjustment bills to change the admission and billing dates of the bills already posted so that none of the dates overlap. If another intermediary submitted the posted bill(s) which must be adjusted, ask it to make the necessary credit/debit or cancel only adjustments and send you confirmation before resubmitting your bill. If your billing dates are incorrect, make the necessary corrections and resubmit the bill.
5701	A bill for this admission date which contained a discharge date has already been posted. This bill is using dates beyond the discharge date of the posted bill; it is also overlapping posted bills on the attached Bill Retrieval Listing. If the billing dates are correct, submit adjustment bills to change the admission and billing dates of the bills already posted so that none of the billing dates overlap. If another intermediary submitted the posted bill(s) which must be adjusted, ask it to make the necessary credit/debit or cancel only adjustments and send confirmation before resubmitting this bill. If your billing dates are incorrect, make the necessary corrections and resubmit.
5702	Our records show we processed a bill for this admission date which contained a discharge date. This bill is showing dates beyond the discharge date of that processed bill. If there should be valid billing after the discharge date of the posted bill, take corrective action (correct discharge date with credit/debit or cancel only adjustments or correct the billing dates on this bill). Otherwise, resubmit this bill in a VOID batch.
5703	This bill is linking two benefit periods on the attached Bill Retrieval Listing. This bill is being deleted because if HCFA were to process it, an overmet and/or overutilization (other than over collected inpatient cash deductible) situation will occur. HCFA will not combine the two benefit periods until this bill is corrected and resubmitted, showing days utilized which are consistent with those days which would remain by combining the two benefit periods. Once the bill in question has been resubmitted, an HCFA-L389 will notify you of adjustments which should be resubmitted to HCFA for bills already posted in the two benefit periods. An HCFA-L1001 will be used to advise you of adjustments made by HCFA involving bills already posted. Uponreceipt of this letter, adjust your internal records, although no bill should be submitted to HCFA.

Error Code	Explanation
5704	The noncovered stay dates shown on this bill are causing this bill to link two benefit periods previously established on HCFA's records. These noncovered stay dates should not be used to extend the benefit period since there are more than 60 days between the noncovered stay through date and the qualifying stay from date on your bill. If your billing dates are incorrect, make the necessary correction(s) and resubmit the bill. If your billing dates are correct, resubmit the bill without showing the prior noncovered stay dates as they do not extend the benefit period or start a new one.
5705	The noncovered stay through date, the qualifying stay through date, or verified stay date shown on this bill overlaps previously processed bills on the attached bill retrieval listing. If any of these dates are incorrect, make the necessary correction(s) and resubmit this bill. If all dates are correct, submit adjustments to correct the billing dates of the overlapped bills which have been previously accepted. After the credit/debit or cancel only adjustments have been accepted by HCFA, resubmit this bill.
5800	Possible Transfer Case. Covered Day or inpatient deductible amount apparently applied to a transfer day billing. See §3620, Item 6.
5900	This orbiting bill has been deleted as a result of your request for corrections on it. Make the necessary corrections and resubmit the bill. If the bill should not have been sent to HCFA, handle it in accordance with §3833.
5901	This bill is identified as a Kron bill but does not meet the Kron bill criteria, i.e., the bill is an inpatient hospital bill not containing inpatient deductible, or the bill is a SNF bill, or the from date of the bill is within 60 days of the discharge date of a covered bill posted to HCFA records.

3828.2 Adjustment Bills—Utilization Bills.—In addition to the possible error codes shown above, the following codes may be shown on the batch record to identify why an Adjustment Bill has been deleted.

Error Code	Explanation
6000	HCFA records indicate the original/duplicate bill (1) has not been processed, (2) has been previously cancelled, or (3) the dates (admission, discharge, "From" and "To") do not correspond to the originally processed bill or to those on a previously processed debit adjustment bill.
6010	HCFA records indicate the "CREDIT ONLY," "CANCEL ONLY," or "DEBIT P" bill does not match an entry (other than the admission, discharge, "FROM" and "TO" dates) on the orginally processed bill.
6100	This indicates the adjustment is not necessary because the "DEBIT" is the same as the originally processed bill.

3828.3 Automatically Corrected Bills.—The following codes and data described are shown on the batch notice for bills automatically corrected.

Correction Code	Explanation
7400	Part A blood deductible has been revised downward to conform with HCFA's records. The first two digits represent the Part A blood deductible pints appearing on the bill; the next six digits represent the applicable blood per pint charges which were on the bill; and the next two digits represent the HCFA adjusted blood deductible pints. Where the charge per pint varies, 999999 will appear in this item.
7401	Part A blood deductible has been revised upward to conform with HCFA's records. The first two digits represent the Part A blood deductible pints appearing on the bill; the next six digits represent the applicable blood per pint charges which were on the bill; and the next two digits represent the HCFA adjusted blood deductible pints. Where the charge per pint varies, 999999 will appear in this item.
7410	Part A cash deductible has been revised downward to conform with HCFA's records. The first five digits represent the Part A cash deductible on the bill and the next five digits represent the HCFA adjusted inpatient deductible.

Correction Code	Explanation
7411	Part A cash deductible has been revised upward to conform with HCFA's records. The first five digits represent the Part A cash deductible on the bill and the next five digits represent the HCFA adjusted inpatient deductible.
7500	The Part A inpatient full reimbursement day(s) shown on the bill has been changed to regular coinsurance days to conform with HCFA's records. HCFA does not change full reimbursement days to coinsurance days where lifetime reserve days are involved. The first two digits represent the number of nonlifetime coinsurance days appearing on the bill, if any; the next five digits represent either the nonlifetime coinsurance rate shown on the bill or the applicable nonlifetime coinsurance rate calculated by HCFA for the benefit period if no nonlifetime coinsurance rate appears on the bill or the coinsurance rate is incorrect, and the next two digits represent the HCFA adjusted non lifetime coinsurance days. The last digit shows whether HCFA adjusted the coinsurance rate higher (H) or lower (L). When no rate was shown on the bill and HCFA makes an entry, and "H" indicator will be shown.
7511	The Part A inpatient nonlifetime coinsurance day(s) shown on your bill has been increased to conform with HCFA's records. The first two digits represent the number of coinsurance days appearing on the bill; the next five digits represent either the nonlifetime coinsurance rate shown on the bill or the applicable nonlifetime coinsurance rate calculated by HCFA for the benefit period if no nonlifetime coinsurance rate appears on the bill or the rate is incorrect; and the next two digits represent the HCFA adjusted nonlifetime coinsurance days. The last digit shows whether HCFA adjusted the coinsurance rate higher (H) or lower (L).
7540	Your bill is for Part A visit(s), but should be for Part B visit(s) or vice versa; therefore, HCFA changed your billing data accordingly. If "B" visits have been changed to "A" visits, the adjustment to "A" visits is shown on the Batch Clearance Tape File, Batch Clearance Detail Record, with an "A" in field 19, location 101 and if "A" visits have been changed to "B" visits, the adjustment to "B" visits is shown by a "B" in this location.

3828.4 Purged Bill Utilization Edit Error Code.—The following error code is used:

Error Code	Explanation
8600	The benefits have been updated via the bill data appearing on a previously purged RTI bill.

Rejected Bill Processing

3829. NON-PILOT INTERMEDIARY PROCESS CODE AND BILL REPLY RECORD

Effective July 1985 Phase II of a study to demonstrate the effectiveness of on-line data base processing began between Blue Cross of Arizona and HCFA. Phase I consisted of setting up the on-line system and putting query and query reply data on-line. Other contractors may become pilot sites or the system implemented nationally depending upon the outcome of the experiment. An on-line system makes it possible to send and receive data within seconds with all parties hooked up to the system.

Extensive bill processing and systems changes are necessary on the part of Blue Cross of Arizona and HCFA. Some of these changes impact non-pilot intermediaries, but only to the extent that they process bills for a beneficiary whose records are on the System to Provide Immediate Data on Eligibility for Reimbursement (SPIDER) files. Non-pilot intermediaries are affected because once a beneficiary's record is entered on the SPIDER files, it remains there indefinitely. Bills for a SPIDER record are processed on a first-in/first-out basis. This means that HCFA automatically adjusts or rejects any bill that is incompatible with its records without regard to the sequence of service dates.

A unique code is used to acknowledge automatic adjustments involving a SPIDER record because more than one condition may be adjusted by this system. Since HCFA uses a batch system to communicate with intermediaries that are not part of the on-line system, the batch clearance tape is the medium used to provide the code and the adjusted data. The unique code appears on both the first and second file of the batch clearance, but the adjusted data appears only on the RTI utilization reject. (See §3831.1, Item 106.)

The unique code and explanation follows:

Code	Explanation
7999	Automatic adjustment involves a SPIDER record. One or more conditions have been corrected. The attached document (modified RTI Utilization Reject) identifies the posted bill and the field(s) on the bill that were changed. Change your records to reflect the corrected data and recalculate the payment. Recoup or refund erroneous payments.

3830. BATCH CLEARANCE RECORD

HCFA sends a magnetic tape (HCSSACL TAPE) to the intermediary to report all bills which fail consistency and utilization edits and to inform the intermediary of the status of all bills in a batch. Intermediaries that have more than one intermediary number will receive a tape for each office with a separate number (except Aetna and Travelers). The HCSSACL TAPE will also contain RTI Consistency Reject records (see §3832) and RTI Utilization Reject records (see §3831) and related Bill History records (see §3840). See §3830.1 for format of the HCSSACL TAPE.

An interim batch record is sent where it appears that all bills in the batch cannot be given a final disposition within 60 days. An initial interim batch record lists all readable bills in the batch according to processing status, that is, accepted bills, deleted bills, and pending bills. Any subsequent interim records show all bills which have had a status change since the previous notice. The final batch record will just list the bill(s) which changed from pending to accepted or rejected in the run causing the final notice if one or more interims have been released. When no interim batch record is released, all deletions and acceptions are listed on a final batch record.

All interim and final batch records are numbered. Also, HCFA enters the number of batch records produced to date which enables the intermediary to detect missing records. See §3841.1 for instructions relating to missing batch records.

BATCH CLEARANCE RECORD

PAGE 111

MA20605696

WOODLAWN
INTERMEDIARY NO 00000
BATCH BALANCE CLEARANCE SHEET

SEQ NO	HICN	NAME	FROM	AMT	PROCESS CODE	CDE	CORRECTED HICN	ADJUSTED/ MISC	INIT	IND
01	000000000A	XXXXXX	08/01/76	$2,594.56	AAAA					
02	000000000A	XXXXXX	08/19/76	$1,582.16	AAAA					
03	000000000A	XXXXXX	08/04/76	$1,153.44	AAAA					
04	000000000A	XXXXXX	07/16/76	$2,559.25	AAAA					
*05	000000000A	XXXXXX	08/06/76	$50.64	7410			1040000000		
06	000000000A	XXXXXX	08/16/76	$1,655.90	AAAA					
07	000000000A	XXXXXX	07/30/76	$2,991.83	AAAA					
08	000000000A	XXXXXX	08/05/76	$947.02	AAAA					
09	000000000A	XXXXXX	08/26/76	$247.98	AAAA					
10	000000000A	XXXXXX	06/24/76	$783.75	AAAA					
11	000000000A	XXXXXX	08/20/76	$1,821.60	AAAA					
12	000000000A	XXXXXX	08/28/76	$317.54	AAAA					
13	000000000A	XXXXXX	05/01/76	$4,047.91	AAAA					
14	000000000A	XXXXXX	07/28/76	$2,698.72	AAAA					
15	000000000A	XXXXXX	07/12/76	$1,407.92	AAAA					
16	000000000A	XXXXXX	07/28/76	$553.30	AAAA					
17	000000000A	XXXXXX	08/17/76	$2,042.95	AAAA					
18	000000000A	XXXXXX	04/27/76	$6,188.25	AAAA					
19	000000000A	XXXXXX	08/22/76	$1,613.65	AAAA					
20	000000000A	XXXXXX	08/05/76	$6,899.80	AAAA					
21	000000000A	XXXXXX	07/27/76	$5,328.25	AAAA					
22	000000000A	XXXXXX	08/16/76	$632.31	AAAA					
23	000000000A	XXXXXX	08/04/76	$2,204.15	AAAA					
24	000000000A	XXXXXX	07/31/76	$5,732.50	AAAA					
25	000000000A	XXXXXX	08/15/76	$783.75	AAAA					
26	000000000A	XXXXXX	08/07/76	$3,700.78	AAAA					
27	000000000A	XXXXXX	08/20/76	$846.20	AAAA					
28	000000000A	XXXXXX	05/04/76	$5,326.27	AAAA					
29	000000000A	XXXXXX	06/04/76	$700.68	AAAA					
30	000000000A	XXXXXX	08/06/76	$2,174.16	AAAA					
31	000000000A	XXXXXX	08/05/76	$2,313.38	AAAA					
32	000000000A	XXXXXX	08/20/76	$664.96	AAAA					
33	000000000A	XXXXXX	08/16/76	$1,671.50	AAAA					
34	000000000A	XXXXXX	08/31/76	$961.30	AAAA					

INTERMEDIARY BATCH NUMBER
N2316292

TYPE OF BILL
INPATIENT/SNF

SSA MASTER BLOCK NUMBER
6311L

NOTICE
FINAL 04 07/22/77

	ITEMS	REIMB. AMT
INTERMEDIARY SUBMISSION	50	$99,406.31
SSA RECEIVED	50	$99,406.31
SSA ACCEPTED	50	$99,406.31
SSA PENDING	0	$0.00
SSA DELETED	0	$0.00
CODE OUT OF BALANCE FOR RECEIVED AND SUBMISSION	0	$0.00

*PREVIOUSLY RETURNED

FORMAT OF THIS REPORT IS BASED UPON PRINT PROGRAM
OBTAINABLE FROM HCFA

3830.1 Description of Batch Clearance and Exception Files.--

A. Batch Clearance Tape Files.--The batch clearance records transmitted on tape consist of two files. The first file is identified by the acronym HCSSACL/S___ and the second file by HCSSBCL/S___. The three blanks following the "S" (segment) are designed for each intermediary's abbreviated number. These files are recorded at 1600 BPI, 9-track, odd parity, with an IBM Standard Label. The first file (HCSSACL) consists of a Header Record; Batch Clearance Records; Batch Clearance Detail Records; and a Trailer Record. Following are the detailed descriptions of the component records comprising the file. The descriptions of the records include Field, Size, Format (Data Type, i.e., A-alphabetic, N-numeric, and X-blank or alphanumeric), Location and Remarks.

The batch clearance tape includes, as the second file (HCSSBCL), the two RTI Reject Files in print image format suitable for production of the hardcopy listings at the intermediary sites utilizing Utility software available from computer manufacturers. File structure for the total tape follows:

The print programs obtained from HCFA must be used without exception.

B. Batch Clearance File Structure.--

VOL 1
HDR 1 — IBM Standard Header - 1st File
HDR 2

Tape Mark

Batch Clearance Header Record

Batch Clearance Control Record

Batch Clearance Detail Record

Batch Clearance Trailer Record

Tape Mark

EOF 1 — IBM Standard Trailer - 1st File
EOF 2

Tape Mark

HDR 1 — IBM Standard Header - 2nd File
HDR 2

Tape Mark

RTI Consistency Reject Header Record

RTI Consistency Reject Listings

RTI Consistency Reject Trailer Record

RTI Utilization Reject and HI Bill Retrieval Header Record

RTI Utilization Reject and HI Bill Retrieval Listings

RTI Utilization Reject and HI Bill Retrieval Trailer Record

Bill History Retrieval Header Record

Bill History Retrieval Listings

Bill History Retrieval Trailer Record

Tape Mark

EOF 1
EOF 2 } → IBM Standard Trailer - 2nd File

Tape Mark

Tape Mark

C. Intermediary Header Record.—

FIELD	SIZE	FMT	LOC	REMARKS
1. Blank	1		1	
2. Identification	5	X	2-6	MDA26
3. Blank	1		7	
4. Intermediary Number	5	N	8-12	Intermediary processing Bills
5. Blank	1		13	
6. Date of Notice	6	N	14-19	MMDDYY Current Processing Date
7. Blank	91		20-110	

D. Batch Clearance Control Record.--

FIELD	SIZE	FMT	LOC	REMARKS
1. Batch Number	8		1-8	See Section 3879.2
a. Sequence Number	4	X	1-4	Control Number assigned to batch by the Intermediary.
b. Julian Date	4	N	5-8	YDAY - date batched by the Intermediary.
2. Sequence Number	2	N	9-10	Constant 00

	FIELD	SIZE	FMT	LOC	REMARKS
3.	Type of Notice	1	A	11	I - Initial N - Interim batch record will reflect only bills changing status F - Final
4.	Intermediary Submission Totals	11	N	12-22	
	a. Items	2	N	12-13	No. of bills in batch.
	b. Reimbursement	9	N	14-22	Total reimbursement amount for bills in batch as reported by the intermediary (signed + or -)
5.	HCFA Receipt Totals	11		23-33	
	a. Items	2	N	23-24	No. of bills received in batch.
	b. Reimbursement Amount	9	N	25-33	Total reimbursement amount for bills in batch received by HCFA. (signed + or -)
6.	Out-of-Balance Indicator	1	X	34	HCFA receipt and the totals reported by intermediary differ. Blank-batch in balance. 1 - Reimbursement Amounts/out-of-balance. 2 - Items out of balance. 3 - Amount and Items both out of balance.
7.	Bill Type Indicator	1	X	35	L Inpatient or Skilled Nursing Fac. M Void N Christian Science P Outpatient Q Home Health "A" or "B" R Final Non-Payment (Bills submitted before 6/1/79 have been converted to one of the above 6 bill types.)

FIELD	SIZE	FMT	LOC	REMARKS
8. Blank	2	X	36-37	
9. HCFA Accepted Totals	11		38-48	For Interim batch records, bills changing to accepted status will be reflected in this field. Initial & Final batch records will reflect all accepted bills in batch.
a. Items	2	N	38-39	Number of bills in batch which have been accepted by HCFA.
b. Reimbursement Amount	9	N	40-48	Reimbursement amount for accepted bills (signed + or -)
10. HCFA Pending Totals	11		49-59	This field will be zero for an interim batch record. NOTE: All pending totals are shown on the Initial batch record.
a. Items	2	N	49-50	Number of bills in batch still pending.
b. Reimbursement Amount	9	N	51-59	Reimbursement amount for pending bills. (signed + or -)
11. HCFA RTI Totals	11		60-70	Interim batch records - reflect only bills changing to RTI status. Initial and Final batch records - reflect all bills in the batch returned to intermediary for correction.
a. Items	2	N	60-61	Numbers of RTI bills in batch.
b. Reimbursement Amount	9	N	62-70	Reimbursement amounts for RTI bills in batch. (signed + or -)

FIELD	SIZE	FMT	LOC	REMARKS
12. Master Block	8		71-78	
a. Julian Date	4	N	71-74	YDDD - date blocked by SSA
b. Bill Type	1	X	75	Letter indicating type of bills.
13. Blank	3	X	76-78	
14. Total Batch Records	2	N	79-80	Number of batch clearance records generated for this batch.
15. Blank	30	X	81-110	

E. Batch Clearance Detail Record.—

FIELD	SIZE	FMT	LOC	REMARKS
1. Batch Number	8		1-8	See Section 3879.2
a. Sequence Number	4	X	1-4	Control number assigned to batch by the intermediary.
b. Julian Date	4	N	5-8	YDAY - Date batched.
2. Sequence Number of Bill Within the Batch	2	N	9-10	Sequence number 01-95 assigned to bill.
3. HI Claim Number	12	X	11-22	Claim number from the bill submitted by the intermediary.
4. Beneficiary Surname	6	A	23-28	Surname from bill.
5. Bill From Date	6	N	29-34	MMDDYY - Starting date of billing period.
6. Reimbursement Amount	8	N	35-42	Reimbursement amount on bill. (signed + or -)
7. Corrected Claim Number	12	X	43-54	Claim number used to process the bill. Blank if no correction.
8. Corrected Claim Number Code	1	X	55	X-cross referred C-correction Blank-no correction

	FIELD	SIZE	FMT	LOC	REMARKS
9.	Corrected Name	6	X	56-61	Name used to process bill. Blank is no correction.
10.	Process Code	4	X	62-65	AAAA - Accepted HHHH - Under investigation RRRR - Orbit (——) - rejected or automatically corrected 4-position error code. Refer to §§ 3825ff. for rejected error codes and codes for automatically corrected claims. ( ) - rejected test claim number.
11.	Multiple Error	1	N	66	Number of other errors on the bill. Initialized zero.
12.	Action Code	1	N	67	0 - Credit Adjustment 1 - Interim Bill 2 - HHA Benefit Exhausted 3 - Final Bill 4 - Final Nonpayment Bill 5 - Debit Adjustment Bill 6 - Void RTI Bill
13.	Miscellaneous Entry	4	N	68-71	Code for rejected bills in order of priority with possible four error combination. Field initialized zeros. 1 - Name/Number discrepancy 2 - No open items 3 - No Part A 4 - No Part B 5 - Misbatched 6 - Pre-77 bill accepted during purge
14.	RTI Control Number	10	X	72-81	Control number assigned to bill returned to the intermediary. (signed plus)

"ALERT ONLY" in this field means RTI correction need not be sent to HCFA.

	FIELD	SIZE	FMT	LOC	REMARKS
15.	Intermediary Control Number	15	X	82-96	Reserved for control number assigned to bill by intermediary.
16.	Alert Code	1	X	97	Asterisk (*) means bill accepted, but provider number on bill did not match provider number present on Hospice Master Record (queried for admission date).
17.	Initials	2	X	98-99	Present only when surname and/or initials on bills differ from surname and/or initials on HCFA's records.
18.	Date of Death/Money Amount Tolerance Indicator	1	X	100	D--means bill has been accepted using home health or outpatient date of death tolerance. T--means bill has been accepted on basis of money tolerance. If HCFA-1453 or HCFA-1486, because total covered charges are less than $50. If HCFA-1483, because total covered charges are less than $50 or provider and patient block amounts combined are equal to less than $50 or amount of calendar year deductible to be met is less than $50. If HCFA-1487, because total covered charges are less than $50. Code 5200, 5210, 5211 or 5220 will appear in field 19, location 101-104, to show the error code which would have appeared in field 10 if the money

FIELD	SIZE	FMT	LOC	REMARKS
				tolerance had not been applied and as an alert that more than a money issue is involved. These codes can appear only in conjunction with the T code. B--means that the date of death and money amount tolerances have both been applied. Otherwise the location is blank. Effective February 1985, A-means potential under application of days or blood deductible. C-means that potential under application of days or blood deductible and money amount tolerance involved. Days remaining after acceptance of this billing appear in field 19, locations 101-106 and blood deductible pints to be met in 107. (See §3835.) The amount(s) potentially under applied is identified by an "A", "B", "C", "D", "E", or "F" in field 19, location 109-110. If no code is present, this location is blank.
19. Automatic Correction of Date of Death/ Deductible/Visits	10	X	101-110	Blank if not utilized.
	4	N	101-104	If code in field 18 is T and code 5200, 5210, 5211, or 5220 is applicable, the 4-position code is entered.
	5	N	102-106	If code in field 18 is D or B, the adjusted date of death from the HI record (YYDAY-Julian date) is entered. This applies to home health or outpatient only.

FIELD	SIZE	FMT	LOC	REMARKS
				If code in field 18 is A or C the following are shown:
	2	N	101-102	Full days available.
	2	N	103-104	Regular coinsurance days available.
	2	N	105-106	Lifetime coinsurance days available.
	1	N	107	Blood deductible pints to be met.
	1	A	108	Blank.
	1	A	109	Types of potential under applications are identified by: A - for full days, B - for regular coinsurance days, and C - for full days and regular coinsurance days.
	1	A	110	Types of potential under applications are identified by: D - for lifetime coinsurance days, E - for blood pints, and F - for lifetime coinsurance days and blood pints.
				If code in field 10 is: 7410
	5		101-105	Original inpatient deductible.
	5		106-110	Downwardly adjusted inpatient deductible.
				7411 Same as code 7410 except upwardly adjusted inpatient deductible.

FIELD	SIZE	FMT	LOC	REMARKS
				7400
	2		101-102	Original blood deductible in pints given on bill.
	6		103-108	Charges per pint.
	2		109-110	Downwardly adjusted blood deductible in pints.
				7401
				Same as code 7400 except: upwardly adjusted blood deductible in pints. NOTE: For codes 7400 and 7401, 999999 will be entered in locations 103-108 when charge per pint varies.
				7500
	2		101-102	Full days given on bill, if any.
	5		103-107	Regular coinsurance rate given on the bill, or the calculated rate if no rate appears on the bill or the rate given is incorrect.
	2		108-109	HCFA adjusted regular coinsurance days.
	1		110	Code: H-upwardly adjusted coinsurance rate, or L-downwardly adjusted coinsurance rate.
				7511
	2		101-102	Regular coinsurance days given on the bill, if any.
	5		103-107	Regular coinsurance rate given on the bill, or the calculated rate if no rate appears on the bill or if the rate given is incorrect.
	2		108-109	HCFA adjusted regular coinsurance days.
	1		110	Code: H—upwardly adjusted coinsurance rate, or L—downwardly adjusted coinsurance rate.

FIELD	SIZE	FMT	LOC	REMARKS
	1		101	7540 An "A" is entered if "B" visits on a bill are changed to "A" visits. If "A" visits on a bill are changed to "B" visits, a "B" is shown.

See § 3843 (C) for a detailed description of automatic correction codes.

F. Intermediary Trailer Record.-

	FIELD	SIZE	FMT	LOC	REMARKS
1.	Trailer Indication Code	1	A	1	Fixed "T".
2.	Blank	1		2	
3.	Batch Count	6	N	3-8	Number of batches still outstanding (Final batch record not prepared for intermediary).
4.	Blank	1		9	
5.	Control Record	6	N	10-15	Number of batch clearance control records in this file.
6.	Blank	1		16	
7.	Detail Record Count	6	N	17-22	Number of batch clearance detail records in this file.
8.	Blank	1		23	
9.	Intermediary	5	N	24-28	Intermediary processing bill.
10.	Blanks	82		29-110	

See § 3830 for an explanation of the batch clearance record and its related detail record and an example of the format produced by the print program obtainable from HCFA.

G. The RTI Consistency Reject File.—

The Header Record.—

	FIELD	SIZE	FMT	LOC	REMARKS
1.	Carriage Control	1	X	1	Fixed "1"
2.	Identification	5	X	2-6	RTICS
3.	Blank	1		7	
4.	Intermediary Number	5	X	8-12	Intermediary processing bills.
5.	Blank	1		13	
6.	Run Date	6	N	14-19	MMDDYY. Date Consistency errors established.
7.	Blanks	114		20-133	

H. The RTI Consistency Reject Record.—

For record layouts and examples refer to Part A Intermediary Manual 3832. For error explanation refer to 3825ff.

The format of the RTI Consistency Reject records are as described in the Part A Manual except for the first position of each record. This position contains the control character which is used for skipping and spacing. The possible control characters follow:

1 = NEW PAGE

b̸ = SINGLE SPACE

0 = DOUBLE SPACE

- = TRIPLE SPACE

An RTI Consistency Reject Header will precede the Consistency Reject record, and an RTI Consistency Reject Trailer will indicate the end of the RTI Consistency Reject records.

I. The RTI Consistency Reject Trailer.—

	FIELD	SIZE	FMT	LOC	REMARKS
1.	Carriage Control	1	X	1	Fixed "1"
2.	Record Identification	1	X	2	Fixed "C"

	FIELD	SIZE	FMT	LOC	REMARKS
3.	Blanks	7		3-9	
4.	Consistency Count	6	N	10-15	Number of consistency listings.
5.	Blanks	8		16-23	
6.	Intermediary Number	5	N	24-28	Intermediary processing bills.
7.	Blanks	105		29-133	

J. The RTI Utilization Reject and HI Bill Retrieval File.--

The RTI Utilization Reject and HI Bill Retrieval Header Record.—

	FIELD	SIZE	FMT	LOC	REMARKS
1.	Carriage Control	1	X	1	Fixed "1"
2.	Record Identification	5	X	2-6	RTIUT
3.	Blank	1		7	
4.	Intermediary Number	5	X	8-12	Intermediary processing bills.
5.	Blank	1		13	
6.	Date of Utilization Reject	6	N	14-19	MMDDYY - date rejects created.
7.	Blanks	114		20-133	

The RTI Utilization Reject and HI Bill Retrieval System Records.—

For record layouts and format examples refer to Part A Intermediary Manual sections 3831 and 3840. For error code explanation refer to section 3827ff.

The formats for the RTI Utilization Reject and HI Bill Retrieval records are as described in the Part A Manual except for the first position of each record. This position contains the control character which is used for skipping and spacing. The possible control characters follow:

1 = NEW PAGE

b̸ = SINGLE SPACE

0 = DOUBLE SPACE

- = TRIPLE SPACE

+ = SUPPRESS SKIPPING TO NEXT PAGE

An RTI Utilization Reject and HI Bill Retrieval Header precedes the Utilization Reject and HI Bill Retrieval records, and an RTI Utilization Reject and HI Bill Retrieval Trailer indicate the end of the records.

The RTI Utilization Reject and HI Bill Retrieval System Trailer Record.—

	FIELD	SIZE	FMT	LOC	REMARKS
1.	Carriage Control	1	X	1	Fixed "1"
2.	Record Identification	1	X	2	Fixed "U"
3.	Blanks	7		3-9	
4.	RTI Count	6	N	10-15	Number of utilization reject and bill retrieval records.
5.	Blanks	8		16-23	
6.	Intermediary Number	5	X	24-28	Intermediary processing bills.
7.	Blanks	105		29-133	

K. The Bill History Retrieval File

The Bill History Retrieval Header Record.—

	FIELD	SIZE	FMT	LOC	REMARKS
1.	Carriage Control	1	X	1	Fixed "1"
2.	Identification	5	X	2-6	BHRET
3.	Blank	1		7	
4.	Intermediary Number	5	X	8-12	Intermediary req. bill history
5.	Blank	1		13	
6.	Run Date	6	N	14-19	MMDDYY. Date of bill history
7.	Blanks	114		20-133	

The Bill History Record.—For record layouts and examples refer to §§3840 and 3840.1.

The format of the Bill History records are described in §§3840 and 3840.1 except for the first position of each record. This position contains the control character used for skipping and spacing.

The possible control characters follow:

1 = new page
b = single space
0 = double space
- = triple space

A Bill History Header precedes the Bill History records and a Bill History Trailer indicates the end of the Bill History Records. Bill histories are listed first and are followed by "No Find" and "Invalid Claim Number" reports. Records for each category are listed in claim number sequence.

The Bill History Retrieval Trailer Record -

	Field	SIZE	FMT	LOC	
1.	Carriage Control	1	X	1	Fixed "1"
2.	Record Identification	1	X	2	Fixed "H"
3.	Blanks	7		3-9	
4.	Bill History Count	6	N	10-15	Number of Bill History Listings ("No Find" and "Invalid Claim Number" reports are not included)
5.	Blanks	8		16-23	
6.	Intermediary Number	5		24-28	Intermediary requesting Bill History
7.	Blanks	105		29-133	

3831. RTI UTILIZATION REJECT

A utilization exception record is released when billing data is rejected by HCFA's utilization edit operation. Information on each bill is compared to the information on the beneficiary's master utilization record or to previously processed bills. When billing data is rejected for incorrect utilization and HCFA is unable to reinstate it into its bill processing system, the exception data is returned for correction and resubmission. Utilization exception data is also released when the beneficiary name and number shown in the billing data cannot be matched with a master record or the beneficiary name and claim number match a record on the purged inactive HI master file. (See §3828.1, code 5211 and §3512.7, disposition codes 38 and/or 43.) The utilization exception data is included on the batch clearance tape (either the interim or final).

For other than identification rejections or rejections involving a purged inactive record, the utilization exception data reflects a considerable amount of data from the beneficiary's current HI master record. However, if the billing data is for a Part A bill, only the Part A master is shown, followed by the reason the billing data has been rejected and all open items. If the billing data is from a Part B bill, only the Part B master is shown, followed by the reason for deletion.

```
                                                     SAMPLE OF INPATIENT FORMAT
        1.                                 2.                                 3.                           4.
PRO UTILIZATION REJECT          PROC BY   MM/DD/YY        TYPE OF BILL - INPATIENT     PRO CONTROL NO.-A904227627

    5.        6.       7.8.   9.      10.      11.   12. 13.   14.   15.   16.   17.   18.  19. 20.  21.   22. 23.  24.  25.    26.  27.
 CLAIM NO   NAME    IN T Q BEN AMT TOT CHG PROVDR BS PLANS  ADM   DSCHG FROM  THRU  TOT  CO  LIF  INSD  DED DED  BPD  BLOOD  P/O LT PRA
000000000A XXXXXX XX 3 3 002410 0131225 090001 70        82H01 82H13 82H01 82H13 012

 28.    29.     30.
XXXXX A904227?9 22626     31.   32.    33.    34.          35.        The adjustment trailers(items 36-53)do not appear on this exhibit.
INTER BATCH NO PRVDR BLE OF  DY CO-DY DRGNO-PR-OUT-DYSCHGAL-GT-DYS    See sample of adjustment format.

 54.                 55.               56.           57.    58.
MASTER    000000000A  PRV            XXXXXX  XXXXX X   SEX F  ID FROM        * 00000-0000C-01002-00000-00000-00003-00000-00000
                                                                                       *Data indicators for HCFA use only
             59.              60.           61.         62.              63.         64.         65.
        PART A CUR ENT 07/66  TRM           OPT         PRV ENT          TRM         OPT         DOD 12/01/92
        PART B CUR ENT 07/66  TRM           OPT T       PRV ENT          TRM         OPT         DOD
             66.              67.           68.         69.              70.         71.           72.

          73.   74.          75.           76.      77.            78.          79.          80.          81.
        HMO  CUR  EFF        TRM           OPT      PRIOR          EFF          TRM          OPT          PERIOD
                                  85. 86. 87. 88.     89.   90.         91.         92.        93. 94.
MASTER 2                             HOSP   SNF        DEDUCTIBLE                                IND
        LIFETIME          84. SPELL FL  CO  FL  CO      IMP    BLD     PRV BL DT   LST BL DT    1  2
     82. RES  PSY 83.            1  47  30  20  80      0000   3.0     06/11/82    06/24/82     0  0   Items 95-105 do not appear on this
        60   190                                                                                        exhibit. See sample of outpatient format.

       106.
REASON FOR DELETION - 5410 - INPATIENT DEDUCTIBLE OVER APPLIED. HCFA RECORDS SHOW THAT 00000 REMAINS TO BE MET
REPLY DATA 00000

  107.     108. 109. 110. 111.    112.  113.     114.       115.      116.       117.       118.          119.     120.
 ADM CTL ,TYPE   T    Q   DISP    INTER PROVDR   ADM DATE   FROM DTE  THRU DTE   DSCHG DT   BATCH/-SQ     DOA      DLA
           8          3   21      99990 090001   06/11/82   06/11/82             06/24/82   A1462?1914    82122    83?24
           8     3    3   01      99990 090001   08/01/82   08/01/82             08/13/82   A904224927    82?04    83?24
```

SAMPLE OF INPATIENT ADJUSTMENT REPORT

```
                  1.                          2.
           ADJUSTMENT REJECT              MM/DD/YY              3.                                    4.
                                                       TYPE OF BILL - INPATIENT         HIT CONTROL NO. A0882250114
     5.            6.        7. 8.   9.        10.       11.     12.    13.     14.    15.      16.     17.    18.  19. 20.  21.    22. 23. 24.  25.     26. 27.
  CLAIM NO       NAME     IN  T  Q REIM AMT  TOT CHG   PROVIDR  NO  FLAGS    ADM   DISCHG    FROM    THRU   TOT  CO  LIF  INDD   DVN DED BFD REMKS   H/O LF PRA
  999887777A     ENGLIS   WG  3  0 0000000   0004183   101010   1D

  99990   A 0882290   23016
  INTRM   BATCH NO    OTHER BLK   OP DT   UR DT   REMARK   H/O-QTY-DTE  QUAL-ST-DTE
   28.      29.         30.        31.     32.      33.       34.           35.

   36.            37.   38.   39.   40.   41.    42.    43.    44.     45.  46.     47.     48.      49.     50.     51.      52.      53.
  ADJRSV          ADY   GAN   PRO   ADM   FROM   THRU   ORG    DISCHG  PD   INPRSN  INDD    BLD AMT  CO AMT  LRDED   TOT DAY  FL DAY   CO DAY
                   2                                                        000     -1000   00000    00000   000     000      000      000

  CLAIM NO       NAME     IN   T  Q  REIM AMT TOT CHG PROVIDR NO FLAGS  ADM    DISCHG FROM   THRU   TOT  CO LIF INDD DVN DED BFD REMKS
                               3  5  0000000  0005183 101010  10        082082 082182 082082 082182 001
  99990 A 0882290   23016
  INTRM  BATCH NO  OTHER BLK  OP DT   UR DT REMARK H/O-QTY-DTE  QUAL-ST-DTE                  See items above for description

  54.                    55.           56.                 57.      58.
  MASTER 999-88-7777A    FOV      ENGLISH, GOOD V.        SEX M    NO FROM     * 00000-00000-01002-00000-00000-00003-00000-00000
          59.                     60.     61.      62.               63.     64.      65.         *Data indicators for HCFA use only.
     PART A ORG EFF 10/63   TRM          OPT      PAY EFF           TRM     OPT      DOB 10/19/02
     PART B ORG EFF 12/66   TRM          OPT Y    PAY EFF           TRM     OPT B    DOD
            66.                   67.      68.      69.               70.     71.      72.

     HMO  ORG   EFF          TRM        OPT    PRIOR              EFF     TRM      OPT          PERIOD
       73.       74.              75.       76.      77.               78.     79.      80.           81.
  MASTER A
                                    HOSP     SNF                DEDUCTIBLE
       LIFETIME           84.    85. 86.  87.88.         89.  90.    91.         92          93.94.        Items 106-120 do not appear on this exhibit.
   82. RES PSY 83.       SPELL   FL CO    FL CO          INP  BLD    DOEBA       DOLBA                     See sample of regular inpatient format.
       60   190            1     59 30    20 80          5183 3.0    05/20/82 5/29/82         1 2
                                                                                              0 0
  REASON FOR DELETION-
```

SAMPLE OF OUTPATIENT REPORT

```
        1.                            2.                      3.                                4.
[illegible]                   [illegible]              TYPE OF BILL - OUTPATIENT        [illegible]

  5.          6.        7.8.  9.      10.        11.  12.  13.  14.   15.    16.     17.  18. 19. 20. 21. 22. 23.24. 25.    26. 27.
[illegible]

  28.     29.      30.
[illegible]                31.   32.   33.   34.          35.
[illegible]

        54.              55.            56.          57.    58.
[illegible]                                                          * [illegible]
                                                                       *Data indicators for [illegible] use only
          59.        60.     61.     62.       63.    64.    65.
[illegible]                                                         (Items 82-94 do not appear on this exhibit. See
[illegible]                                                              sample of Inpatient format.)
          66.        67.     68.     69.       70.    71.    72.

[illegible]
         73.   74.  75.     76.     77.        78.    79.    80.       81.

[illegible] 95. 96.
   [illegible]    98.PART B UTIL     1978       1979       1980       1981       1982
   [illegible]    99.[illegible]        000        000        000        000        000
                  100.[illegible]        .0         .0         .0         .0         .0
                  101.[illegible]  00000.00   00000.00   00000.00   00000.00   00000.00
       97.        102.[illegible]    000.00     000.00     000.00     000.00     000.00
   [illegible]    103.[illegible]    000.00     000.00     000.00     000.00     000.00
   [illegible]    104.[illegible]    000.00     000.00     000.00     000.00     000.00
                  105.[illegible]
       106.                          (Items 107-120 do not appear on this exhibit. See sample of Inpatient format.)
[illegible]
[illegible]
```

3831.1 Explanation of Items Appearing on the RTI Utilization Reject File.--The format of the report is similar to those shown on the exhibits. Each item on the listing is identified by comparing the numbered items below with the numbers on the exhibit.

ITEM 1 & 2. RTI UTILIZATION REJECT AND DATE.
The title of the exception listing is followed by the date the bill was rejected. If a purged inactive HI master file is involved, DUMMY IDENT appears between the RTI UTILIZATION REJECT title and PROC DT. Data can appear only in items 3-35, 54, 56, 57, 59 or 66, 65, 72, and 106 when a record from the purged inactive master file has been matched to the name and claim number on incoming billing data. If "SPIDER (see 3829) has been substituted for the title and HCFA adjusts the incoming billing data, consider the billing data shown as posted. Item 106 identifies the data that has been adjusted.

ITEM 3. TYPE OF BILL.
The bill is identified as:

Inpatient	(Hospital)
TB/PSYCH	(Tuberculosis or Psychiatric)
SNF	(Skilled Nursing Facility)
HHA	Home Health (Part A)
HHB	Home Health (Part B)
Outpatient	
Christian Science	
Noncovered	
Hospice	

ITEM 4. RTI CONTROL NUMBER.
The 10-position number used to control rejected bills. (See 3804.) The RTI control number consists of the 4-position batch number you assigned, the 4-position Julian date batched, and a 2-position sequence number assigned by HCFA. Show this number on the resubmitted bill to remove the bill from HCFA's RTI control file.

ITEM 5. CLAIM NUMBER.
The claim number consisting of a 9-position numeric portion of the HCFA HI claim number shown on the bill followed by a 2 or 3 position beneficiary identification code of at least 1 alpha character. HCFA's converted version of Railroad Board claim numbers is shown on the report. The original Railroad Board number is shown on the interim or final batch record.

ITEM 6. NAME INITIAL.
Six positions of the surname and up to two initials to identify the beneficiary are shown.

ITEM 7. TRANSACTION CODE.
Indicates the type of bill printed out in Item 3. The possible transaction codes are:

0 = Christian Science
1 = Inpatient Psychiatric Hospital
2 = Inpatient TB Hospital
3 = Inpatient Hospital
4 = SNF
5 = HHA
6 = Outpatient Hospital Bill
H = Hospice Bill

ITEM 8. QUERY (CODE).
The following codes apply to the billing data returned to the intermediary:

0 = Credit Adjustment Bill
1 = Interim Bill
2 = HHA Benefits Exhausted Interim Bill
3 = Final Bill (covered or partially covered services)
4 = Discharge Bill (completely noncovered)
5 = Debit Adjustment Bill

ITEM 9. REIMBURSEMENT AMOUNT.
The amount of reimbursement claimed by the provider for the services covered by this billing data after the deductible and coinsurance amounts and after an adjustment for the actual cost of services provided.

ITEM 10. TOTAL CHARGES.
The total charges (covered and noncovered) in the billing data before reduction for the deductible and coinsurance amounts and before an adjustment for the cost of services provided.

ITEM 11. PROVIDER NUMBER.
A 6-position number that identifies the facility providing services to the beneficiary. The first 2 digits represent the State or foreign country in which the provider is located. The third and sometimes fourth digits indicate the type of institution. The last 2 or 3 digits are sequential.

ITEM 12. BILL SEQUENCE NUMBER.
A 2-position number assigned to each bill in a batch and used by HCFA for control purposes. The bill sequence number is also the last 2 digits of an RTI control number. The last digit of this entry appears as an alphabetic or special character which has a numeric counterpart. (See §3840 for a list of alphabetic characters and their numeric counterparts.)

ITEM 13. PLAN ESTABLISHED.
The date on which a physician established a plan of care under the home health provision.

ITEM 14. ADMISSION.
Applies to:

a. the admission date if the bill is for inpatient hospital or extended care services.

b. the start-of-care date if the bill is for home health services.

c. the date the first service began if the bill is for outpatient services

ITEM 15. DISCHARGE.
The date the patient left the hospital or SNF or died or did not recover (Christian Science). If the bill is for home health services, it is the date the patient is no longer receiving covered services.

The absence of a date in this field indicates the bill is an interim, not a final, bill.

If the bill is for outpatient services, the date shown is the date of last service.

ITEMS 16 & 17. FROM AND THRU.
These are billing dates. If the bill is for hospital, SNF or home health services, two dates are shown. The dates represent the period covered by the "FROM" and "THRU" dates on the bill.

ITEM 18. TOTAL DAYS.
The total number of full, coinsurance, and lifetime reserve days on the bill for which payment has been made. If the bill is for home health visits, the number of covered visits shown on the bill appears.

ITEM 19. COINSURANCE DAYS.
The total number of covered days on the bill for which the patient is responsible for a portion of the charges. This excludes lifetime reserve days, if used.

ITEM 20. LIFETIME DAYS.
The number of lifetime reserve days as used on the bill is shown. This item applies only to inpatient hospital days.

ITEM 21. INPATIENT DEDUCTIBLE.
The amount of the inpatient hospital deductible applied on the bill. Four zeros are shown if no deductible is shown on the bill.

ITEM 22. BLOOD FURNISHED.
The total number of pints of blood furnished is entered.

ITEM 23. BLOOD NOT REPLACED.
The total number of pints of blood shown on your tape as not replaced by the patient and for which the provider is charging.

ITEM 24. BLOOD APPLIED.
The number of pints on the bill creditable toward the 3-pint Part A blood deductible is shown.

ITEM 25. BLOOD CHARGES.
The amount shown on the bill or tape as charged by the provider for unreplaced blood.

ITEM 26. NONCOVERED LEAVE DAYS.
The number of days during the period covered by the bill that the patient was not present in the hospital or SNF, and the number of days during the billing period which were not covered by Medicare for reasons such as benefits exhausted, custodial care, workmen's compensation, payment by Veterans Administration, or other third party.

ITEM 27. PDA (PRE-ENTITLEMENT DAYS).
The number of days shown on the bill that the patient was confined to a psychiatric hospital in the 150-day period immediately preceding entitlement to Part A benefits.

ITEM 28. INTERMEDIARY.
A 5-position number used to identify the intermediary which submitted the bill being returned.

ITEM 29. BATCH NUMBER.
This field identifies the batch in which you forwarded the bill and the date it was batched. The first 4 digits are the batch number (an alpha in the first position indicates the batch was submitted on magnetic tape). The last 4 digits represent the date of batching. The last 3 digits show the Julian day. These digits are preceded by the last digit of the year, such as 3 for 1983, 4 for 1984. January 8, 1984, is expressed as 3004.

ITEM 30. MASTER BLOCK.
Displays the Master Block Number. It is HCFA's control number and reference to it in communications to HCFA expedites the processing of replies.

ITEM 31. GUARANTEE OF PAYMENT DATE.
An entry is made here only when the bill involves the guarantee of payment provision. The first day for which payment is claimed under that provision is shown when the patient has no available coverage. It does not apply to SNF stays.

ITEM 32. UTILIZATION REVIEW DATE.
The date a utilization review committee advised the provider that a further hospital or SNF stay is no longer medically necessary is entered if the date appeared in Item 22 of the HCFA-1453.

ITEM 33. BENEFITS EXHAUSTED.
If the entire bill is for noncovered services and the nonpayment code is "B," the "B" is shown in this field.

ITEM 34. NONCOVERED STAY DATES.
This field shows 2 dates representing a noncovered stay (if any) which preceded the stay on the rejected bill. The dates are taken from Item 32 on the HCFA-1453. If the bill is a home health bill, disregard any dates entered.

ITEM 35. QUALIFYING STAY DATES.
This field may contain the dates of the hospital stay of at least 3 days which qualifies the individual for SNF benefits. The dates are entered on the first SNF bill immediately following the qualifying hospital stay. Nothing is entered for hospital bills.

ITEM 36. ADJUSTMENT TRAILER.
Items 36 through 53 represent data which is displayed if the rejected bill is an adjustment bill. The utilization data shown represents the net difference of the utilization changes caused by the adjustment. If the adjustment is only for a money change, the utilization fields are blank.

ITEM 37. ACTION.
This field contains a coded item that explains the type of adjustment bill. The codes are:

2 = Credit action of a combination adjustment
3 = Debit action of a combination adjustment
4 = "Cancel Only" adjustment
5 = "Debit Only" adjustment

ITEM 38. CANCEL.
Indicates the reason for the "Cancel Only" adjustment. The possible codes are:

S = Scramble
P = Plan Transfer
D = Duplicate Bill Processed
C = Coverage Transfer
H = Other

ITEM 39. PROCESS CODE.
Useful only in HCFA's internal operation.

ITEM 40. ADMISSION.
This field shows the admission date on the debit, if different from the credit. If the dates are the same, this item is blank.

ITEM 41. FROM.
This field indicates the "from" date on the debit, if different from the credit. If the dates are the same, this item is blank.

ITEM 42. THRU.
This field indicates the "thru" date from the debit, if different from the credit. If the dates are the same, this item is blank.

ITEM 43. CHANCE.
This field indicates any changes in the patient's status between the credit and the debit. These codes are:

J = Credit - discharge, debit - deceased
K = Credit - discharge, debit - still patient
L = Credit - deceased, debit - still patient
M = Credit - deceased, debit - discharge
N = Credit - still patient, debit - discharge
O = Credit - still patient, debit - deceased

ITEM 44. DISCHARGE.
This field shows the discharge date on the debit, if different from the credit. If there is a change and the debit is "still patient," asterisks are shown. If the credit and debit are the same, this item is blank.

ITEM 45. PRIOR STAY.
If there is a difference between the credit and debit in the verified prior stay dates, a "C" is shown. If the dates are the same, this item is blank.

ITEM 46. BLOOD FURNISHED.
This item shows the difference in the total pints of blood shown as furnished on the credit and debit bills (if a minus, a minus figure is shown). If there is no change, this item shows zero.

ITEM 47. INPATIENT DEDUCTIBLE.
The difference in the amount of deductible shown on the credit and debit bills (if a minus, a minus figure is shown). If there is no change, this item shows zero.

ITEM 48. BLOOD AMOUNT.
This item shows the difference in the amount of unreplaced blood charges on the credit and debit bills (if a minus, a minus figure is shown). If there is no change, this item shows zero.

ITEM 49. COINSURNACE AMOUNT.
This item shows the difference in the amount of coinsurance on the credit and debit bills (if a minus, a minus figure is shown). If there is no change, this item shows zero.

ITEM 50. LIFETIME RESERVE DAYS.
This item shows the difference in the lifetime reserve days on the credit and debit bills (if a minus, a minus figure is shown). If there is no change, this item shows zero.

ITEM 51. TOTAL DAYS.
This item shows the difference in the total covered days on the credit and debit bills (if a minus, a minus figure is shown). The difference in the number of home health visits appear if the bill is for home health services. If there is no change, this item shows zero.

ITEM 52. FULL DAYS.
This item shows the difference in the number of full covered days on the credit and debit bills (if a minus, a minus figure is shown). The difference in the number of home health visits appear if the bill is for home health services. If there is no change, this item shows zero.

ITEM 53. COINSURANCE DAYS.
This item shows the difference in the number of covered regular coinsurance days on the credit and debit bills (if a minus, a minus figure is shown). If there is no change, this item shows zero.

ITEM 54. MASTER IDENTIFICATION RECORD.
The title for that part of the record which contains beneficiary identification data and entitlement information for the beneficiary. Following the title is the beneficiary's claim number.

ITEM 55. PREVIOUS IDENTIFICATION CODE.
A beneficiary's status may change requiring a change in the identification code. One of the most frequent changes, for example, occurs when a woman's

status changes from wife to widow. A claim being processed matches the master record if the beneficiary identification code agrees with either the current beneficiary identification code or the previous one. The previous identification code is shown.

ITEM 56. NAME.
This 25-position field shows the beneficiary's last name, first name and middle initial.

ITEM 57. SEX.
"M" is shown for male, "F" for female, and "U" for unknown.

ITEM 58. CROSS REFER FROM.
A prior cross-referenced claim number is shown if applicable.

ITEM 59. PART A CURRENT ENTITLEMENT.
The first month the individual was entitled to hospital insurance benefits is shown. The day of entitlement is always the first day of the month. (July 1966 is the first possible date of entitlement.) If the record is from the purged inactive HI master file, the date of death is shown instead of the entitlement date.

ITEM 60. TERMINATION (CURRENT).
If benefits have been terminated, the month and year are shown. Benefits are terminated on the last day of the month or on the day of death. (The date of death is not shown here; it is shown in Item 72.) "9s" in this field indicate the individual should never have been entitled to Part A benefits.

ITEM 61. OPTION.
This is a 1-position code reflecting the individual's option for Part A coverage. The valid codes and their explanations are:

C = No; due to cessation of disability
D = No; Part A coverage denied
E = Yes; automatic entitlement
G = Yes; enrollment was through good cause provision
S = No; terminated - no longer entitled under Chronic Renal Disease provision
T = No; termination for nonpayment of premiums
W = No; beneficiary withdrew
Y = Yes; premium is payable.

ITEM 62. PREVIOUS ENTITLEMENT.
The entitlement date of any previous period of Part A coverage.

ITEM 63. TERMINATION (PREVIOUS).
The termination date for any previous period of Part A coverage.

ITEM 64. OPTION (PREVIOUS).
A 1 position code reflecting the individual's previous option for Part A coverage, if any. The valid codes are the same as indicated for Item 61.

ITEM 65. DATE OF BIRTH.
This 6 position field contains the beneficiary's date of birth.

ITEM 66. CURRENT PART B ENTITLEMENT.
The date of current entitlement to Part B coverage. Only the month and year are shown but entitlement exists from the first day of the month. If there is no entry in this item, no Part B entitlement exists. If the record is from the purged inactive HI master file, the date of death is shown instead of the entitlement date.

ITEM 67. CURRENT PART B TERMINATION.
The month and year Part B benefits were terminated for reasons other than death. Termination of coverage is effective the last day of the month. "9s" indicate a retroactive denial of entitlement.

ITEM 68. CURRENT ENROLLMENT OPTION.
A 1 position code reflecting the individual's option for Part B coverage. The codes and their explanations are:

C = No; due to cessation of disability
D = No; Part B coverage was denied
G = Yes; enrollment was through good cause provisions
N = No; no response was received to enrollment requests
P = The Railroad Retirement Board has jurisdiction over medical insurance (insured and prouty beneficiary only)
R = No; the beneficiary refused Part B coverage
S = No; no longer under renal disease
T = No; Part B coverage was terminated for nonpayment of premiums
W = No; the beneficiary withdrew from coverage
Y = Yes; the beneficiary has Part B coverage.

ITEM 69. PREVIOUS PART B ENTITLEMENT.
The entitlement date for any prior period of Part B coverage. (Item 66 shows the entitlement date for the current period of coverage.)

ITEM 70. PREVIOUS PART B TERMINATION.
The termination date for any previous period of Part B coverage. (Item 67 shows the termination date for the current period of coverage.)

ITEM 71. PREVIOUS ENROLLMENT OPTION.
A 1 position code reflecting the individual's previous option for Part B coverage. (Item 68 shows the code for the current enrollment option.)

ITEM 72. DATE OF DEATH.
The date of death may be entered on HCFA Health Insurance Records by a bill or by a SSA Program Center or RRB notification.

ITEM 73. HMO CURRENT.
The number following is the plan number of the current Health Maintenance Organization.

ITEM 74. EFFECTIVE.
The 4 position date is the effective starting date of the HMO period.

ITEM 75. TERMINATION.
The 4 position date is the termination date of the HMO period.

ITEM 76. OPTION.
The 1 position code is the HMO option code. One of the following appears:

1 - HCFA processes all provider bills for non-lock-in beneficiaries.
2 - HMO processes only in-plan Part A and in-area Part B bills for lock-in beneficiaries.
A - HCFA processes all provider bills for lock-in beneficiaries.
B - HMO processes only in-plan Part A and in-area Part B bills for lock-in beneficiaries.
C - HMO processes all Part A and Part B bills for lock-in beneficiaries.

ITEM 77. PRIOR.
The information described in 73 through 76 above is displayed following the legend "PRIOR" if more than one HMO period is involved.

ITEM 78. EFFECTIVE.
The 4 position date is the effective starting date of the prior HMO period.

ITEM 79. TERMINATION.
The 4 position date is the termination date of the prior HMO period.

ITEM 80. OPTION.
The 1 position code is the prior HMO option code. See item 76 for codes and description.

ITEM 81. PERIOD.
The number following represents the number of HMO periods in which the beneficiary has participated.

MASTER A DATA

ITEM 82. LIFETIME RESERVE DAYS.
Each beneficiary has a lifetime reserve of 60 days of inpatient hospital coverage. These reserve days may not be used until full and coinsurance days have been exhausted for the benefit period. Each of the reserve days is subject to a coinsurance rate. This item shows the number of lifetime reserve days available.

ITEM 83. LIFETIME PSYCHIATRIC DAYS.
A beneficiary may not receive more than 190 days of inpatient psychiatric hospital care benefits during his lifetime. The field shows the number of remaining lifetime psychiatric days.

ITEM 84. SPELL.
The information in line 1 relates to the current benefit period. Subsequent lines (maximum of 4) relate to previous benefit periods.

ITEM 85. HOSPITAL FULL DAYS.
In each benefit period, an individual is entitled to 60 full coverage days of inpatient hospital services. Full days must be exhausted before coinsurance days can be used. The number of remaining days of full coverage is shown.

ITEM 86. HOSPITAL COINSURANCE DAYS.
Payment may be made for up to 30 coinsurance days of inpatient hospital services for each benefit period. Coinsurance days must be exhausted before lifetime reserve days can be used. This field shows the number of coinsurance days remaining.

ITEM 87. SKILLED NURSING FACILITY FULL DAYS.
In each benefit period, payment can be made for up to 20 full coverage days of service in an SNF. Full days must be exhausted before coinsurance days are used. This field shows the number of full days remaining. (See §3023 for a description of coverage for services received in a Christian Science Sanatorium.)

ITEM 88. SKILLED NURSING FACILITY COINSURANCE DAYS.
In each benefit period, payment can be made for up to 80 coinsurance days of services received in an SNF. This field shows the number of coinsurance days remaining. (In a Christian Science Sanatorium, payment may be made for up to 30 coinsurance days in a benefit period.)

ITEM 89. INPATIENT DEDUCTIBLE.
This field shows how much of the inpatient hospital deductible has to be met. (See §3211.)

ITEM 90. PART A BLOOD DEDUCTIBLE.
The part A blood deductible is three pints for each benefit period. This field shows the number of pints to be met.

ITEM 91. FIRST BILL DATE.
This field usually reflects the admission date of an earlier processed bill which started the benefit period. Only admission dates from earlier inpatient hospital and SNF bills are entered, as home health agency bills do not start a benefit period. An admission date for the qualifying stay or a stay in a nonparticipating provider shown on the bill being processed is recorded as the beginning date for the benefit period where that date has not been recorded from an earlier bill.

ITEM 92. LAST BILL DATE.
This date reflects the discharge date or through date, if an interim bill is involved, of the last processed inpatient hospital bill or SNF bill in the same benefit period. Home health agency bill dates are not entered as they do not affect a benefit period. However, in some instances, the discharge date for a qualifying stay shown on a processed Part A home health bill may be shown in this field.

ITEMS 93 & 94. DATA INDICATORS.
These indicators are used by HCFA's internal operations.

MASTER B DATA

ITEM 95. INTERMEDIARIES.
The 5-position numbers identifying up to three intermediaries or carriers which submitted Part B queries are shown. If more than three intermediaries or carriers have submitted queries, the identification numbers shown are for those which have queried services for the most recent years.

ITEM 96. YEAR.
This 2 position field contains 2 year indicator codes. The first is under the letter "Y"; the second is under the letter "R." The possible codes are:

"Y" CODES

O = There has been no query activity for 1981 and 1982.
1 = There is query activity for 1981.
2 = There is query activity for 1982.
3 = There is query activity for both 1981 and 1982.

"R" CODES

0 = There has been no query activity for 1979 and 1980.
1 = There is query activity for 1979.
2 = There is query activity for 1980.
3 = There is query activity for both 1979 and 1980.

ITEM 97. PART B DEDUCTIBLE MET.

The first three positions of the field cover 5 years of Part B deductible data. Each position indicator, with the exception of the last indicator, represents 2 years as follows:

Position (Left to Right)	1	2	3
Years Covered	1979-1980	1981-1982	1978

The last two positions of the 5 positions field are not used. The codes for indicators 1 through 3 are illustrated on the chart:

		Definitions
0	(Position 1)	Deductible not met for 1979 or 1980
1	(Position 1)	Deductible met for 1979
2	(Position 1)	Deductible met for 1980
3	(Position 1)	Deductible met for both 1979 and 1980
0	(Position 2)	Deductible not met for 1981 or 1982
1	(Position 2)	Deductible met for 1981
2	(Position 2)	Deductible met for 1978
3	(Position 2)	Deductible met for both 1981 and 1982
0	(Position 3)	Deductible not met for 1978
1	(Position 3)	Deductible met for 1978
2	(Position 3)	Not used
3	(Position 3)	Deductible met for 1978

ITEM 98. PART B UTILIZATION.
The date to the right covers a 5-year period (1978 thru 1982). The data relate to Part B utilization and deductibles and are broken down under each calendar year.

ITEM 99. PART B HOME HEALTH AGENCY VISITS.
The cumulative number of Part A and B home health visits (combined) for each calendar year appearing on the record.

ITEM 100. PART B BLOOD DEDUCTIBLE APPLIED.
There is a blood deductible under Part B coverage of 3 pints per calendar year. Unlike Part A blood deductible (Item 88), this field is updated by the query. A zero in this field indicates no blood has been queried; therefore, 3 pints are needed to meet the deductible.

ITEM 101. MEDICAL EXPENSES.
This field represents the amount of Part B medical expenses incurred during each of the calendar years shown under the heading. The field is updated by a query and not by a processed bill. From January 1, 1973 through December 31, 1981, the Part B deductible was $60 for each calendar year. Beginning January 1, 1982 it is $75 for each calendar year. All expenses shown in the medical expense field are credited against the deductible. Both medical expenses and psychiatric expenses must be examined to determine whether the deductible has been met.

ITEM 102. PSYCHIATRIC EXPENSES.
This field represents the amount of outpatient psychiatric expenses queried for each calendar year shown. Only 62 1/2 percent of the amount shown can be credited toward the Part B deductible.

ITEM-103. PSYCHIATRIC MAXIMUM.
This psychiatric maximum money field is initially shown as zeroes. It is incremented by Part B payment records. The maximum psychiatric expenses shown is $500.00.

ITEM 104. PHYSICAL THERAPY EXPENSE.
This field represents the amount of outpatient physical therapy expenses queried for the calendar year.

ITEM 105. PHYSICAL THERAPY PAYMENT.
This physical therapy payment field is initially shown as zeroes. It is incremented by Part B payment records and the maximum is $100.00.

ITEM 106. REASON FOR DELETION.
This field contains a 4-position deletion code which indicates the reason the bill is being returned. Immediately following this deletion code is a narrative description of the error condition. (See §§3832.9 and 3832.10 for a description of delete codes.) If a "SPIDER" record is involved, and two or more automatic adjustments were made to the bill, code 7999 is entered with its narrative description showing the data submitted and adjusted as follows: (See §3829.)

IDED	FL	CO	LIF	N/UTIL	UTIL
		SUBMITTED BILL DATA			
XXXX.XX	XX	XX(lst YR) XX(2nd YR)	XX	XXXX XXX	XXX XXX
		HCFA APPLIED BILL DATA			
XXXX.XX	XX	XX(lst YR) XX(2nd YR)	XX	XXXX	XXX

ITEM 107. ADMISSION CONTROL.
If the rejected bill is a part A bill, Items 107 through 119 of this listing contains HCFA's admission control information. (No open items appear for automatic adjustments applied on a SPIDER record.)

ITEM 108. TYPE OF TRAILER.
This 1-position code indicates the type of trailer. The types are:

C = Closed (All bills have been posted for the admission.)
D = Open (Admission query received, no bill processed.)
O = Orbit (Bill is in orbit.)
R = RTI (Bill has been returned to the intermediary for correction or deletion.)
U = Utilization (Bill is under clerical investigation for a possible utilization error.)
G = Open (If HCFA has received a bill but does not have a corresponding admission query, HCFA will generate an admission from the bill data. Also, if HCFA has a query and a matching bill that is interim, HCFA generates the next "from" date.)
X = Closed (The bill(s) has been posted, but all interim bills for the admission have not been posted.)

ITEM 109. TRANSACTION CODE.
This code indicates the type of bill. These transaction codes are:

0 = Christian Science Sanatorium
1 = Psychiatric Hospital
2 = Tuberculosis Hospital
3 = Inpatient Hospital
4 = SNF
H = Hospice

ITEM 110. QUERY CODE.
This code indicates the type of action. If HCFA has no bill, the query code is blank. The possible query codes are:

best copy available

1 = Interim Bill
3 = Final Bill
4 = Discharge Notice

ITEM 111. DISPOSITION CODE.
This 2 position code indicates the type of reply you received in response to your query. The numeric dispositon codes are in §3512.7.

ITEM 112. INTERMEDIARY CODE.
The number that identifies the intermediary which submitted the query.

ITEM 113. PROVIDER NUMBER.
(Same as Item 11.)

ITEM 114. ADMISSION DATE.
The date the beneficiary was admitted to the hospital or SNF.

ITEM 115. FROM DATE.
The first day of services covered by the bill.

ITEM 116. THRU DATE.
The last day of the billing period on the bill. It is the thru date for interim and the discharge date for final bills.

ITEM 117. DISCHARGE DATE.
The date that the patient left the provider, died or did not recover (Christian Science).

ITEM 118. BATCH # SEQUENCE.
This 10 position field identifies the batch in which you forwarded the bill, the date it was batched and the sequence number of the bill in the batch. The first 4 positions are the batch number. (An alpha in the first position denotes a magnetic tape submittal.) The next 4 positions are the Julian date. The last 2 are the sequence number of the particular bill within the batch.

ITEM 119. DATE OF ACCRETION.
The date the trailer was created. (The date does not change once it is established.)

ITEM 120. DATE OF LATEST ACTION.
The date of the latest modification to the trailer data.

3832. RTI CONSISTENCY REJECT

A. General.—When HCFA rejects a bill for a consistency edit error, i.e., a discrepancy in the information shown in the bill, an exception record is produced and returned.

All types of consistency reject records have a fixed position which includes the title - "RTI Consistency Reject," HCFA's processing date, the type of bill (inpatient, SNF, Christian Science, outpatient, home health - A, home health - B, noncovered) and the RTI Control Number. The first 32 positions on the first line of any consistency reject record are fixed. The information displayed is: Intermediary Number, Batch Number and Julian Date Batched, HCFA Master Block Number, the Sequence Number assigned by SSA to each bill in the batch, and nine batch indicators used by HCFA in its internal operation.

Each field following the fixed portion is preceded by a three-position alpha-numeric code. The first two positions in the code identify the item number on the bill. For example, "Date of this admission" in the HCFA-1453 would be 070. The third position in the code gives the alphabetical breakdown of the item. For example, the item titled "Pints replaced" on the HCFA-1483 is 17B. When there is a breakdown of items other than alphabetical breakdown, a third position numeric identifies the specific item. For example, in the "Statement covers period," on form HCFA-1453, 201 identifies the "From" date and 202 identifies the "Thru" date. The number "1" is always used for the first numerical breakdown, "2" for the second numerical breakdown, etc. If there are no breakdowns for an item on the bill, a zero is shown in the third position. All date fields on the record (other than Batch Date) are shown as six positions — a two-position month, a two-position day and a two-position year. For example, May 1, 1973, appears on the record as 05/01/73. All money fields are right justified. For example, the "totals" in Item 19U of the HCFA-1453 appears as 0038180 or $381.80.

Each item on the listing has two lines. The upper line displays the information taken from the corresponding item on the bill. The lower line shows the item number and a series of dots if the entry is consistent. If there is an error, a numeric entry follows the item number on the lower line. The item number plus the numeric entry yields the error code. For example,

```
    070 11/26/72 no error
        ........

    070 11/26/72 error 0701 (impossible admission date).
        11111111
```

If an error appears on the bill, the word "error" is indicated at the right of that line on the record. Up to three codes are also displayed at the bottom of the record followed by a brief explanation of the error.

All error codes and explanations are included in §§ 3824-3828ff. The number of additional errors (up to a total of 9) is displayed following the narrative.

An exhibit and explanation for each format follows:

SAMPLE OF INPATIENT FORMAT

```
114
    RTI CONSISTENCY REJECT     PROC DT 11/05/73          TYPE OF BILL - INPATIENT                         RTI CONTROL NO. 3259312006

    99990  3259 3120 3130L   06    1     00     SICK   4      123456789A          27/03/72      120123
    ..... .... .... ........ .. . . . .... .. 010 .......... 030 ............. 070 ......... 090 ......

        00/00/00 00/00/00       A                          C0/00/00                C000 0000 0300 0C0000 0000000 0000000
    110 ........ ........ 130 . 160 ..... 170 ..... 181 ......... 182 ..... 19A ........................................

         C 011 00036300 00000000         000 0000000 0000000          000 0000000 0000000        000 0000000 0200000
    191 ...................... 192 ....................... 193 ........................ 194 ......................

         000 0000C00 0000000          0000000 0000000           C000000 0000000           0000000 0000000
    195 ...................... 19H ................... 19I .................. 19J ..................

         0000010 0000000       L 0001415 C000000       M 0013120 0000000       N 0011100 0000000       O 0000850 0000000
    19K .................. 19L ................... 19M ................... 19N ................... 19O ..................

         0000000 0000000        0000000 0000000        0000000 0000000        S 0000050 0000000        T 0001500 0000000
    19P .................. 19Q .................. 19R .................. 19S .................. 19T ..................

         0000000 0000000        0000000 0000000        0000000 0000000        0000000 0000000        00064335 00000000
    196 .................. 197 .................. 198 .................. 199 .................. 19U ..................

         00000      C00 000000 000000      011 01500 0016500      00016500      07/03/73      07/14/72      00/00/00
    19V ..... 19W ................... 19X .................... 19Y ......... 201 22222222 202 33333333 210 ........           ERROR

        00/00/00      00/00/00      00/00/00      A 07/14/73      00       0000      011      04/02/73
    220 ........ 230 ........ 240 ........ 250 ..33333333 260 .. 270 .... 280 222 290 ........                               ERROR

        00034100      00/00/00      00/00/00               000     04/03/73
    310 ........ 321 ......... 322 ........ 330 . 340 ... 350 ........ 999 ..........

                                                          REASON FOR DELETION

        2802 - THE NUMBER OF COVERED DAYS DOES NOT EQUAL THE NUMBER OF DAYS IN STATEMENT COVERS PERIOD IN ITEM 20 LESS NONCOVERED
               DAYS IN ITEM 27.

        2012 - FROM DATE LATER THAN THRU DATE.

        2023 - THE TOTAL NUMBER OF ACCOMMODATION DAYS IN ITEMS 198 THRU 196 EXCEED THE TOTAL NUMBER OF DAYS IN THE STATEMENT COVERS
               PERIOD.

                                                             ONE  ADDITIONAL ERRORS
```

Rev. 762

SAMPLE OF SKILLED NURSING FACILITY FORMAT

```
     RTI CONSISTENCY REJECT     PROC DT 11/05/73       TYPE OF BILL -  SKILLED NURSING FACILITY          RTI CONTROL NO. T614327421
  99990 T614 3274 32764   21   1     00      SICK   M        123456789A         08/30/73     125012
  ..... .... .... ........ .. . . .... .. 010 ......... 030 ............ 070 ......... 090 ......

      07/23/73 08/30/73     M     XXXY0       YYYY0      00/00/00                    0000 0000 0000 000000 0000000 0000000
  110 ................ 130   160 ...... 170 ...... 181 ......... 182 ...... 19A .......................................

      C 012 00034560 00000000        000 0000000 0000000         000 0000000 0000000         000 0000000 0000000
  191 ....................... 192 ...................... 193 ...................... 194 ......................

        000 0000000 0000000          0000000 0000000          0000000 0000000          0000000 0000000
  195 ...................... 19H ................... 19I ................... 19J ...................

        0000000 0000000          0000000 0000000          0000000 0000000          0000000 0000000          0000000 0000000
  19K .................. 19L .................. 19M .................. 19N .................. 190 ..................

        0000000 0000000          0000000 0000000          0000000 0000000          0000000 0000000          0000000 0000000
  19P .................. 19Q .................. 19R .................. 19S .................. 19T ..................

        0000000 0000000          0000000 0000000          0000000 0000000          0000000 0000000          00034560 00000000
  196 .................. 197 .................. 198 .................. 199 .................. 19U ..................

      00000     000 000000 000000      000 00000 0000000      00000000      08/30/73      09/10/73      00/00/00
  19V ...... 19W ................. 19X ................... 19Y ......... 201 ......... 202 33333333 210 .........               ERROR

      00/00/00     00/00/00     00/00/00      A 09/10/73     00     0000     011      09/24/73
  220 ........ 230 ........ 240 ........ 250 .......... 260 .. 270 .... 280 ... 290 ........

      00027500     00/00/00     00/00/00            000                09/24/73
  310 ......... 321 ......... 322 ......... 330   340 ... 350   360 ......... 999 ...........

                                             REASON FOR DELETION

    2023 - THE TOTAL NUMBER OF ACCOMMODATION DAYS IN ITEMS 193, 19C, AND 190 EXCEED THE TOTAL NUMBER OF DAYS IN THE STATEMENT
           COVERS PERIOD.
                                                  NO ADDITIONAL ERRORS
```

C. **Five Basic Formats of Consistency Edit Exception.**--

1. **HCFA-1453 (Inpatient Hospital and Extended Care Admission and Billing.**--

ITEM	
010	Patient's Name and Initials
030	HI Claim Number
070	Date of This Admission
090	Provider Number
110	Dates of Qualifying Stay
	From Date and Thru Date
130	Insuring Organization
	(a 1-position code used by SSA)
160	Admitting Diagnosis
	(a 5-position code entered and used by SSA)
170	Discharge or Current Diagnosis
	(a 5-position code entered and used by SSA)
181	Surgical Procedure Date
182	Surgical Procedure Code
	(a 5-position code entered and used by SSA)
19A	Blood Usage (39 Positions)
	Position 1 - Code (used by SSA)
	blank
	Positions 3-6 - xxxx - Pints Furnished
	blank
	Positions 8-11 - xxxx - Pints Replaced
	blank
	Positions 13-16 - xxxx - Pints Not Replaced
	blank
	Positions 18-23 - $$$$¢¢ - Charge Per Pint
	blank
	Positions 25-31 - $$$$$¢¢ - Total Charges
	blank
	Positions 38-39 - $$$$$¢¢ - Noncovered Charges
I91	Accommodation (B-F Accommodations)
	Position 1 - Code BCDE or F
	blank
	Positions 3-5 - Total Days
	blank
	Positions 7-14 - $$$$$$¢¢ - Total Charges
	blank
	Positions 16-23 - $$$$$$¢¢ - Noncovered Charges
	Accommodation (G)
	Position 1 - Code (C for PIP Bills)
	blank
	blank
	blank
	blank
	blank

ITEM	
191(Cont.)	Positions 7-14 - $$$$$$¢¢ - Total Charges
	blank
	Positions 16-23 $$$$$$¢¢ - Noncovered Charges
192-195	Second - Fifth Accommodation
	Position 1 - Code
	blank
	Positions 3-5 - Total Days
	blank
	Positions 7-13 - $$$$$¢¢ - Total Charges
	blank
	Positions 15-21 - $$$$$¢¢ - Noncovered Charges
19H-T and 196-199 (other services)	Services
	Position 1 - Code H-T
	blank
	Positions 3-8 - $$$$$¢¢ - Total Charges
	blank
	Positions 10-15 - $$$$$¢¢ - Noncovered Charges
19U	Totals
	Positions 1-8 - $$$$$$¢¢ - Total Charges
	blank
	Positions 10-17 - $$$$$$¢¢ - Noncovered Charges
19V	Inpatient Deductible - $$$¢¢
19W	Blood Deductible
	xxx Blood Pints
	blank
	$$$$¢¢ - Charge Per Pint
	blank
	$$$$¢¢ - Blood Charges Paid by Patient
19X	Coinsurance
	Days
	blank
	$$$¢¢ - Rate
	blank
	$$$$$¢¢ - Amount of Coinsurance
19Y	Total Deductions - $$$$$$¢¢
201	From Date
202	Thru Date
210	Date Guarantee of Payment Began
220	Date Utilization Review Notice Received
230	Date Active Care Ended
240	Date Benefits Exhausted
250	Patient Status
	A = Date Discharged
	B = Date of Death
	C = Still Patient (interim billing)
260	Lifetime Reserve Days

ITEM	
270	Noncovered Days (or Leave Days)
280	Covered Days
290	Date Forwarded by Provider
310	Reimbursement Amount - $$$$$$¢¢
321	Noncovered Stay From Date
322	Noncovered Stay Thru Date
330	Nonpayment Code
340	Pre-Entitlement Psychiatric Days Used
350	Transfer Code for SNF
360	Date Approved
999	RTI Control Number

SAMPLE OF OUTPATIENT FORMAT

```
RTI CONSISTENCY REJECT     PROC DT 11/05/73     TYPE OF BILL - OUTPATIENT                    RTI CONTROL NO, 5186315107

99990 5186 315L 3173P   07 4  1       00     SICK    H     123456789A         120123              A
..... .... .... ........ .. . . . .... .. 010 ......... 020 ............ 070 ...... 090 1 100 .
                                                                                                  ERROR
   B              00/00/00                        000 0000000        000 0000000     C 0001900    0 0021684
131 . 132 ..... 141 ........ 142 ..... 15A ............. 15B ............. 15C ......... 15D 222222222   ERROR

      0000000         0000000         0090000       H 0002000      I 0002930      I 0007500      I 0004000
15E .......... 15F .......... 15G .......... 15H ..........151    .......... 152 .......... 153 ..........

      0000000         0000000         0000000         0040014       04/09/73      04/12/73      000     000     000
154 .......... 155 .......... 156 .......... 15J ........ 161 ......... 162 ......... 17A ... 17B ... 17C ...

     000000      000000      000000      001400      000000      00/00/00      000000      05/10/73      000000
17D ...... 17E ...... 18A ...... 18B 333333 190 ...... 200 ........ 210 ...... 230 ........ 24A ......
                                                                                                  ERROR
     00000      C08003      0032011      0000000      05/22/73
24B ..... 24C 222222 251 ........ 252 ........ 260 ......... 999 ..........   ERROR

                                        REASON FOR DELETION

     24C2 - THE COINSURANCE AMOUNT IS NOT EQUAL TO 20% OF TOTAL COVERED CHARGES IN ITEM 15J MINUS ALL OF THE AMOUNTS IN ITEMS
            18A, 18B, 19, 24A, AND 24D.

     0901 - TYPE OF SERVICE IS NOT A, B, OR C.

     15D2 - COVERED CHARGES ARE SHOWN, BUT TYPE OF SERVICE IS NOT A OR B.

                                        ONE  ADDITIONAL ERRORS
```

2. HCFA-1483 (Provider Billing for Medical and Other Health Services).--

ITEM	
010	Patient's Name
020	HI Claim Number
070	Provider Number
090	Type of Service
	A = Inpatient
	B = Outpatient
	C = Other
100	Insuring Organization
	(a 1-position code used by SSA)
131	Employment Related Injury
132	Nature of Illness
	(a 5-position code entered and used by SSA)
141	Surgical Procedure Date
142	Surgical Procedure Code
	(a 5-position code entered and used by SSA)

Statement of Services

15A	Clinic Visit and Emergency Room
15B	Code A = Clinic Visit
	Code B = Emergency Room
	blank
	Visits
	blank
	$$$$$¢¢ - Covered Charges
15C-H	Services
and 151-156	Code
	C = Laboratory
	D = Radiology
	E = Pharmacy
	F = Blood
	G = Ambulance
	H = Physical Therapy
	I = Other (up to 5 "other" services)
	blank
	$$$$$¢¢ - Covered Charges
15J	Totals - $$$$$¢¢
161	Date of First Service
162	Date of Last Service
17A	Pints of Blood Furnished - xxx
17B	Pints of Blood Replaced - xxx
17C	Pints Not Replaced - xxx
17D	Charge Per Pint - $$$$¢¢

ITEM	
17E	Patient Paid for Blood Deductible - $$$$¢¢
18A	Professional Component (Pathology) - $$$$¢¢
18B	Professional Component (Radiology) - $$$$¢¢
190	Other Professional Component - $$$$¢¢
200	Date Benefits Exhausted
210	Patient Paid - $$$$¢¢
230	Date Forwarded by Provider
24A	Blood Deductible - $$$$¢¢
24B	Cash Deductible - $$$¢¢
24C	Coinsurance - $$$$¢¢
251	Payment Distribution (Provider) - $$$$$¢¢
252	Payment Distribution (Patient) - $$$$$¢¢
260	Date Approved by Intermediary
990	RTI Control Number

SAMPLE OF CHRISTIAN SCIENCE FORMAT

```
     BILL CONSISTENCY REJECT      PROC DT 11/05/73        TYPE OF BILL - CHRISTIAN SCIENCE              BILL CONTROL NO. D413326705
 99990 0413 3267 3282M   05    1      CO     SICK   H      123456789A       08/29/73      126999
 ..... .... .... ........ .. . . . .... .. 010 ......... 030 ........... 070 ........ 090 ......
     B     B     B     A 004 00011500 00005750     B 015 0005280 0002305      0000000 0000000
 120 . 150 . 160 . 16A ..................... 16B ..................... 16C .................
      0000000 0000000       0000000 0000000       0000000 0000000       0000000 0000000       0000000 0000000
 161 ................. 162 ................. 163 ................. 164 ................. 165 .................
      0000000 0000000       0000000 0000000       0000000 0000000       0000000 0000000       00016780 00008055
 166 ................. 167 ................. 168 ................. 169 ................. 170 .................
    00000      000 00000 0000000    00000000    08/29/73    09/02/73     00/00/00     00/00/00
 18A ..... 18B 333.............. 18C ........ 191 ........ 192 ........ 200 ........ 210 ........                        ERROR
    00/00/00     00/00/00     A 09/02/73     00     0002     002     09/19/73     00007372
 220 ........ 230 ........ 240 .......... 250 .. 260 .... 270 ... 280 ........ 300 ........
    00/00/00     00/00/00             00/00/00
 311 ........ 312 ........ 320 . 330 ........ 999 ..........

                                             REASON FOR DELETION
    1083 - COINSURANCE DAYS ON SNF BILL SHOWN AS ZERO  ON INPATIENT BILL COVERED DAYS IN ITEM 27 MINUS COINSURANCE DAYS IN
          ITEM 18B EXCEED 60.
                                                      NO  ADDITIONAL ERRORS
```

3. HCFA-1486 (Inpatient Admission and Billing - Christian Science Sanatorium.--

ITEM	
010	Patient's Name
030	HI Claim Number
070	Date of Admission
090	Provider Number
120	Insuring Organization
	(a 1-position code used by SSA)
150	Employment Related Code
160	Type of Service
	(Inpatient or Extended Care)
16A,	Accommodations
16B	Code - A or B
	blank
	Days
	blank
	Code A - $$$$$$¢¢ - Total Charges - Code B - $$$$$¢¢
	blank
	Code A - $$$$$$¢¢ - Noncovered Charges - Code B - $$$$$¢¢
16C,	Nursing Supplies - Other
16D	Code - C or D
(1-9)	blank
	$$$$$¢¢ - Total Charges
	blank
	$$$$$¢¢ - Noncovered Charges
170	Totals
	$$$$$$¢¢ - Total Charges
	blank
	$$$$$$¢¢ - Noncovered Charges
18A	Inpatient Deductible - $$¢¢
18B	Coinsurance
	Days
	blank
	Rate - $$$¢¢
	blank
	Total Amount - $$$$$¢¢
18C	Total Deductions - $$$$¢¢
191	From Date
192	Thru Date
200	Date Guarantee of Payment Began
210	Date Utilization Review Notice Received
220	Date Active Care Ended
230	Date Benefits Exhausted
240	Patient Status
	Code
	A = Discharge
	B = Death
	C = Still Patient

ITEM	
	blank
	Date
250	Lifetime Reserve Days
260	Noncovered Days
270	Covered Days
280	Date Forwarded by Provider
300	Reimbursement Amount
311	Noncovered Stay From Date
312	Noncovered Stay Thru Date
320	Nonpayment Code
330	Date Approved by Intermediary
999	RTI Control Number

SAMPLE OF HOME HEALTH FORMAT

Rev. 762

```
RTI CONSISTENCY REJECT     PROC DT 11/05/73     TYPE OF BILL - HOME HEALTH                      RTI CONTROL NO. 9980316331

99990 9980 3163 3179Q  31 1     00    SICK   H        123456789a       127123     05/15/73
..... .... .... ........ .. . .... .. 010 .......... 020 ............ 070 ...... 100 ........

     00/00/00     00/00/00     05/15/73     A     R                          P     05/15/73
121 11111111 122 ......... 130 ......... 140 . 161 . 162 ..... 163 .... 164 . 171 ........                      ERROR

     05/31/73     C     00/00/00     A 006 0007800       000 0000000       000 0000000       000 0000000
172 ........ 190 . 200 ........ 21A .............. 21B .............. 21C .............. 21D .............

     000 0000000       000 0000000       000 0000000       000 0000000       000       00000
21E ............... 21F ............... 211 ............... 212 ............... 21H ..... 211 .......

     006 0007800     K 0001690       0000000       0000000       0000000       0009490       0000000
21J ............ 213 .......... 214 .......... 215 .......... 216 .......... 21L ........ 21M .......

     06/07/73           0009490     1000     00009490     00000     000000     0000000     0000
217 ......... 221 . 22A ........ 22B .... 22C ......... 23A ..... 23B ...... 23C ....... 23D 2222

     0000000     0000000     00009490     0000000     0000000     06/08/73
23E ....... 23F ....... 23G ........ 23H ....... 231 ....... 231 ........ 999 ..........
```

REASON FOR DELETION

1211 - THE FROM DATE IS IMPOSSIBLE, OR IS MISSING WHEN DATE CARE STARTED EQUALS FROM DATE IN ITEM 17 EXCEPT FOR PLAN CODE M.

NO ADDITIONAL ERRORS

4. **HCFA-1487 (Home Health Agency Report and Billing).**--

ITEM	
010	Patient's Name
020	HI Claim Number
070	Provider Number
100	Date Care Started
121	Verified Prior Stay From Date
122	Verified Prior Stay To Date
130	Date HH Plan Established
140	Payment Source
161	Employment Related
162	Diagnosis Code (Entered and used by SSA)
163	Appliance Code (Entered and used by SSA)
164	Plan Code
	P = Part A
	M = Part B
171	Statement Covers FROM Date
172	Statement Covers TO Date
190	Patient Status
	A = Discharged
	B = Died
	C = Still Receives Services
	D = Visits Exhausted
200	Date Applicable to Status
21A-F	Services
and 211-212	Code - 1 position
	A = Skilled Nursing
	B = Physical Therapy
	C = Speech Therapy
	D = Occupational Therapy
	E = Medical Social Services
	F = HH Aide
	G = Other
	blank
	Positions 3-5 - Visits
	blank
	Positions 7-13 - Charges - $$$$$¢¢
21H	Total Number of Units of Service
21I	Charge Per Unit of Service
21J	Totals
	Visits
	blank
	Charges - $$$$$¢¢
213-216	Other Services
	Code - K
	blank
	$$$$$¢¢

ITEM	
21L	Total Charges
21M	Amount Paid by Patient
217	Date Forwarded by Provider
221	Plan Code P = Part A M = Part B
22A	Total Charges
22B	Reimbursement Rate
22C	Reimbursement Amount
23A	Verified Deductible
23B	Verified Coinsurance
23C	Total Charges
23D	Reimbursement Rate
23E	Item 23C X 23D
23F	Item 23E - 23A
23G	Reimbursement Amount
23H	Refund to Patient
23I	Net Amount to Agency
231	Date Approved by Intermediary
999	RTI Control Number

SAMPLE OF NONCOVERED BILL

```
   BTI CONSISTENCY REJECT          PROC DT 02/21/73        TYPE OF BILL - NONCOVERED                BTI CONTROL NO. 2280210900

00270 2280 2109 2123 R    04 m n 1 0000 00      SYLVES G       0080790010        12/22/71      475017
.......................................... 010 ......... 020 ............ 030 ........ 040 ......

    8     07                     0074545      00/00/00       02/07/72      A 02/07/72      C      000
050 . 060 ..... 070 ..... 080 ....... 091 11111111  092 ........ 100 .......... 110 . 120 ...                                  ERROR

    03/30/72       03/31/72
130 ........ 140 ........ 999 ..........
```

REASON FOR DELETION - 1911 - FROM DT is impossible or incomplete

5. HCFA-1450 (Provider Billing for Inpatient Hospital and SNF).—

ITEM	
68	Patient Claim Number
3	Patient Control Number
040	Type of Bill
070	Provider Number
100	Patient's Name and Initials
120	Date of Birth
130	Sex
150	Date of Admission
210	Patient Status
220	Statement Covers Period (From Date and Thru Date)
230	Covered Days
240	Non-Covered Days (or Leave Days)
250	Co-Insurance Days
	a. First Year Co-Insurance Days
	b. Second Year Co-Insurance Days
260	Lifetime Reserve Days
	a.Total Lifetime Reserve Days
	b.Second Year Lifetime Reserve Days
281	Occurrence Code — 1
	Occurrence Date — 1
282	Occurrence Code — 2
	Occurrence Date — 2
283	Occurrence Code — 3
	Occurrence Date — 3
284	Occurrence Code — 4
	Occurrence Date — 4
285	Occurrence Code — 5
	Occurrence Date — 5
286	Occurrence Code — 6
	Occurrence Date — 6
287	Occurrence Code — 7
	Occurrence Date — 7
288	Occurrence Code — 8
	Occurrence Date — 8
289	Occurrence Code — 9
	Occurrence Date — 9
280	Occurrence Code — 10
	Occurrence Date — 10

ITEM	
331	Occurrence Span Code —1 Occurrence Span Dates —1 (From and Thru)
332	Occurrence Span Code —2 Occurrence Span Dates —2 (From and Thru)
333	Occurrence Span Code —3 Occurrence Span Dates —3 (From and Thru)
334	Occurrence Span Code — 4 Occurrence Span Dates — 4 (From and Thru)
335	Occurrence Span Code — 5 Occurrence Span Dates — 5 (From and Thru)
336	Occurrence Span Code — 6 Occurrence Span Dates — 6 (From and Thru)
337	Occurrence Span Code — 7 Occurrence Span Dates — 7 (From and Thru)
338	Occurrence Span Code — 8 Occurrence Span Dates — 8 (From and Thru)
339	Occurrence Span Code — 9 Occurrence Span Dates — 9 (From and Thru)
330	Occurrence Span Code — 10 Occurrence Span Dates — 10 (From and Thru)
351	Condition Code — 1
352	Condition Code — 2
353	Condition Code — 3
354	Condition Code — 4
355	Condition Code — 5
356	Condition Code — 6
357	Condition Code — 7
358	Condition Code — 8
359	Condition Code — 9
350	Condition Code — 10
400	Blood — Furnished Pints
410	Blood — Replaced Pints
420	Blood — Unreplaced Pints
430	Blood — Deductible Pints
440	Special Program Indicator

ITEM	
461	Value Code — 1
	Value Amount — 1
462	Value Code — 2
	Value Amount — 2
463	Value Code — 3
	Value Amount — 3
464	Value Code — 4
	Value Amount — 4
465	Value Code — 5
	Value Amount — 5
466	Value Code — 6
	Value Amount — 6
467	Value Code — 7
	Value Amount — 7
468	Value Code — 8
	Value Amount — 8
469	Value Code — 9
	Value Amount — 9
460	Value Code — 10
	Value Amount — 10

Revenue Code Fields Contain: 51 Code 52 Unit 53 Total Charges 54 Non-Cov Charges

(This item can occur up to 28 times: 511-510, 51A-51R)

511	Revenue Code
	Units
	TotalCharges
	Non-Covered Charges
512	Revenue Code
	Units
	TotalCharges
	Non-Covered Charges
513	Revenue Code
	Units
	TotalCharges
	Non-Covered Charges
514	Revenue Code
	Units
	TotalCharges
	Non-Covered Charges
515	Revenue Code
	Units
	Total Charges
	Non-Covered Charges

ITEM	
516	Revenue Code
	Units
	Total Charges
	Non-Covered Charges
517	Revenue Code
	Units
	Total Charges
	Non-Covered Charges
518	Revenue Code
	Units
	Total Charges
	Non-Covered Charges
001	Totals
Total Deduct	Total Deductible
770	Principal and Other Diagnosis Codes (ICD-9-CM) Show the principal diagnosis first.
840	Principal and Other Procedure Codes Show the principal procedure first.
94F	Reimbursement Amount

Missing Data Elements

OCC CODE	Occurrence Code
SPAN CODE	Span Code
COND CODE	Condition Code
REV CODE	Revenue Code
DRG	Diagnosis Related Grouping
PR DRG	Prior Diagnosis Related Grouping
HCFA DRG	HCFA Diagnosis Related Grouping
VER NC STAY	Verified Non-Covered Stay
PR PSC D	Prior Psychiatric Days
N-PYM CD	Non-Payment Code

Sample of Inpatient Hospital and SNF Format

```
                                                                                          ***** PAGE 00329 *****
HI1 CONSISTENCY REJECT     PROC DT 01/17/85     TYPE OF BILL - INPAT      (UNIBILL)    HI1 CONTROL NO. 4351627003

00270  A836  5031  5031L  00      1                                     431256789A
.....  ....  ....  .....  ..      .      .       ..      .      .     .  ...........  ................
INTER  BATCH NO    BLOCK  SEQ    ACT    CD     ANBC    PAT    JOIN   RNG  CLAIM NUMBER  PAT CNTL NUMBER
 NO                              CDE    CDE    CDE     FILE   IND    FD   (ITEM 6a)       (ITEM 3)

    111       300001       UPPXN  LK       10/05/08        2      08/14/84       01        08/14/84 08/13/84       001
040 ...  070 ......  100 ...... ..  120 ........  130 .  150 ........  210 ..  220 2222222222222222  230 ...       ERROR

    0000     000 000      000 000      00 00000000      00 00000000      00 00000000      00 00000000      00 00000000
240 ....  250 .......  260 .......  281 ...........  282 ...........  283 ...........  284 ...........  285 ...........

    00 00000000     00 00000000     00 00000000     00 00000000     00 00000000     00 00000000 00000000
286 ...........  287 ...........  288 ...........  289 ...........  280 ...........  331 ....................

    00 00000000 00000000     00 00000000 00000000     00 00000000 00000000     00 00000000 00000000
332 ....................  333 ....................  334 ....................  335 ....................

    00 00000000 00000000     00 00000000 00000000     00 00000000 00000000     00 00000000 00000000
336 ....................  337 ....................  338 ....................  339 ....................

    00 00000000 00000000     00      00      00      00      00      00      00      00      00      00
330 ....................  351 ..  352 ..  353 ..  354 ..  355 ..  356 ..  357 ..  358 ..  359 ..  350 ..

    000      000      000      00              01 00001210     07 00003540     00 00000000     00 00000000
400 ...  410 ...  420 ...  430 ..  440 ..  441 ...........  442 ...........  443 ...........  444 ...........

    00 00000000     00 00000000     00 00000000     00 00000000     00 00000000     00 00000000
445 ...........  446 ...........  447 ...........  448 ...........  449 ...........  460 ...........

REVENUE CODE FIELDS CONTAIN:  51 CODE 52 UNIT 53 TOTAL CHARGES 54 NONCOV CHARGES
UP TO 7 LINES (Occurs 23 Times) 511-519, 51A-51N

    200 001 00002650 00000000       300 000 00000776 00000000       320 000 00000783 00000000       941 000 00000303 00000000
511 .........................  512 .........................  513 .........................  514 .........................

    001 000 00004512 00000000       000 000 00000000 00000000       000 000 00000000 00000000       000 000 00000000 00000000
515 .........................  516 .........................  517 .........................  518 .........................

                                  - THIS HI1 CONTINUES ON NEXT PAGE -
```

```
      001 000 00004512 00000000                    4019

TOTALS .......................... TOTAL  ........ 770 .............................. 040 .................
(001)                             DEDUCT

            00000000

REIMB AMT (04F) ......... MISSING DATA ELEMENTS :  OCC CODE ..  SPAN CODE ..  COND CODE ..  REV CODE ..

     134        000                              00/00/00 00/00/00 000
DXG  ...  PR DXG ...  HCPA DXG  ...  VAR AC STAY  ..................  PR PSC D  ...  N-PSN-CD .


                                          REASON FOR DELETION

3302 -  The "From" date is later than the "Thru" date.


                                          NO ADDITIONAL ERRORS
```

6. HCFA-1450 (Provider Billing for Outpatient/Hospice/Home Health and CORF).-

ITEM	
68	Patient Claim Number
3	Patient Control Number
040	Type of Bill
070	Provider Number
100	Patient's Name and Initials
120	Date of Birth
130	Sex
150	Date of Admission
210	Patient Status
220	Statement Covers Period (From Date and Thru Date)
230	Covered Days
240	Non-Covered Days (or Leave Days)
250	Co-Insurance Days
	a. First Year Co-Insurance Days
	b. Second Year Co-Insurance Days
260	Lifetime Reserve Days
	a. Total Lifetime Reserve Days
	b. Second Year Lifetime Reserve Days
281	Occurrence Code — 1
	Occurrence Date — 1
282	Occurrence Code — 2
	Occurrence Date — 2
283	Occurrence Code — 3
	Occurrence Date — 3
284	Occurrence Code — 4
	Occurrence Date -- 4
285	Occurrence Code — 5
	Occurrence Date — 5
286	Occurrence Code — 6
	Occurrence Date — 6
287	Occurrence Code — 7
	Occurrence Date -- 7
288	Occurrence Code — 8
	Occurrence Date -- 8
289	Occurrence Code — 9
	Occurrence Date -- 9
280	Occurrence Code — 10
	Occurrence Date — 10

ITEM	
331	Occurrence Span Code —1
	Occurrence Span Dates —1 (From and Thru)
332	Occurrence Span Code —2
	Occurrence Span Dates —2 (From and Thru)
333	Occurrence Span Code —3
	Occurrence Span Dates —3 (From and Thru)
334	Occurrence Span Code — 4
	Occurrence Span Dates — 4 (From and Thru)
335	Occurrence Span Code — 5
	Occurrence Span Dates — 5 (From and Thru)
336	Occurrence Span Code — 6
	Occurrence Span Dates — 6 (From and Thru)
337	Occurrence Span Code — 7
	Occurrence Span Dates — 7 (From and Thru)
338	Occurrence Span Code — 8
	Occurrence Span Dates — 8 (From and Thru)
339	Occurrence Span Code — 9
	Occurrence Span Dates — 9 (From and Thru)
330	Occurrence Span Code — 10
	Occurrence Span Dates — 10 (From and Thru)
351	Condition Code — 1
352	Condition Code — 2
353	Condition Code — 3
354	Condition Code — 4
355	Condition Code — 5
356	Condition Code — 6
357	Condition Code — 7
358	Condition Code — 8
359	Condition Code — 9
350	Condition Code — 10
400	Blood — Furnished Pints
410	Blood — Replaced Pints
420	Blood — Unreplaced Pints
430	Blood — Deductible Pints
440	Special Program Indicator

ITEM	
461	Value Code — 1 Value Amount — 1
462	Value Code — 2 Value Amount — 2
463	Value Code — 3 Value Amount — 3
464	Value Code — 4 Value Amount — 4
465	Value Code — 5 Value Amount — 5
466	Value Code — 6 Value Amount — 6
467	Value Code — 7 Value Amount — 7
468	Value Code — 8 Value Amount — 8
469	Value Code — 9 Value Amount — 9
460	Value Code — 10 Value Amount — 10

Revenue Code Fields Contain: 51 Code 52 Unit 53 Total Charges 54 Non-Cov Charges

(This item can occur up to 28 times: 511-510, 51A-51R)

511	Revenue Code Units TotalCharges Non-Covered Charges
512	Revenue Code Units TotalCharges Non-Covered Charges
513	Revenue Code Units TotalCharges Non-Covered Charges
514	Revenue Code Units TotalCharges Non-Covered Charges

ITEM

001	Totals
Total Deduct	Total Deductible
770	Principal and Other Diagnosis Codes (ICD-9-CM) Show the principal diagnosis first.
840	Principal and Other Procedure Codes Show the principal procedure first.
94F	Reimbursement Amount

Missing Data Elements

OCC CODE	Occurrence Code
SPAN CODE	Span Code
COND CODE	Condition Code
REV CODE	Revenue Code
BLD DED	Blood Deductible
CASH DED	Cash Deductible
COIN	Coinsurance
PROV DIST	Provider Distribution
PAT DIST	Patient Distribution

Sample of Outpatient/Hospice/Home Health and CORF Format

```
                                                                      ***** PAGE 00106 *****

BTI CONSISTENCY REJECT      PROC DT 01/11/85       TYPE OF BILL - OUTPAT      (UNIBILL)     BTI CONTROL NO.  0000316333

00020  L033  4335  4270P  34     1                                        210007654A
.....  ....  ....  .....  ..     .     .      ..     .      .      .     ...........   ................
INTER  BATCH  NO   BLOCK  SEQ   ACT    CD    ASSC   PAT    RRUN   IND   CLAIM NUMBER  PAT CNTL NUMBER
 NO                             CDE    CDE   CDE    FILE   IND    PD     (ITEM 60)        (ITEM 3)

   131       040030      HANSON JA      07/14/10      1      00/00/00              07/06/84 07/06/84      000
040 ...  070 ......  100 ...... ..  120 ........  130 .  150 ........  210 ..  220 ................  230 ...

   0000       000 000       000 000       00 00000000       00 00000000       00 00000000       00 00000000       00 00000000
240 ....  250 .......  260 .......  281 ...........  282 ...........  283 ...........  284 ...........  285 ...........

   00 00000000      00 00000000      00 00000000      00 00000000      00 00000000      00 00000000 00000000
286 ...........  287 ...........  288 ...........  289 ...........  290 ...........  331 ....................

   00 00000000 00000000      00 00000000 00000000      00 00000000 00000000      00 00000000 00000000
332 ....................  333 ....................  334 ....................  335 ....................

   00 00000000 00000000      00 00000000 00000000      00 00000000 00000000      00 00000000 00000000
336 ....................  337 ....................  338 ....................  339 ....................

   00 00000000 00000000      00      00      00      00      00      00      00      00      00      00
340 ....................  351 ..  352 ..  353 ..  354 ..  355 ..  356 ..  357 ..  358 ..  359 ..  360 ..

   000      000      000      00               05 00000250      00 00000000      00 00000000      00 00000000
400 ...  410 ...  420 ...  430 ..  440 ..  441 ...........  442 ...........  443 ...........  444 ...........

   00 00000000      00 00000000      00 00000000      00 00000000      00 00000000      00 00000000
445 ...........  446 ...........  447 ...........  448 ...........  449 ...........  450 ...........

REVENUE CODE FIELDS CONTAIN:  51 CODE 52 UNIT 53 TOTAL CHARGES 54 NONCOV CHARGES
UP TO 7 LINES (Occurs 28 Times) 511-510, 51A-51K

    450 001 00000190 00000000      731 000 00000330 00000000      981 000 00000250 00000000      001 001 00000770 00000000
 511 ........................  512 ........................  513 ........................  514 ........................

                                   - THIS BTI CONTINUES ON NEXT PAGE -
```

```
       001 001 00000770 00000000
TOTALS ...........................  TOTAL  ........  770 ...............................  840 ..................
(001)                               DEDUCT

              00004160
REIMB AMT (94F) .........  MISSING DATA ELEMENTS :  UCC CLAIM ..  [illegible] CLAIM ..  CLMD CLAIM ..  [illegible] CLAIM ..

         0000000            0000000         0001040                 0004160            0000000
BLD DED .......  CASH  DED .......  COIN 1111111  PROV DIST .......  PAT DIST .......

                                                                                                        ERROR

                                   REASON FOR REJECTION
#031 -  This amount is not equal to 20 percent of the total of covered charges minus the sum of the verified blood and
        cash deductible amounts.

                                   NO ADDITIONAL ERRORS
```

3833. ACTION ON RETURNED BILLS AND/OR BILLS AUTOMATICALLY CORRECTED AND REINSTATED BY HCFA.

A. Rejected Bills.—When a bill is deleted by HCFA due to failing a consistency or utilization/identification edit, HCFA identifies the rejected bill and shows the reason for its deletion on the interim or final batch record. When notified of an error condition, refer to the file copy of the bill and correct the error(s). Resubmit corrected billing data to HCFA unless:

1. A duplicate billing is identified by the error condition; or
2. An automatic correction has been performed by HCFA for the error condition.

An exception record, RTI Consistency Reject or RTI Utilization Reject listing, furnished in conjunction with all error conditions, except those conditions automatically corrected contain data to help correct the error condition. The exception record also contains the RTI control number which must accompany the resubmitted billing data. Refer to §§ 3804ff., for complete instructions for processing rejected bills.

1. Void Bills—Void any rejected bill which should not have been submitted. The void bill will delete the open admission queried (admission date appears on the void bill) and decontrol the rejected bill from the RTI control file.

Voiding rejected bills should not be confused with "Cancel Only" adjustment bills discussed in §3816C2. A "Cancel Only" adjustment bill is used to delete a bill which has been posted to the beneficiary's record. A VOID bill is used to delete a rejected and returned bill.

2. Correction Bills--When the admission date on a corrected bill differs from the admission date on the original bill, delete query the erroneous admission date. The HI system uses the admission date as one of the matching criteria. If the corrected bill carries a different admission date, the system cannot identify and remove the rejected item from the beneficiary's record. If the delete query does not change the erroneous date, the corrected bill may be blocked from posting. If the admission date must be changed on more than one bill for the same beneficiary for the same stay, transmit one delete query for each bill affected or refer to the procedures in § 3838.

Refer to § 3804ff., for additional instructions for processing controlled rejected bills.

B. Bills Automatically Corrected by HCFA—HCFA automatically corrects bills failing certain edits instead of returning them for correction.

The types of situations adjusted by HCFA are:

1. Overapplied Part A blood deductible.

2. Underapplied Part A Blood deductible.
3. Overapplied Part A cash deductible.
4. Overutilization of full days.
5. Underutilization of nonlifetime coinsurance days.

The above adjustments are identified on batch records via a specific correction code. (See §3828.3.) If a bill fails additional edits, the bill data is returned to you for correction. When you are notified that billing data has been adjusted by HCFA, refer to the file copy of the bill, if available, and/or history file, and make the changes indicated by the process code.

All necessary refunds for overcollected Part A cash and blood deductibles and overcollected coinsurance (§§ 3715-3715.7) or recoupments of undercollected Part A blood deductibles and undercollected coinsurance (§§3707-3714.4) must be made. If you possess supporting documentation which disagrees with the HCFA correction, prepare adjustment bills. (See §3816.) Make certain that the "credit" portion of an adjustment action shows the data which HCFA recorded after it made an automatic correction; i.e., if HCFA removes the cash deductible, any "credit" or "cancel only" actions must not show a cash deductible. Only the "debit" portion should show the cash deductible as applied.

Direct all automatic correction problems which you are unable to resolve to:

Health Care Financing Administration
Division of Provider Procedures, BPO
1-H-3 Meadows East Bldg.
Baltimore, MD 21207

NOTE: You are expected to correct your internal records when an automatic correction code is received on a submitted bill whether or not the bill represents the start of a benefit period. (Make the appropriate refund if an overcollection is involved.) The only exception is if a bill should have started the benefit period and a smaller deductible would have been applicable. In this case, adjust the bill for subsequent services, which has already been updated, and resubmit the bill which was automatically corrected. Send a letter of explanation with a copy of the automatically corrected bill and related batch record to the above address.

C. Other Returned Bills.--In addition to bills removed from the processing system prior to the updating of the utilization records, certain bills may be returned to you after the completion of processing. They are not RTI bills and could involve requests for development or investigation of some aspect of the bill or verification of certain data. HCFA clearly identifies and distinguishes each of these from bills which must be reentered into the processing system for updating purposes.

D. MCE Errors.--Bills failing MCE edits in HCFA are identified as errors. You do not need to correct individual bills. However, you must determine the cause of the error and correct the problem. Bills failing MCE edits are accepted and processed by HCFA if there are no other errors.

Bill Processing Criteria

3835. INPATIENT BILL PROCESSING CRITERIA

Phase I "as is" Bill Processing

Effective February 1983, inpatient hospital bills containing a deductible amount greater than zero have been processed on the following basis:

1. If there is no blocking open item (earlier admission which has not been closed by a billing), all consistency and utilization edits are applied. If the billing does not fail any of these edits, it is posted.

2. If there is only 1 blocking open item, it is bypassed if:

a. There is no Part A record present (no Part A bills have been processed);

b. There is a Part A record present and the blocking open item is not linked to a benefit period (the difference between the date of last billing action and blocking open item admission date is more than 60 days); or

c. There is a Part A record and the blocking open item is linked to a benefit period and the blocking open item admission/from date or billing "thru" date, if present; e.g., bill in orbit, is 75 days or more from the earliest billing date on the incoming bill.

3. If there are 2 or more blocking open items, the incoming bill is put on the orbit file.

4. If the incoming bill passes the under met deductible edit, it is used to begin a new benefit period under both conditions 1 or 2. If the bill fails this edit, the bill rejects under condition 1*, but the bill is put on the orbit file under condition 2.

*EXCEPTION: The incoming bill is accepted (posted) whether or not any hospital inpatient deductible amount has been applied on the bill and whether or not any deductible remains to be met, provided the deductible on the bill is not greater than that to be met and it matches an open admission queried which received a disposition code 37 (see §3512.7), and:

a. There is an open admission for a later date which received a disposition code 25 or 01 (see §3512.7) and it is for an inpatient hospital provider number; and

b. The interim billing through/discharge date is within the same benefit period as the 25/01 admission date.

If all of the *EXCEPTION criteria are not met, the bill goes through the usual deductible edits.

Phase II "as is" Bill Processing (Replaces Phase I)

Effective February 1985, bills are processed "as is" using out-of-sequence routines to post as many bills as possible. Bills are posted in order of receipt, provided the applicable "Benefit period" (spell of illness) can be determined and sufficient benefits of the type shown on the incoming bill are available.

Benefit periods are activated or continued by comparing prior stay dates (see §3620), ITEM 32) and/or current stay billing dates on an incoming bill with open admissions and benefit period information contained on the master records as follows:

1. An incoming bill (SNF or inpatient hospital) is processed and activates a new benefit period if:

a. Less than a full inpatient deductible (none or partial) applied to the incoming bill.
Fewer than 60 days elapse between an earlier admission-from-discharge date of record and the admission and/or from date on the incoming bill.
No date of last billing action (DOLBA);

b. Less than a full inpatient (none or partial) applied to the incoming bill.
Fewer than 60 days elapse between an earlier admission-from-discharge date of record and the admission and/or from date(s) on the incoming bill.
60 or more days elapse between the admission-from date of record and each DOLBA;

c. The admission and/or from date(s) on the incoming bill are each 60 or m[illegible] days later than each DOLBA of record.
There is no earlier open admission-from date-of-record (presence or absence of an inpatient deductible amount on the incoming bill is not material to activating a benefit period, but if a covered bill is involved, it may result in a rejection for an underapplied inpatient deductible);

d. A full inpatient deductible is present on the incoming bill.
75 or more days elapse, between the admission and/or from date(s) on the incoming bill.
Each DOLBA of record (presence or absence of an earlier open admission or the number of days elapsing between an earlier admission of record and an admission-from date on the incoming bill is not material to activating a benefit period in this instance).

2. A benefit period of record is continued with the processing (posting or deleting) of an incoming bill if the admission-from dates on the bill are fewer than 60 days later than at least one DOLBA of record, or an open admission of record which is less than 60 days of a DOLBA of record.

3. To post bills beginning or continuing benefit periods, the benefits shown as used on the bill must conform to benefits available for the benefit period and the inpatient deductible and/or coinsurance amounts must be applied on the bill as required.

An incoming bill is placed on the orbit file only if it cannot continue or begin a benefit period under the criteria set forth above. Thus, an inpatient hospital bill is placed on the orbit file only if it does not contain an inpatient deductible, and if:

A. All earlier open admissions of record are 60 or more days later than all DOLBA's of record and the admission-from dates on the incoming bill are 60 or more days later than the earlier open admission-from date of record;

B. An earlier open admission-from date exists which is less than 60 days later than DOLBA of record, but the admission-from date(s) on the incoming bill are 60 or more days later than the admission-from date of record; or

C. The admission-from date(s) is subsequent to the billing through date of a bill placed on the orbit file under the conditions in A or B, and the admission-from date is less than 60 days later than the earlier orbiting bill through date.

An inpatient SNF bill is placed on the orbit file if one of the conditions in A through C is applicable.

Whenever a bill is posted in a spell of illness where full or coinsurance days have not been used to the extent possible, HCFA places indicator "A" on the BATCH CLEARANCE DETAIL RECORD of the BATCH CLEARANCE TAPE along with the days remaining after subtracting the benefits used on the incoming bill from the record. (See §3830.1.)

If a bill is posted in a spell of illness which shows 1 or more pints of blood furnished and a like number of blood pints have not been applied toward the blood deductible and HCFA's master record shows that the 3 pint blood deductible remains to be met, an indicator code A with the amount of blood deductible to be met appears on the BATCH CLEARANCE DETAIL RECORD of the BATCH CLEARANCE TAPE.

Examples Using "As Is Bill Processing Criteria (phase II):

DOEBA = Date of Earliest Billing Action for a benefit period.

DOLBA = Date of Latest Billing Action for a benefit period.

Trailer Codes:

C = Closed (Bill Posted)

D = Open (Admission)

G = Open (Generated)

O = Orbit (Benefit period cannot be established and billing is out of sequence)

R = RTI (Rejected)

U = Utilization (Utilization investigation)

Criteria 1a.

Master Part A record - Before Posting Bill

Hospital	SNF	Inpat. Deduct to be Met	DOEBA	DOLBA
Full Co.	Full Co.			

Admission Control Record - Before Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XXOXXX	04/03/80		
D	XXOXXX	05/29/80		

Bill for May 29, 1980 admission shows:

- Inpatient deductible of $160.00 (discounted charges or covered charges equal to applied deductible),
- Current billing dates of May 29, 1980 through May 31, 1980, and
- Two full inpatient hospital days.

The current billing would be posted since less than 60 days have elapsed between the current stay admission date and the admission-from date on the master record. The presumption is that the earlier open item must be for a noncovered stay or a covered stay with a partially applied deductible that would have started the benefit period if posted. Therefore, the current stay billing is permitted to activate the benefit period by posting and continuing it. The same would be true even if 60 or more days had elapsed between the billing current stay admission and the admission of record if the current stay billing contained a prior stay "from" date which was within 60 days of the admission-from date of record.

Master Part A Record - After Posting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
58	30	20	80	$10.00	05/29/80	05/31/80

Admission Control Record - Before Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XXOXXX	04/03/80		
C	XXOXXX	05/29/80	05/29/80	05/31/80

Criteria lb.

Master Part A Record - Before Posting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
40	30	20	80	None	04/20/82	05/10/82

Admission Control Record - Before Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XXOXXX	01/20/82		
D	XXOXXX	01/25/82		

Bill for January 25, 1982, admission shows:

- o Inpatient deductible of $100.00 (discounted charges or covered charges equal to applied deductible),
- o Current billing dates of January 25, 1982, through January 26, 1982, and
- o One full inpatient hospital day

The current stay billing would be posted since less than 60 days have elapsed between the current stay admission date and the admission-from date for the open item on the master record. The presumption is that the earlier open item must be for a noncovered stay or a covered stay with a partially applied deductible that would have started the benefit period if posted. Therefore, the current stay billing is permitted to post and activate the benefit period and continue it. If the current stay billing had shown a discharge date of March 31, 1982 (discharge date within 60 days of April 20, 1982 DOEBA), the bill would have been linked to the benefit period of April 20, 1982 through May 10, 1982 and be automatically corrected for overapplied inpatient deductible.

Master Part A Record - After Posting Bill

Hospital		SNF		Inpat. Deduct. to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
40	30	20	80	None	04/20/82	05/10/82
59	30	20	80	$160.00	01/25/82	01/26/82

Admission Control Record - After Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	01/20/82		
C	XX0XXX	01/25/82	01/25/82	01/26/82

Criteria 1c.

Master Part A Record - Before Posting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
57	30	20	80	None	07/01/82	07/04/82
51	30	20	80	None	04/01/82	04/10/82
41	30	20	80	None	01/01/82	01/20/82

Admission Control Record - Before Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	09/02/82		
D	XX0XXX	09/15/82		

Bill for September 2, 1982, admission shows:

- Inpatient deductible of $260.00,
- Current billing dates of September 2, 1982 though September 10, 1982, and
- Eight full inpatient hospital days.

The current stay billing would be posted since it contains an inpatient hospital deductible and is consistent with activating and starting a benefit period once it is posted. If the bill did not show any deductible applied, the bill would reject for an underapplied deductible condition. If the bill for the September 15, 1982 admission had been posted showing the $260.00 deductible applied first, the billing for the September 2, 1982 admission would have been automatically corrected because of an overapplied deductible.

Master Part A Record - After Posting Bill

Hospital		SNF		Inpat. Deduct. to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
52	30	20	80	None	09/02/82	09/10/82
57	30	20	80	None	07/01/82	07/04/82
51	30	20	80	None	04/01/82	04/10/82
41	30	20	80	None	01/01/82	01/20/82

Admission Control Record - After Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
C	XX0XXX	09/02/82	09/02/82	09/10/82
D	XX0XXX	09/15/82		

Criteria 1d.

Master Part A Record - Before Posting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
51	30	20	80	None	07/01/82	07/10/82
51	30	20	80	None	04/01/82	04/10/82

Admission Control Record - Before Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX5XXX	09/07/82		
D	XX0XXX	09/30/82		

Bill for September 30, 1982 admission shows:

- Inpatient deductible of $260.00,
- Current billing dates of September 30, 1982, through October 4, 1982, and
- Five full inpatient hospital days.

The current stay billing would be posted since it contains a full inpatient deductible. A presumption is made that the stay for the September 7, 1982, admission is noncovered. The admission of September 7, 1982 is a SNF (5 in third position of provider number) which makes this presumption valid because of the qualifying stay requirement. However, the noncovered presumption would be made even if the September 7, 1982, admission had been for an inpatient hospital (0 in third position of provider number).

Master Part A Record - After Posting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
55	30	20	80	None	09/30/82	10/04/82
57	30	20	80	None	07/01/82	07/04/82
51	30	20	80	None	04/01/82	04/10/82

Admission Control Record - After Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	09/07/82		
C	XX0XXX	09/15/82	09/15/82	09/20/82

Criteria 2.

Master Part A Record - Before Posting Bill

Hospital	SNF	Inpat. Deduct to be Met	DOEBA	DOLBA

Full	Co.	Full	Co.			
14	30	20	80	None	06/15/82	07/30/82
51	30	20	80	None	04/01/82	04/10/82

Admission Control Record - Before Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	08/01/82		
D	XX0XXX	09/01/82		

Bill for September 1, 1982, shows:

- o Ten coinsurance days, and
- o Current billing dates of September 1, 1982, through September 11, 1982 (discharge).

The bill would be posted as continuing the benefit period since its billing dates are within 60 days of the July 30, 1982, DOLBA. The presumption is that the admission of August 1, 1982, exhausted the 14 full days shown as available. If the August 1, 1982 admission were not present, the bill for the September 1, 1982, admission would reject for underapplied full days. If the bill for the September 1, 1982 admission showed all full or a combination of full and coinsurance days, the presumption would be that the bill for the August 1, 1982, admission did NOT use all of the full days available and the current stay bill would be posted.

Master Part A Record - After Posting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
14	20	20	80	None	06/15/82	09/11/82
51	30	20	80	None	04/01/82	04/10/82

Admission Control Record - After Posting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	08/01/82		
C	XX0XXX	09/01/82	09/01/82	09/11/82

Criteria 3.

Master Part A Record - Before Rejecting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
00	20	20	80	None	05/01/82	07/10/82

Admission Control Record - After Rejecting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	09/02/82		
R	XX0XXX	09/15/82	09/15/82	10/05/82

Orbit Criteria for criteria A-C

Master Part A Record - Before Orbiting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
40	30	20	80	None	04/01/82	04/21/82
50	30	20	80	None	01/01/82	01/11/82

Admission Control Record - Before Orbiting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	07/01/82		
D	XX0XXX	09/07/82		

Bill for September 7, 1982, shows:

- Ten full days, and
- Current billing dates of September 7, 1982, through September 17, 1982 (discharge).

The bill is placed on the orbit file since:

- No inpatient deductible is present,
- More than 60 days elapse between the September 7, 1982, admission on the billing, the open admission, and DOLBA of record.

If the bill had contained an inpatient hospital deductible, it would be posted (provided the proper deductible was shown on the bill) because it would be consistent with starting a new benefit period.

Master Part A Record - After Orbiting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
40	30	20	80	None	04/01/82	04/21/82
50	30	20	80	None	01/01/82	01/11/82

Admission Control Record - After Orbiting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	07/01/82		
D	XX0XXX	09/07/82	09/07/82	09/17/82

Master Part A Record - Before Orbiting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
40	30	20	80	None	04/01/82	04/21/82
50	30	20	80	None	01/01/82	01/11/82

Admission Control Record - Before Orbiting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	06/01/82		
D	XX0XXX	09/07/82		

Bill for September 7, 1982, shows:

- Ten noncovered days, and
- Current billing dates of September 7, 1982, through September 17, 1982 (discharge).

The bill is placed on the orbit file since:

- More than 60 days elapse between the September 7, 1982, and the earlier June 1, 1982 admission of record, and

- o Each DOLBA of record.

The bill could begin or continue a benefit period, but a valid decision cannot be made until the discharge date is known for the June 1, 1982 admission.

Master Part A Record - After Orbiting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
40	30	20	80	None	04/01/82	04/21/82
50	30	20	80	None	01/01/82	01/11/82

Admission Control Record - After Orbiting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	06/01/82		
D	XX0XXX	09/07/82	09/07/82	09/17/82

Master Part A Record - Before Orbiting Bill

Hospital		SNF		Inpat. Deduct to be Met	DOEBA	DOLBA
Full	Co.	Full	Co.			
40	30	20	80	None	04/01/82	04/21/82
50	30	20	80	None	01/01/82	01/11/82

Admission Control Record - Before Orbiting Bill

Trailer	Provdr. No.	Admission	From	Discharge
D	XX0XXX	06/01/82		
O	XX0XXX	09/07/82	09/07/82	09/17/82
D	XX0XXX	09/25/82		

If a bill is received for the 9/25/82 admission, it is placed on the orbit file since its admission date is within 60 days of the 9/17/82 discharge date (billing through) of the bill in orbit.

The same routines (comparisons of billing dates) take place for SNF stays under the "Orbit Criteria for A-C Criteria," but the absence of an inpatient hospital deductible would not be a factor in placing such stays on the orbit file.

Health Care Financing Administration

Records Requirement and Analysis Branch
Room 596 East Bldg.
Baltimore, Maryland 21235

Date: ____________________

Page ___ **of** ___

I. **Intermediary request for return of orbit bills and removal of "G" and erroneous "R" open items.**

(An explanation of the use of this letter can be found in the Part A Intermediary Manual, Section 3838.)

Request submitted by: ______________, **Telephone No.:** ____________________

(PLEASE TYPE INFORMATION)

#	Surname	F. I.	M. I.	Health Insurance Number	Adm. Date	From Date	Batch Number	Julian Date
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

II. **HCFA acknowledgment of intermediary request:**

HCFA received: __/__/__, **by:** ________________, **Telephone No.** ____________

Please allow 60 days to receive the "RTI UTILIZATION REJECT" notices for the bills requested (error code: 5900). Should you have questions regarding the above, you may contact the person acknowledging your request.

(Type Intermediary address within space)

Intermediary Number:

___ ___ ___ ___ ___

3838 REQUESTS FOR DELETION OF SELECTED ORBITING BILLS AND OPEN ITEMS (G AND ERRONEOUS R TRAILERS)

When you investigate the cause for the receipt of a rejected bill, you may determine that a bill is in orbit which contains erroneous information and that it should be returned to you for correction. For example, a bill may have been returned for error code 5611 (bill dates overlap the next open item). In this case, once you determine that the related orbiting bill(s) is in error, have the related orbiting bill(s) deleted from HCFA's system (error code 5900) prior to resubmitting the related rejected bill. When the incorrect orbiting bill(s) are received, the pending rejected bill(s) may then be resubmitted. The bill(s) returned from orbit should also be corrected and resubmitted to HCFA. If the incorrect orbiting bill(s) is the responsibility of another intermediary, that other intermediary should be contacted and requested to delete the erroneous orbiting bill(s). Confirmation that the other intermediary has in fact had the erroneous orbiting bill(s) deleted should also be requested (and received prior to resubmitting the original rejected bill back to HCFA.)

Since HCFA does not create an open item for bills deleted as error code 5900, it may be advisable to submit an admission query for the correct date in order to prevent the processing of subsequent (correct) orbiting bills that may be released when the requested oribiting bill is deleted.

To facilitate intermediary access to the orbit file, a standardized letter has been developed (you should make copies as needed from the sample provided).

The following information pertains to its use:

1. The day, the month, and the year the letter is submitted to HCFA should be entered in the "date" area in the upper right hand corner of the letter.

2. The full name and telephone number and extension of the person requesting the orbiting bills should be provided in case HCFA needs clarification of the information provided. This information will also assist you in directing the acknowledgment to the appropriate person.

3. As many of the letters of the surname, that space permits, should be given, as well as the first and middle initials.

4. The Admission (Adm.) and From dates should consist of six numeric characters. This information is very important, and care should be taken to enter the information accurately.

5. Always enter the complete batch number and Julian date of the orbiting bill(s) to be deleted.

6. The HCFA employee receiving the request will enter the date the request is received by him and sign the letter in the space provided, and also give his telephone number.

A xerox of the letter will be made and returned to the intermediary. This will serve as the only interim correspondence. The final disposition will be with the RTI utilization reject data (error code 5900) showing the requested bill. If you do not receive the respective RTI utilization reject data in approximately 60 days following the receipt date entered by HCFA, Submit a status query of the beneficiary's record, if the open item is still showing, contact should be made with the appropriate HCFA employee. If the open item is not listed, proceed with correcting the beneficiary's record.

7. If the requested orbit bill had generated a "G" open item, HCFA will also delete that open item (G). See § 3831.1, item 110 for an explanation of "G" open items.

8. This letter should also be used to request HCFA to remove open items that the intermediary cannot delete query. The same information required to return orbitting bills is also needed for this procedure.

EXAMPLE: The intermediary has multiple "R" open items with the same admission date for the same beneficiary and determines that some or all of these bills should be voided or that the admission date must be corrected. "R" open items are created by bills being returned to the intermediary with errors. See § 3833 for instructions on correcting and voiding bills.

You should wait 30 days from the day entered by HCFA as the day the request was received.

After the 30 days have elapsed, query (status query code 5) the beneficiary's record to confirm the deletion of the erroneous "R" open item (HCFA does not generate a notice indicating the removal of the erroneous open item).

9. At the bottom of the letter, a rectangular space is provided for your address. The return address should include the requester's name. Also, your identification number should be entered to the right of the rectangular space. No part of the address should be entered outside of the lines of this figure.

If more than 10 beneficiaries are involved, enter the pertinent information for each beneficiary (in the same order as provided in the sample) on a blank sheet(s) of paper and staple it to the standardized letter.

If more than one bill on a particular record is being requested from "orbit," you need only enter the Admission Date, From Date, and Batch Number and Julian Date for the additional bills under the first bill requested.

3838.7 Elimination of Blocking Open Items From Saturated Records.--As transactions are posted at HCFA the beneficiary record will sometimes become saturated, i.e., the file will contain the maximum number of 30 open items. When this occurs it becomes necessary to eliminate the oldest blocking item in order to process subsequent transactions.

In these instances HCFA will automatically forward a health insurance insurance printout (HIPO) (see § 3838.8) designating the oldest blocking item. You should resolve the blocking item within 30 days by:

A. Submitting or resubmitting a corrected bill through the approved bill submission process. When this it done, forward a xerox copy of the bill submitted accompanied by the appropriate batch number in which the bill was submitted to:

Health Care Financing Administration
Claims Processing Branch
Bureau of Support Services
3-H-21 Operations Building
Baltimore, Maryland 21235

B. Generating a delete query if appropriate, or

C. Informing the Medicare Bureau that you are not able to process the claim within 30 days of the date of the HIPO. When this occurs telephone the Part A Systems Branch at (301) 594-8732.

3838.8 Health Insurance Printout-Purpose and Scope.--The HIPO provides up-to-date reference to the HI master tape record. All pertinent fields on the tape, many of which are coded, are converted to straight alphabetical/nemerical data, captioned for ease of reference, and displayed in a logical sequence.

The data displayed on a HIPO represents the data contained on the HI master tape records as of the date the finder card was processed in the HI daily system. If a series of nines (i.e., 999999) is displayed in any date field on a HIPO, this means that the date on the HI master tape record is invalid. A complete explanation of the HIPO data display is contained in the following pages.

MASTER IDENTIFICATION RECORD LAYOUT

```
         569-66-0349-A    MI PRINTOUT    PROCESSED 08/10/77    Code Refer to IM 3838.7*
MASTER   569-65-0349-A  PRV    ASIRECORD.PARTS&ANDS.W.   SEX M XR FROM                                                       FEO BY 03MS
         3 WINDBLOWN COURT,APT 101,BALTIMORE MD 21209                     00003-01000-01000-00000-00000-00002-00000-10030

         PART A CUR ENT 07/66 TER   /   OPT E PRV ENT   /   TER   /   OPT   DOB 01/15/99 DOA 03/21/77 DLA 04/28/77      *
         PART B CUR ENT 07/74 TER   /   OPT Y PRV ENT 07/66 TER 12/73 OPT T DOD 01/31/77 RPL   /  /   LAF PC SC C PC   TPC A 0
         HMO CURRENT         EFF   /   TER   /   OPT               PRIOR       EFF   /   TER   /   OPT   PERIODS 0       TPC B 0
```

*Denotes Intermediary Manual Section to be Referenced

A. Master Identification Record Layout and Description.--The data displayed reflects the information contained in the master identification record. This record will appear if the HIPO is for a claim number which belongs to an individual who is alive or, if dead, whose accoont has had recent activity.

MASTER
The claim number following the legend "MASTER" belongs to the beneficiary identified in the master identification record.

CLAIM NUMBER
The claim number must include a nine position account number. If a suffix is not included a HIPO will be generated for each family membe: in file for the requested account number. If a suffix is included a HIPO will be generated for that beneficiary only. Railroad Board numbers will show the HCFA converted claims number.

PRV
The code following the legend "PRV" is the beneficiary's previous beneficiary identification code (BIC). If this field is blank, the beneficiary did not have a previous BIC.

NAME
The name field is twenty-five positions long with twelve positions for surname, ten positions for given name, and one position for middle initial. The surname, given name, and middle initial will be separated by a period.

SEX
The code following the legend "SEX" indicates the beneficiary's sex: F (female), M (male), U (unknown).

XR FROM
The claim number following the legend "XR FROM" is an inactive number associated with the beneficairy. If this field is blank, a cross-reference is not involved.

DATA INDICATORS
This field consists of thirty-five data indicators.

ADDRESS
This field begins beneath the first position of the claim number. The address field can contain up to 122 positions. The zip code is contained in the last five positions of the address line.

PART A CUR ENT (MM/YY)
The four position date following the legend "PART A CUR ENT" is the beginning date of the current period of entitlement to hospital insurance coverage. If this field is blank, the beneficiary is not currently entitled to hospital insurance.

TER (MM/YY)
The four position date following the Legend "TER" is the date of termination of the current period of entitlement to hospital insurance coverage. XXXX in this field indicates that the current period of entitlement to hospital insurance coverage is erroneous.

OPT
The one position code following the legend "OPT" represents the current status of the beneficiary's entitlement to hospital insurance coverage.

PRV ENT (MM/YY)
The four position date following the legend "PRV ENT" is the beginning date a previous period of entitlement to hospital insurance coverage. If this field is blank, the beneficiary was not previously entitled to hospital insurance coverage.

TER (MM/YY)
The four position date following the legend "TER" is the date of termination of a previous period of entitlement to hospital insurance coverage.

OPT
The one position code following the legend "OPT" represents the previous status of the beneficiary's entitlement to hospital insurance coverage.

DOB (MM/DD/YY)
The six position date following the legend "DOB" is the beneficiary's date of birth.

DOA (MM/DD/YY)
The six position date following the legend "DOA" is the date the master record was accreted to the HI system.

DLA (MM/DD/YY)
The six position date following the legend "DLA" is the date of the latest Part A or Part B activity.

TPC A
The code following the legend "TPC A" is the Part A Third Party Code. One of the following codes will appear:

0 - No Third Party Involvement
1 - State Buy-In
3 - Oklahoma Buy-In
5 - Civil Service
7 - Third Party

PART B CUR ENT (MM/YY)
The four position date following the legend "PART B CUR ENT" is the beginning date of the current period of entitlement to medical insurance coverage. If this field is blank, the beneficiary is not currently entitled to medical insurance.

TER (MM/YY)
The four position date following the legend "TER" is the date of termination of the current period of entitlement to medical insurance coverage. XXXX in this field indicates that the current period of entitlement to medical insurance coverage is erroneous.

OPT
The one position code following the legend "OPT" represents the current status of the beneficiary's entitlement to medical insurance coverage. An explanation of Part B option codes is contained in the glossary.

PRV ENT (MM/YY)
The four position date following the legend "PRV ENT" is the beginning date of a previous period of entitlement to medical insurance coverage. If this field is blank, the beneficiary was not previously entitled to medical insurance coverage.

TER (MM/YY)
The four position date following the legend "TER" is the date of termination of a previous period of entitlement to medical insurance coverage.

OPT
The one position code following the legend "OPT" represents the previous status of the beneficiary's entitlement to Medical insurance coverage.

DOD (MM/DD/YY)
The six position date following the legend "DOD" is the beneficiary's date of death. If this field is blank, the beneficiary is presumed to be alive.

RPD (MM/DD/YY)
The six position date following the legend "RPD" is the run processing date. This is the date the MBR generated the Universal RIC.

LAF
The code following the legend "LAF" is the Ledger Account File Code.

SC
The code following the legend "SC" indicates the source of the master record. One of the following codes will appear:

A - Accretion/Attainment
B - Cross-reference
C - Clerical
D - Verified Cross-reference
E - Verified Clerical

PC
The code following the legend "PC" is the Program Center Code.

TPC B
The code following the legend "TPC B" is the Part B Third Party Code. One of the following codes will appear:

0 - No Third Party Involvement
1 - State Buy-In
3 - Oklahoma Buy-In
5 - Civil Service
7 - Third Party

HMO CURRENT
The number following the legend "HMO CURRENT" is the plan number of the current Health Maintence Organization.

EFF (MM/YY)
The four position date following the legend "EFF" is the effective start date of the HMO period.

TER (MM/YY)
The four position date following the legend "TER" is the termination date of the HMO period.

OPT
The one position code following the legend "OPT" is the HMO option code. One of the following codes will appear:

1 - will process all provider bills for non-lock-in beneficiaries.

2 - HMO will process only in-plan Part A and in-area Part B bills for non-lock-in beneficiaries.

A - will process all provider bills for lock-in beneficiaries,

B - HMO will process only in-plan Part A and in-area Part B bills for lock-in beneficiaries.

C - HMO will process all Part A and Part B bills for lock-in beneficiaries.

The information described (in 30 through 33) above will be displayed following the legend "PRIOR" if more than one HMO period is participated in.

PERIODS
The number following the legend "PERIODS" represents the number of HMO periods in which the beneficiary has participated.

MASTER PART A RECORD LAYOUT

```
          588-66-0301-A     MI PRINTOUT    PROCESSED  08/10/77    CASE CODE-3E210  7107                                  REQ BY C3MQ
MASTER    588-66-0301-A  PRV    DISABILITY.RECOR.D.       SEX M XR FROM             00000-00000-01000-01000-00000-00003-20011-00000
          BOX 24.MONKTON MD  21111

          PART A CUR ENT 07/73 TER   /   OPT E PRV ENT   /   TER   /   OPT   DOB 05/18/25 DOA 03/21/77 DLA 05/13/77     TPC A 0
          PART B CUR ENT 07/73 TER . /   OPT Y PRV ENT   /   TER   /   OPT   DOD   /  /   RPD   /  /   LAF PC SC C PC   TPC B 0
          HMO CURRENT          EFF   /   TER   /   OPT              PRIOR         EFF   /   TER   /   OPT    PERIODS 0
MASTER A                                    HOSP   SNF            DEDUCTIBLE                               IND
          LIFETIME                  SPELL  FL CO  FL CO   HHA    INP    BLD     DOEBA      DOLBA     1 2
          RES  PSY                    1    44 30  20 80   100   00000   3.0   07/19/76   08/04/76   1 0
                                      2    00 25  20 00   100   00000   3.0   03/10/75   05/14/75   1 0
           60  180                    3    50 30  00 63   065   00000   2.0   07/01/73   08/16/73   1 0
                                      4    00 00  00 00   000   00000    .0    /  /       /  /
                                      5    00 00  00 00   000   00000    .0    /  /       /  /
MASTER-B  INTER YR                  PART B UTIL     1973      1974      1975      1976      1977
                00                  HH B VISITS      100       100       100       100       100
                00                  BLD DED APL       .0        .0        .0        .0        .0
                00                  MEDICAL EXP    65.00     80.00    100.00    170.00     20.00
                                    PSYCH   EXP      .00       .00       .00       .00       .00
          DED MET                   PSYCH   PAY      .00       .00       .00       .00       .00
          10023                     PHY TPY EXP      .00       .00       .00       .00       .00
                                    PHY TPY PAY      .00       .00       .00       .00       .00
                                    FOURTH  QTR    25.00       .00       .00     80.00       .00
```

B. Master Part A Record Layout and Description.--The data displayed reflects the information contained in the master Part A record. This record will appear if there is any HI utilization for the beneficiary.

LIFETIME RES
The number displayed under the legend "LIFETIME RES" represents the number of lifetime reserve days remaining.

LIFETIME PSY
The number displayed under the legend "LIFETIME PSY" represents the number of lifetime psychiatric days remaining.

SPELL
The number displayed under the legend "SPELL" indicates a spell of illness represented by the data displayed to the right of the number. Up to five spells will be displayed. The latest spell will appear as spell number one.

HOSP FL
The number displayed under the legend "HOSP FL" represents the number of full coverage days of inpatient hospital services remaining for a spell of illness.

HOSP CO
The number displayed under the legend "HOSP CO" represents the number of coinsurance days of inpatient hospital services remaining for a spell of illness.

SNF FL
The number displayed under the legend "SNF FL" represents the number of full coverage days of skilled nursing facility services remaining for a spell of illness.

SNF CO
The number displayed under the legend "SNF CO" represents the number of coinsurance coverage days of skilled nursing facility services remaining for a spell of illness.

HHA
The number displayed under the legend "HHA" represents the number of covered home health visits remaining for a spell of illness.

DEDUCTIBLE IMP
The money amount displayed under the legend "DEDUCTIBLE IMP" represents the amount of inpatient hospital deductible remaining to be met for a spell of illness.

DEDUCTIBLE BLD
The number displayed under the legend "DEDUCTIBLE BLD" represents the remaining number of pints of blood to be met for a spell of illness.

DOEBA (MM/DD/YY)
The six position date displayed under the legend "DOEBA" is the date of earliest billing action for a spell of illness.

DOLBA (MM/DD/YY)
The six position date displayed under the legend "DOLBA" is the date of latest billing action for a spell of illness.

IND 1 AND 2
The number displayed under the legends IND 1 and IND 2 are spell of illness indicators. The possible indicator codes are as follows:

IND #1

0 - There has been no clerical involvement and no Christian Science SNF usage.
1 - There has been clerical involvement.
2 - There has been Christian Science SNF usuage.
3 - Both conditions 1 and 2 above are present.

IND #2

0 - The DOLBA is not interim and the blood has been initialized in the redesigned system.
1 - The DOLBA is interim.
2 - The blood has not been initialized in the redesigned system.
3 - Both conditions 1 and 2 above are present.

ADMISSION CONTROL RECORD LAYOUT

```
          588-66-0302-T    MI PRINTOUT    PROCESSED 08/12/77    CASE CODE CLERICAL RIC J         25                   REQ BY 03M3

MASTER    588-66-0302-T  PRV    CHRONICRENA.LDISEAS.E.     SEX M XR FROM              .00000-00000-01000-00000-00000-00303-00022-00800
          3 WINDBLOWN COURT.APT 101.BALTIMORE MD 21208

          PART A CUR ENT 07/73 TER    /   OPT E PRV ENT    /   TER   /   OPT   DOB 05/18/25 DCA 03/21/77 DLA 08/11/77      TPC A 0
          PART B CUR ENT 07/73 TER    /   OPT Y PRV ENT    /   TER   /   OPT   DOD   /  /   RPD   /  /   LAF PC SC C PC   TPC B 0
          HMO CURRENT          EFF   /   TER   /   OPT             PRIOR        EFF   /   TER   /   OPT.    PERIODS 0
MASTER A                                    HOSP   SNF          DEDUCTIBLE                          IND
          LIFETIME                   SPELL  FL CO  FL CO  HHA    INP    BLG     DOEBA      DOLBA    1 2
          RES  PSY                     1    59 30  20 60  100   01000   3.0  01/10/77   01/11/77   1 0
                                       2    58 30  20 80  100   00000   3.0  09/14/73   09/16/73   1 0
           60  190                     3    00 00  00 00  000   00000    .0    /  /       /  /
                                       4    00 00  00 00  000   00000    .0    /  /       /  /
                                       5    00 00  00 00  000   00000    .0    /  /       /  /

MASTER B  INTER YR                   PART B UTIL     1973       1974      1975      1976      1977
                00                   HH B VISITS      100        100       100       100       100
                00                   BLD DED APL       .0         .0        .0        .0        .0
                00                   MEDICAL EXP    45.00     155.00     80.00    120.00     40.00
                                     PSYCH   EXP      .00        .00       .00       .00       .00
          DED MET                    PSYCH   PAY      .00        .00       .00       .00       .00
          10033                      PHY TPY EXP      .00        .00       .00       .00       .00
                                     PHY TPY PAY      .00        .00       .00       .00       .00
                                     FOURTH  OTR    45.00     100.00       .00     60.00       .00
-----------------------------------------------------------------------------------------------------------------
ADM CNTR  TYPE  T  Q  DISP  INTER  PROVDR  ADM DATE  FROM DTE  THRU DTE  DSCHG DT  BATCH-#-SO    DOA       DLA      OC
           D    3      25   58300  980432  06/06/77  06/06/77    /  /  .   /  /            00  08/11/77  08/11/77   00
-----------------------------------------------------------------------------------------------------------------
```

C. Admission Control Record Layout and Description.--The data displayed reflects the information contained in the admission control record. This record will appear when any of the items listed below have been processed. A maximum of 30 items may be displayed.

TYPE
The one position code displayed under the legend "TYPE" identifies the type of trailer displayed. One of the following codes will appear:

C - Closed
D - Open (Admission)
G - Open (Generated)
O - Orbit
R - RTI
U - Utilization

T
The one position code displayed under the legend "T" is the transaction code. One of the following codes will appear:

0 - Christian Science SNF
1 - Psychiatric Hospital
2 - Tuberculosis Hospital
3 - Inpatient Hospital
4 - Regular SNF

Q
The one position code displayed under the legend "Q" is the query code. One of the following codes will appear:

1 - Interim
3 - Final Bill
4 - Discharge Notice

DISP
The two position code displayed under the legend "DISP" is the disposition code transmitted with the original reply.

INTER
The five position code displayed under the legend "INTER" is the identification number of the intermediary submitting the query.

PROVDR
The six position code displayed under the legend "PROVDR" identifies the facility providing the services.

ADM DATE (MM/DD/YY)
The six position date displayed under the legend "ADM DATE" is the date the beneficiary was admitted to the hospital or skilled nursing facility.

FROM DTE (MM/DD/YY)
The six position date displayed under the legend "FROM DTE" is the date of the first day of services covered by the bill.

THRU DTE (MM/DD/YY)
The six position date displayed under the legend "THRU DTE" is the date of the last day of services covered by the bill.

DSCHG DT (MM/DD/YY)
The six position date displayed under the legend "DSCHG DT" is the date the beneficiary left the hospital or skilled nursing facility or died.

BATCH-#-SQ
The ten position field displayed under the legend "BATCH-#-SQ" identifies the batch in which the intermediary forwarded the bill, the date it was batched and the sequence number of the bill assigned by HCFA. The first four positions are the batch number, the next four positions are the Julian date and the last two positions are the sequence number of the bill within the batch.

DOA (MM/DD/YY)
The six position date displayed under the legend "DOA" is the date the trailer was accreted.

DLA (MM/DD/YY)
The six position date displayed under the legend "DLA" is the date of the latest modification to the trailer data.

OC
The number displayed under the legend "OC" represents the number of times that the bill has orbited.

Bill History

3840. HI BILL RETRIEVAL RECORD (BILL HISTORY)—GENERAL

This record is provided when:

1. An error code listed below is assigned by HCFA:

6000	5600	*5620	5701	5703	5705
6010	5601	5700	5702	5704	

*History is provided only if FROM date on bill is earlier than the FIRST BL DT on HCFA's HI Master Record.

2. A request is received for this record.

All history records are released via the HCSSCL/SXXX tape file. A related exception record is intermixed with each bill history record if it is released due to a bill error. If the bill is requested, it appears as the last record on the tape file. (See §3830.1K.)

Compare rejected bills and their related bill history with the provider's or your records. Correct any overlapping billing dates and resubmit the billing data. Do not resubmit billing data for duplicate billings. Delete any open admissions established for a duplicate billing.

Selected data is shown for accepted inpatient hospital (including psychiatric hospitals), SNFs, Part A and Part B home health billings, HOSPICE and Christian Science billings. Adjustments to these billings are also shown. No outpatient bills are displayed.

The accepted billings for each HICN are grouped according to:

A. Bills affecting benefit periods; these bills are:

- Christian Science
- Inpatient Hospital
- SNF
- All home health Part A bills with a FROM date prior to January 1, 1982. (Only Part A home health bills may affect the benefit period.)

B. A summary line of utilization data for the benefit period and the exception data (if any) are shown. No exception data is shown when a history is prepared based upon a request instead of a bill reject.

C. HOSPICE bills.

D. Home health bills with a "FROM" date later than December 31, 1981. Part B home health bills are identified with a "B" on the right margin.

Whenever bills are purged from the history record, utilization involving the 190 psychiatric lifetime days and 60 hospital reserve days are consolidated and shown as the first billing (dummy bill) on the history record. This consolidation ensures that the same number of lifetime days are shown as utilized on both the bill history record and the HI Master.

Some of the entries end in an alphabetic or special character which has a numeric counter part. They are:

& = 0 B = 2 D = 4 F = 6 H = 8
A = 1 C = 3 E = 5 G = 7 I = 9

Five position date fields consist of the year in the first 2-positions followed by a 1 position month and a 2 position day. For example, January 1, 1984, is coded 84A01. The alphabetic characters for the months are:

A = January
B = February
C = March
D = April
E = May
F = June
G = July
H = August
I = September
- = October
J = November
K = December

3840.1 Item Descriptions.—

A. HI Bill Retrieval—Identify each item of data by comparing the numbered items with those on the exhibit. Items 1 through 3 relate to the identification of the document, Items 4 through 27 first line of billing data, Items 28 through 41 to the second line of billing data, and Items 42 through 53 to the third line of billing data. Items 54 through 64 relate to the benefit period, Items 65 through 68 to billing data that does not impact the benefit period, and Items 69 through 70 to bill reject data.

Item 1. HEADER.

The title of the record is "BILL RETRIEVAL."

Item 2. DATE.

A 6-position numerical date for the history run date.

ITEM 3. PAGE NO.

The page number is 2-positions and printed on the first line of each page. If the total printed data for an Health Insurance Claim Number requires more than one page, the subsequent page is numbered 02, 03, etc.

ITEM 4. CLAIM NO. (HI Claim Number)

Either the 9-position numeric portion of the SSA claim number or the first 9 positions of a converted Railroad Retirement Board (RRB) claim number and followed by 2-position beneficiary identification code (BIC). The SSA BIC consists of at least one alpha character and may also consist of additional numeric digits. An RRB symbol, when converted by SSA, consists of 2 numeric positions. SSA converts RRB numbers for processing through its EDP system and RRB numbers are shown in their converted format. The original (unconverted) RRB number is shown on the interim or final batch clearance record.

ITEM 5. NAME.

The first 6-letters of the beneficiary's surname.

ITEM 6. IN (initials).

These 2-positions show the beneficiary's first and second initials (if available).

ITEM 7. TQ (transaction and query codes).

This is a 2-position field. The transaction code represents the type of bill and the query code shows whether a bill is an adjustment action, interim bill, or final bill.

TRANSACTION CODES

0 = Christian Science
1 = Inpatient Psychiatric Hospital
2 = Inpatient TB Hospital
3 = Inpatient Hospital
4 = Skilled Nursing Facility
5 = Home Health Agency
H = HOSPICE Bill

QUERY CODES

0 and 5 = Adjustment codes
1 and 2 = Interim bill codes
3 and 4 = Final bill codes

ITEM 8. TOTL-CHG (total charges).

An 8-position money amount showing the total charges (covered and noncovered) before deductions for actual cost of services.

ITEM 9. REIM AMT (reimbursement).

An 8-position money amount paid to the provider for services covered by the bill after subtracting deductibles and/or coinsurance amounts.

ITEM 10. ADM (admission date).

This 5-position date is the date the beneficiary was admitted to the hospital, HOSPICE, or SNF. It is the start of care date if the bill is for home health services.

ITEM 11. DSCHG (discharge date).

This 5-position date is the date the beneficiary was discharged from the hospital/SNF/HOSPICE or died. For home health services, it represents the date services were no longer received.

ITEM 12. FROM (from date).

This 5-position date is the date of the first day of services covered by the bill.

ITEM 13. THRU (through date).

This 5-position date is the date of the last day of services covered by the bill.

ITEM 14. HTO (hospital totals).

These 3-positions are the total number of covered full, coinsurance, and lifetime reserve days on the billing. To determine the number of hospital full days, subtract the number of coinsurance days and/or lifetime reserve days, if any. Coinsurance and lifetime reserve days are shown in the next 2 fields (ITEMS 15 and 16).

ITEM 15. HCO (hospital covered days).

These 3-positions are the total number of coinsurance days on the billing exclusive of lifetime reserve days. Up to 30 coinsurance days are allowed in a benefit period for inpatient hospital services.

ITEM 16. LRD (lifetime reserve days).

These 3-positions are the total number of lifetime reserve days used, if any. This field is only applicable to inpatient hospital stays.

ITEM 17. IDED (inpatient deductible).

These 5-positions show the amount of inpatient cash deductible applied to the billing. The beneficiary is responsible for a cash deductible in each benefit period. The chart in 3211 shows the maximum rates for which a beneficiary can be liable in each benefit period.

ITEM 18. BD (blood deductible).

These 2-positions are the number of blood pints applied toward the blood pint deductible on the billing. The first position is for whole pints and the second for half-pints. If only whole pints are involved, the second position is always zero (0). If half-pints are involved, the second position is always five (5). For example, 030 = 3 pints and 025 = 2 1/2 pints.

ITEM 19. BFN (blood furnished).

These 4-positions are the total number of pints or half-pints of blood shown on the billing. The last position shows any half-pints involved as shown in ITEM 18 above.

ITEM 20. BNR (blood not replaced).

These 4-positions are the total number of pints or half-pints not replaced by the beneficiary, as shown on the billing.

ITEM 21. BCPT (blood charge).

These 5-positions are the charge per pint for blood furnished.

ITEM 22. N/C (noncovered/leave days).

These 4-positions are the number of noncovered days and/or leave days on the billing. Noncovered days during the billing period are days which are denied for such reasons as benefits exhausted, custodial care, workmen's compensation, payment by the VA, etc. Leave days during the billing period are days for which the patient was not present in the hospital or SNF.

ITEM 23. PDA (prior days).

These 3-positions are the number of days the patient was confined to a psychiatric hospital in the 150-day period immediately preceding the date of entitlement to Part A benefits.

ITEM 24. NP (nonpayment).

This 1-position code identifies the reason for no payment. The codes are:

W = Workers' compensation
B = Benefits exhausted
C = Noncovered care
N = Other reasons

ITEM 25. STO (SNF total days used).

These 3-positions are the total number of SNF and/or Christian Science Sanatorium full and coinsurance days used in the billing period. See §3023 for Christian Science coverage. Determine the number of SNF full days by subtracting total coinsurance days from total covered days. SNF coinsurance days, if any, appear in ITEM 26.

ITEM 26. SCO (SNF coinsurance days used).

These 3-positions are the total number of SNF and/or Christian Science Sanatorium coinsurance days used in the billing period. See §3023 for Christian Science coverage.

ITEM 27. HHA (home health visits).

These 3-positions are either the number of covered Part A or Part B home health visits used in the billing period. Part B data is identified by a "B" to the right of the visits.

ITEM 28. PROVDR. (provider number).

These 6-positions are the identification number of the facility which provided the services.

ITEM 29. INTRM (intermediary number).

These 5-positions are the identification number of the intermediary that submitted the billing.

ITEM 30. BATCH (batch number).

These 8-positions are the batch number and the date of batching assigned by the intermediary that submitted the billing. The first 4-positions are the batch number and the next 4 are the Julian date (1-position year digit followed by 3-position day). An alphabetic character in the first position of the batch number denotes a batch submitted by an intermediary and a numeric means an internal adjustment by HCFA. An internal bill is prepared whenever HCFA's active history records are purged and psychiatric or lifetime reserve days have been reduced.

ITEM 31. BS (bill sequence).

These 2-positions are the sequence number assigned to the bill by HCFA.

ITEM 32. MSBLK (master block number).

These 5-positions are the block number assigned to the batch of bills by HCFA for internal purposes. The first 4-positions are the Julian date and the code in the last position identifies the type of billing batch. The codes are:

Inpatient Hospital and SNF = L
Christian Science = N
Home Health "A" and "B" = Q
Noncovered Bills = R

ITEM 33. PROC (processed date).

These 5-positions are the date the billing data was accepted by HCFA.

ITEM 34. PRF-CMP (professional component)

These 7-positions show the total amount of professional charges (if any).

ITEM 35. ASIS OI-DTS

This field, if completed, shows either of two dates.

The first 5-positions show the date of the earliest open admission preceding the billing FROM date of an accepted billing. The last 5-positions show the date of the latest billing THRU/DISCHARGE date recorded for an open admission that is subsequent to an accepted billing. These dates are used by HCFA to determine the proper benefit period for a billing.

ITEM 36. PRI STY DTS (prior stay dates).

Two separate 5-position dates show the beginning and ending date of a noncovered stay that preceded the admission date on the billing.

ITEM 37. 2 CO (second year coinsurance days).

These 3 positions show the total number of coinsurance days used in the second year, if coinsurance days are utilized on the billing and they overlap two years (e.g., 12/10/84 through 01/20/85).

ITEM 38. UTL (utilization days).

Reserved for future use.

ITEM 39. "H" (identifier).

A 1-position code that identifies an HMO paid bill.

0 = No HMO payment.
1 = HMO paid

ITEM 40. "K" (identifier).

A 1-position code that shows whether or not a bill is received and processed with a benefit period override code. (See §3880.2.) Possible codes are:

K = Received and processed bill using override code.
L = Received bill with override code, but code was unnecessary and not used.
M = Received bill with override code, but the bill is linked to a benefit period that shows only bills without "Verified non-covered stays".

ITEM 41. DATA INDICATORS.

The codes in this 40-position field are for HCFA's internal use.

ITEM 42. LEFT ASTERISK (*) OR "A" (identifier).

An asterisk entered along the left margin identifies the bill that is overlapped by the exception bill displayed at the bottom of the page. An "A" identifies provider bills internally adjusted by HCFA when available benefits have been either overutilized or underutilized. (See ITEM 69.)

ITEM 43. PRIM PAY DYS.

This field consists of 11-positions. The first eight are separated from the last 3 by space. The first position shows the primary payer code. The next seven positions show the amount that the primary payer paid. The three positions after the space show the total number of days covered by the primary payer. The primary payer codes are:

A = Working Aged Beneficiary/Spouse with EGHP.
B = ESRD Beneficiary in the 12 Month Coordination Period with an EGHP.
C = Conditional Payment by Medicare; Future Reimbursement Expected.
D = Automobile No-Fault or any Liability Insurance

E = WC Including BL
F = VA, PHS or Other Federal Agency
Z = Medicare is Primary Payer

ITEM 44. DRG (diagnosis related group).

These 3-positions identify the diagnosis related group used for payment.

ITEM 45. DS (discharge destination).

These 2-positions show the patient's status as of the last service date on the billing. See §3638 for the list of codes and their narrative descriptions.

ITEM 46. OUTLR—AMT (outlier code and amount).

These 9-positions show the outlier code and outlier amount. The first position is the outlier code followed by the 8-position amount. Outlier codes are:

0 = No outlier
1 = Day outlier
6 = Valid outlier (exempted States only)
7 = HCFA developed DRG
8 = HCFA developed DRG using patient status code
9 = Not groupable

ITEM 47. DIAGNOSTIC - CODES/NARRATIVE.

This field contains up to five 5-position codes or narratives from the submitted billing data. If codes are shown, the first code describes the principal diagnosis and the remaining codes correspond to additional conditions that co-existed at the time of admission, or developed subsequently, and have an effect on the treatment received or the length of stay.

ITEM 48. SURG-CDS/NARR (surgical procedure codes).

This field contains up to three 4-position codes or narratives from the submitted billing data. If codes are shown, the first code identifies the principal procedure performed during the period covered by this bill. The remaining codes, if any, identify the procedures, other than the principal procedure, performed during the billing period.

ITEM 49. GPDT (guarantee of payment date).

These 5-positions show the guarantee of payment date entered on the billing (first day for hospital payment claimed under the guarantee of payment provision when the beneficiary has no available coverage).

ITEM 50. URDT (utilization review date).

These 5-positions show the date that the utilization review committee advised the provider that a further hospital or SNF was no longer necessary.

ITEM 51. ACDT (active treatment date).

These 5-positions are the date covered level of care ended.

ITEM 52. BEDT (benefits exhausted date).

These 5-positions are the benefits exhausted date on the billing.

ITEM 53. * (right asterisk).

An asterisk along the right margin of the page identifies the bill(s), if any, that is netted out due to adjustment actions of various types (CREDIT/DEBIT or CANCEL ONLY). This symbol also identifies duplicate billings. If a duplicate covered and noncovered billing is processed, the noncovered billing is netted out. If the duplicate billings are both covered or both noncovered, the billing with the earlier process date is netted out. Only bill data lines without an asterisk to the right are included in the summary of benefit period utilization data.

ITEM 54. SPELL.

These 2-positions represent the sequence of the benefit period. The items following the sequence number contain related utilization data for the benefit period. All billing data above this line (except home health billings) are used to calculate remaining benefits and deductibles to be met.

NOTE: Since some billing days are accepted out-of-sequence, it may be that:

a. A reduction is reflected for coinsurance days while full days still remain;

b. A reduction is reflected for lifetime reserve days while coinsurance is still available in the benefit period; or

c. A negative amount is shown on a bill exceeding allowable days and is forced accepted.

ITEM 55. HFL (full hospital).

These 2-positions show the number of full inpatient hospital days remaining for the benefit period. Up to 60 full days are available. Exhaust full days before applying coinsurance days.

ITEM 56. HCO (hospital coinsurance).

These 2-positions show the number of coinsurance inpatient hospital days remaining for the benefit period. Up to 30 coinsurance days are available. Exhaust coinsurance days before applying lifetime reserve days.

ITEM 57. SFL (full SNF).

These 2-positions show the number of full SNF days remaining unless a Christian Science bill was accepted in the benefit period. Up to 20 full SNF days (none for Christian Science) are allowable in a benefit period. Exhaust full days before applying coinsurance days, except in Christian Science billings. Full days are not applicable to Christian Science facilities—only coinsurance days. If a Christian Science bill has been accepted, full days remaining are shown as zero.

ITEM 58. SCO (coinsurance SNF).

These 2-positions show the number of coinsurance SNF days remaining (80 or less) unless a Christian Science bill was accepted in the benefit period. Up to 80 coinsurance (30 for a Christian Science stay) days are allowed. Therefore, remaining coinsurance days can never be more than 80 after acceptance of a non-Christian Science billing or more than 30 after acceptance of a Christian Science billing. If the last 4 digits of the provider number for an accepted billing are 1990-1999, a Christian Science billing is involved.

ITEM 59. IDED (inpatient deductible).

These 5-positions show the amount of inpatient hospital cash deductible remaining to be met in the benefit period. If zeros are shown, the deductible is met. See chart in §3211 for the amount of the deductible to be met in each benefit period.

ITEM 60. BDED (blood deductible).

These 3-positions show the number of blood pints remaining to be met in the benefit period.

ITEM 61. 1st BL DT (admission date).

These 5-positions show the admission date of the accepted bill that started the benefit period.

ITEM 62. LST BL DT (discharge/billing through date).

These 5-positions show the discharge/billing through date of the last processed inpatient hospital or SNF bill in the benefit period.

ITEM 63. LRD (lifetime reserve days).

These 2-positions show the number of hospital lifetime reserve days remaining.

ITEM 64. LPD (lifetime psychiatric days).

These 3-positions show the number of psychiatric lifetime days remaining.

ITEM 65. HOSPICE BILLS.

Each HOSPICE billing accepted is listed. See ITEMS 1 through 64 above for a description of possible entries.

ITEM 66. TOTAL HOSPICE DAYS.

The 2-positions to the right of this title show the number of HOSPICE days billed and accepted as of the history preparation date.

ITEM 67. HOME HEALTH BILLS AFTER 1981.

Both Part B and Part A home health billings with a FROM date after December 31, 1981 are listed since they do not affect benefit periods. Part B billings are distinguished from Part A by a "B" in the right margin. See ITEMS 1 through 64 above for a description of possible entries.

ITEM 68. TOTAL HHA VISITS FOR (year) PART A (XX) PART B (XX).

The 3-positions to the right of PART A show the number of Part A home health visits used during the year shown. The 3-positions to the right of PART B are the PART B visits used.

ITEM 69. EXCEPTION BILL ERROR CODE, OR L1001.

If a 1-position code, it identifies the potential type of error. This data is for HCFA use only. An L1001 is followed by one of the following messages:

FULL DAYS CHANGED-(INCREASED OR DECREASED).
FULL DAYS CHANGED AND THE INPATIENT DEDUCTIBLE AMOUNT REMOVED.
COVERED DAYS CHANGED TO NON COVERED DAYS.
INPATIENT DEDUCTIBLE AMOUNT CHANGED - INCREASED OR DECREASED
MULTIPLE ADJUSTMENTS.

The message is followed by:

> THIS BILL RETRIEVAL RECORD IDENTIFIES PROVIDER BILLS THAT WERE ADJUSTED BY HCFA BECAUSE AVAILABLE BENEFITS FOR THIS BENEFICIARY WERE EITHER OVERUTILIZED OR UNDERUTILIZED. THE ADJUSTED BILL(S) HAVE AN "A" IN THE LEFT HAND MARGIN. PLEASE TAKE THE APPROPRIATE STEPS TO INSURE THAT YOUR IN-HOUSE RECORDS COMPLY WITH THE INTERNAL ADJUSTMENT(S) MADE BY HCFA. IF YOU HAVE ANY QUESTIONS ABOUT THE ADJUSTMENT(S) MADE BY HCFA, PLEASE CONTACT: HCFA, OMB, OAS, DMOS, TRANSACTION BRANCH, ADJUSTMENT MODULE, P.O. BOX 17078, BALTIMORE, MD 21203.

ITEM 70. FINAL DELETE CODE.

The words FINAL DELETE CODE appear with the delete code. See §§3825.1-3828.3 for a list of codes and their narratives.

B. No Find and Invalid Claim Number Reports.--Released whenever billing data cannot be provided from the bill retrieval file. The format is the same for both reports--only the name of the report varies. Identify each item of data by comparing the numbered items below with the titles on the exhibits.

ITEM 1. NO FIND REPORT/INVALID CLAIM NUMBER REPORT.

If this item shows "NO FIND REPORT," it means the bill retrieval request contained a valid HICN, but no bill data is shown as accepted on the bill retrieval records. If "INVALID CLAIM NUMBER REPORT" appears, it means the bill retrieval request contained an invalid HICN.

ITEM 2. BILL RETRIEVAL.

This item reflects the name of the file and the 6-position date of the run.

ITEM 3. PAGE NO.

The page number is printed on the first line of each page. If the total printed data for a HICN requires more than one sheet, the subsequent sheets are 002, 003, etc.

ITEM 4. CLAIM NO. (number).

This reflects the HICN as shown on the bill retrieval (query) request. Up to four HICNs across, in HICN sequence, appear. Either a 9-position numeric portion of the HICN or the first 9-positions of a converted RRB HICN is followed by a 2-position BIC. The HI BIC consists of at least one alpha character and may also consist of additional numeric digits. An RRB symbol, when converted, consists of two numeric positions. RRB numbers are shown in the converted format on the history file. The original (unconverted) RRB number is shown on the batch clearance records.

ITEM 5. REQSTR (requestor) ID (identification).

Your number is reflected as shown on your bill retrieval (query) request. Up to five positions are entered.

```
                       1.     2.                                                                                                 3.
                 BILL RETRIEVAL  XX/XX/XX                                                                                 PAGE NO XX

  4.        5.     6. 7.    8.         9.      10.     11.    12.     13.   14. 15. 16. 17.    18. 19. 20.  21.    22.  23. 24. 25. 26. 27.
CLAIM NO  NAME     IN TQ TOTL-CHG REIM-AMT ADM   DSCHG FROM  THRU  HTO HCO LRD IDED  BD BFN  BNR  BCPT  N/C  PDA NP STO SCO HHA
XXXXXXXXX XXXXXX XX XX XXXXXXXX XXXXXXXX XXXXX XXXXX XXXXX XXXXX XXX XXX XXX XXXXX XX XXXX XXXX XXXXX XXXX XXX X  XXX XXX XXX
  28.   29.   30.      31. 32.   33.    34.      35.         36.       37. 38.39.40.   41.
PROVDR INTRM BATCH     BS MSBLK PROC  PRF-CMP ASIS-OI-DTS PRI-STY-DTS 2CO UTL H K DATA-INDICATORS
XXXXXX XXXXX XXXXXXXX XX XXXXX XXXXX XXXXXXX XXXXX XXXXX XXXXX XXXXX XXX XXX X X XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
42.   43.      44. 45.  46.         47.                             48.        49.   50.   51.   52.                          53.
* PRIM-PAY-DYS DRG DS OUTLR--AMT DIAGNOSTIC-CODES/NARRATIVE     SURG-CDS/NARR  GPDT  URDT  ACDT  BEDT                           *
  XXXXXXXX XXX XXX XX XXXXXXXXX  XXXXX XXXXX XXXXX XXXXX XXXXX XXXX XXXX XXXX XXXXX XXXXX XXXXX XXXXX

                 54.  55. 56. 57. 58. 59.   60.     61.        62.     63. 64.
                 SPELL HFL HCO SFL SCO IDED  BDED 1ST BL DT  LST BL DT LRD LPD
                 XX    XX  XX  XX  XX  XXXXX XXX  XXXXX      XXXXX     XX  XXX


                                              65.
                                          HOSPICE BILLS

                           66.
                    TOTAL HOSPICE DAYS XX

                                             67.
                                   HOME HEALTH BILLS AFTER 1981

                            68.
                    TOTAL HHA VISITS FOR (year)   PART A XXX   PART B XXX

                      69.                          70.
                 EXCEPTION BILL ERROR CODE X         FINAL DELETE CODE XXXX
```

```
    1.                      2.
NO-FIND REPORT    BILL RETRIEVAL - XX/XX/XX
                                                                                      3.
                                                                                 PAGE NO XXX

  4.           5.
CLAIM NO     REQSTR ID   CLAIM NO     REQSTR ID    CLAIM NO     REQSTR ID    CLAIM NO     REQSTR ID
XXXXXXXXXXX  XXXXX       XXXXXXXXXXX  XXXXX        XXXXXXXXXXX  XXXXX        XXXXXXXXXXX  XXXXX
```

```
                    1                                   2                                                       3
 INVALID CLAIM NUMBER REPORT         BILL RETRIEVAL - 05/09/80                                         PAGE NO 008

    4              5
 CLAIM NO       REQSTR ID       CLAIM NO       REQSTR ID       CLAIM NO       REQSTR ID       CLAIM NO       REQSTR ID
xxxxxxxxxxx       xxxxx        xxxxxxxxxxx       xxxxx        xxxxxxxxxxx       xxxxx        xxxxxxxxxxx       xxxxx
```

3840.2 Intermediary Requests for HI Bill Retrieval Record (Bill History).--When you are unable to determine a beneficiary's prior or current health insurance (HI) utilization status, an HI Bill Retrieval record should be requested from us via your wire system. (See 3507.3.) For example, you receive a disposition code 27 (see 3512.7) indicating that the date of admission on your current query precedes the last discharge date (or last interim bill date) recorded on our records and the discharge date on your current claim is more than 60 days before our last discharge date, the days shown as available in our reply may not be for the same benefit period as your current claim. An HI Bill Retrieval in this instance would help you determine the benefit period which relates to your billing data.

HI Bill Retrieval records are not furnished if one of the following is applicable:

1. An intermediary number is not provided with the query.

2. An invalid health insurance claim number is queried. (Set 3840.1B)

3. At the time of receipt of the query no bills have been recorded on our bill retrieval record. (See 3840.1B)

If you have not received an HI Bill Retrieval record within 30 days of the date of your query, determine whether condition "2" or "3" above is applicable. These situations, when present, are sequenced after the bill retrieval records, if any, at the end of the HCSSACL/SXXX tape file (see 3830.1K). If conditions "2" or "3" are present, determine the proper HI claim number (see 3512.7, disposition code "00" or "52") and query the correct number. If condition "1" is applicable (presume this is the case if you have no indications "2" or "3" exist and 30 days have elapsed since you transmitted your query), requery the original HI claim number, but be certain your intermediary number is correct and present in your query. If the intermediary number you provide happens to belong to some other intermediary, the bill retrieval data will be sent to the other intermediary. Impossible intermediary numbers are treated as if no intermediary number was queried.

```
                                                    BATCH STATUS REPORT JAN 80

                                                      INTERMEDIARY 00000                                                          PAGE 090
BATCH DATE       DATE   RCVD    CLEARED VOID MISS    PEND  TOTAL   ACCEPT  CLER   CON ED  UTL ED  ORBIT  RO-ERR  REPLY   REJECT  SSA BLK
NO               RCVD   THIS MO                            BILLS                  INVEST  INVEST                 PENDG
  R441 0009     01-80     X                          X01   90      70      00     00      01      18     00      00      01      0015R
  R442 0009     01-80     X                          X01   90      66      00     00      01      19     00      00      04      0015R
  R443 0009     0T-80     X                          X01   90      64      00     00      00      22     00      00      04      0015R
  R444 0009     01-80     X                          X01   37      22      00     00      01      13     00      00      01      0015R

  R445 THROUGH R506   NUMBER OF MISSING BATCHES (00062)

  R507 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R508 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R509 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R510 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R511 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R512 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R513 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R514 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R515 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R516 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R517 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R518 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R519 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R520 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
  R521 0023     01-80     X                          X00   90      00      00     00      00      00     00      90#     00      0025L
 1980 SUBTOTALS FOR INTER 00000
     TOTAL
      000193      000131      00031 0000 00062 00100 0011156 0004162  00000  00000   00030   00282   0000   26664   00038


  GRAND TOTAL FOR INTER 00000
      004342      000384      00176 0000 00062 04104 0219737 0198679  00000  00000   00212   12381   0000   11581   08974

  MISSING BATCHES
 1-3 MOS      4 OR MORE MOS      TOTAL            % MISSING 1-3 MOS
 00062           00000           00062                100.0%
```

Batch Status Report

3842. MONTHLY BATCH STATUS REPORT

A. HCFA furnishes all Part A intermediaries with a batch status report.—The report is electronically produced in the form of a listing the first week of each month. The report includes information about batch processing for the previous month through the last Tuesday of the month in which the report is prepared. Batch numbers which do not appear on the listing have been cleared by HCFA in a month prior to the report month.

The cut-off date for the Batch Status Report is the same as for the Provider Statistical and Reimbursement Report and the modifications in the format of the Batch Status reports.

Batches are listed in order of the date batched by the intermediary for the current and one previous year in numerical sequence by batch number. This means all 1980 batches are shown in numerical sequence followed by all 1981 batches, and so on. If an intermediary repeats batch numbers within the same year, the earlier dated batches appear before the later ones. For example, two batches numbered A234 submitted in 1981 would appear on the listing in the following manner:

A234 1005
A234 1265

B. Description of Items on the New Batch Status Report.—For each batch there are 18 columns representing the possible status of the batch. The column headings are as follows:

BATCH NO (Batch Number)
This is the batch number shown on the intermediary's transmittal.

DATE
This is the date of batching expressed as a Julian date batched appearing on the intermediary's incoming tape.

DATE RECD (Date Received)
This is the month and year the batch entered SSA's EDP system. No entry appears in this column if the batch is missing.

RECD THIS MO (Received This Month)
If the batch was received during the period covered by the batch status report, an "X" will appear in this item. If the batch was received during a prior report period, the item is blank.

CLEARED
If the batch was cleared during the report period, an "X" appears in this item. Following the "X" is the total number of batch records produced by HCFA for that batch.

VOID
If the intermediary voids the batch during the report period, an "X" appears in this column. If HCFA temporarily deletes a batch number during internal processing, a "D" appears in this column until the batch number is reinstated. No action is required by the intermediary when a batch number is listed as a "D" VOID. However, if the "D" appears for 3 consecutive months, the intermediary should notify:

Health Care Financing Administration
Systems Requirements Branch, BPO
6325 Security Boulevard
Baltimore, Maryland 21207

MISS
This item shows an "X" if at the end of the report month, HCFA has not received this batch and has received one or more batches from the intermediary with a higher number. If the batch number was not used, either submit bills assigned to the batch number or notify HCFA to void the batch number as explained in 3887. Where the batch has been sent to HCFA, the intermediary need not take any action unless the missing batch is again listed the next month. When a batch has been listed as missing for 2 consecutive months, the intermediary should resubmit the batch to HCFA. Annotate the Summary Total Sheet, "BATCH (number) RESUBMITTED. MISSING ON TWO CONSECUTIVE BATCH STATUS REPORTS." See section 3867.2.

HCFA will not list separately 11 or more consecutive missing batches. To highlight 11 or more consecutive missing batches, a summary line will be used and the number of missing batches will appear in parenthesis. A blank line will precede and follow each missing batch summary line to separate it from other batches.

PEND
This column contains an "X" if the batch has not been completely processed during the report period. The number of interim batch records prepared by HCFA as of the end of the report which appears to the right of the "X." "X00" appears if no interim batch record has been prepared for the batch. "X01," "X02," etc., appear when HCFA has produced interim batch notices.

TOTAL BILLS
This column shows the total number of bills in a batch received by HCFA.

ACCEPT
This is the total number of bills from the batch which have been accepted by HCFA as of the last day of the report period.

CON ED INVES (Consistency Edit Investigation)
This is the total number of bills in the batch which are being reviewed for consistency errors as of the end of the report month.

UTL ED INVEST (Utilization Edit Investigation)
This is the total number of bills in the batch which are being investigated by HCFA for utilization errors. During the investigation, HCFA attempts to reinstate the bills into the bill processing system. The total is shown as of the last day of the report period.

ORBIT
This the total number of bills in the batch which are blocked from processing (in orbit) as of the last day of the report period.

REPLY PENDG (Reply Pending)
Bills which are sent to be matched against HCFA's master utilization record near the end of the report month will be reflected in this column whenever the final disposition is unknown because sufficient processing time has not elapsed. The actual disposition will appear on the report for the next month; that is, the bills will be shown under the columns headed "ACCEPT," "UTL ED INVEST," "ORBIT," or "REJECT." A pound sign (#) appears to the right of the number of bills reflected in this column if the bills in the batch are not included in the PS&R for the month.

REJECT
This is the total number of bills in the batch which were rejected for either consistency or utilization error, as of the end of the report month.

HCFA BLOCK (HCFA Master Block Number)
This column shows the 5-position master block number (HCFA's control number) for every batch listed except missing batches and batch numbers that have been voided. The first four positions of the master block number are the current Julian date. The fifth position identifies the type of bill according to the following: "L" for inpatient or skilled nursing facility, "M" for void bills, "N" for Christian Science, "Q" for home health, "P" for outpatient, and "R" for final nonpayment bills. For batch numbers that have been voided, a 1-position year and a 3-position Julian date appear in this column representing the date HCFA electronically processed the voiding action. For a missing batch, no entry appears in this column.

SUBTOTALS
Subtotals for batches submitted are broken down by each year. Also, accumulative subtotals for all years are listed.

GRAND TOTAL
At the end of the report for each intermediary, a grand total is shown.

MISSING BATCHES
A separate line will show the total and percentage for the following categories:

1. Batches missing 1 - 3 months,
2. Batches missing 4 months or more,
3. Total number of missing batches,
4. Percentage of the total missing less than 4 months.

These figures are provided monthly so that you can determine, on a current basis, if you are in compliance with established performance criteria.

3842.1 Intermediary Action Upon Receipt of Monthly Batch Status Report.—If your records show that one or more batch records (see § 3830) have not been received, flag the missing notice for followup 60 days after receipt of the first batch status report showing that HCFA has released a given number of interim batch records or a final batch record for that batch. It is important that a thorough internal check be made for the batch notice before requesting another one from HCFA. The HCFA search is time consuming and unnecessary requests may result in further delays.

If the batch notice is not located, complete Form Letter "A" to request batch clearance information (see the exhibits of form letter "A" which follow this section for the method of completion and for reproduction purposes). In completing form letter "A," batches should be listed in order by the year that they were sent to HCFA. Also show the master block number (if available), batch number, and date of batching. (The date of batching is indicated as the 3-digit Julian date preceded by the last digit of the year, e.g., January 10, 1981, is listed 1010.) All of this identifying data is normally available from the batch status report.

Upon receipt of Form Letter "A," HCFA will furnish, on hardcopy for pending batches, a special interim batch record which displays the current disposition of all bills in the batch. If the batch has cleared and no more than 18 calendar months have elapsed since the date of the clearance, HCFA furnishes a special final batch record. Make certain that requests for special batch records are submitted to HCFA within the time limitation of 18 calendar months to insure receipt of the notices. However, if HCFA's records show that the batch was cleared 18 calendar months or more prior to the request for the special batch record, you will receive a batch record which lists summary totals but not itemized individual bills within the batch. Under the "remarks" column of the special batch notice, two electronical messages will be displayed: "Batch Cert." MM/DD/YY and "Cert. Over 18 Months." Both special interim and final batch records are produced once a month for those Letter "A's received prior to the scheduled run date.

In some instances, you will receive batch records which contain no bill processing data. However, under the "remarks" column will appear one of the following messages:

Batch Out of Balance
Over 90 bills
Misbatched

These messages represent internal situations that have displayed processing of the batch(es) in question. These situations must be clerically resolved within HCFA before a batch record(s) can be furnished. No intermediary action need be taken upon receipt of batch records bearing there messages.

In addition, there are other specific messages that may appear under the "remarks" column of the batch record. They are:

NIF (No record of receipt of this batch)
VOID (Batch number has been previously voided)
Batch Cert. MM/DD/YY (If HCFA's records show that the batch was cleared 18 calendar months or more prior to the request for the special batch record, the intermediary will receive a batch record which lists summary totals for the batch but does not itemize individual bills within the batch)

If HCFA has not replied within 60 days, resubmit the request showing "second request" and the date of the prior request in red on the right hand corner of the request.

NOTE: Once the batch status report specifies that a particular batch has cleared, the batch is not listed on subsequent batch status reports.

LETTER A

Health Care Financing Administration
Bureau of Support Services
Transaction Processing Branch
Adjustment & Identification Section
Baltimore, Maryland 21235

Date ____________________

Intermediary ____________________

Individual Making Request
Still Waiting
Data above should be
shown by the intermediary

We can find no record of receiving interim and/or final batch records for the following listed batches. We have entered the master block number, and the batch number and the (Julian) date batched from the monthly Batch Status Report. Please forward a copy of the special interim/final batch record for each listed batch.

Master Block Number	Batch Number	Date Batched
	4367	5070
	4483	5170
8301L	A 617	8240
	A 618	8241

Data above should always be shown by the intermediary if available.

Data above should always be shown by the intermediary.

Data above should always be shown by the intermediary.

LETTER A

Health Care Financing Administration
Bureau of Support Services
Transaction Processing Branch
Adjustment & Identification Section
Baltimore, Maryland 21235

Date____________________

Intermediary____________________

Individual Making Request
Still Waiting

We can find no record of receiving interim and/or final batch records for the following listed batches. We have entered the master block number, and the batch number and the (Julian) date batched from the monthly Batch Status Report. Please forward a copy of the special interim/final batch record for each listed batch.

Master Block Number	Batch Number	Date Batched

3843. DESCRIPTION OF DATA APPEARING ON HARDCOPY BATCH CLEARANCE RECORD OBTAINED VIA "LETTER A."

A. Identification Data.--

1. Intermediary.--The intermediary identification is obtained from the original magnetic tape record submitted by the intermediary.

2. Batch Number.--The intermediary batch number assigned and the date batched by the intermediary.

3. Type of Notice.--HCFA enters "INTERIM" or "FINAL" and the number of notices produced to date.

4. Date of Notice.--This is the date the interim or final batch record is prepared by HCFA.

5. Type of Bill.--The following entries are possible:

INP/SNF	-bills for inpatient hospital or skilled nursing facility care
OUTPAT	-bills for outpatient care reimbursed under either Part A or B
CH SCI	-bills for Christian Science Sanatorium care
HH	-bills for home health agency care reimbursed under either Part A or B
NON COV	-bills (from all providers) for noncovered care
VOID	-previously submitted and rejected bills (from all providers) which are being voided

6. HCFA Master Block Number.-- The master block number assigned by HCFA will be shown. It is HCFA's control number and its reference in communications with HCFA will speed the processing of replies.

B. Batch Summary Data.--

7. Submission Totals.--The total number of bills (items) submitted by the intermediary and the total reimbursement amount for those bills are shown. This information is taken from your magnetic tape record.

8. HCFA Receipt Totals.--The number of bills (items) and the reimbursement amount actually received by HCFA are shown. The amounts shown should always equal the totals of the items titled "HCFA Accepted Totals, HCFA deleted Totals and HCFA Pending Totals."

9. Out-of Balance Amount.--The difference between the total number of bills and reimbursement amount reported (Intermediary Submission Totals) and the total number of bills received (counted by HCFA) and their total reimbursement amount (HCFA receipt Totals) will be provided.

If the number of bills received by HCFA does not agree with the number of bills shown on the intermediary's batch summary record, locate the missing or extra bill(s). If HCFA received fewer bills than shown on the intermediary batch summary record, resubmit the missing bill(s) in a new batch. If HCFA received more bills than shown on the intermediary batch summary records only.

10. HCFA Accepted Totals.--This is the total number of bills and the total amount of reimbursement of the bills in the batch posted by HCFA to its records as of the date the batch clearance record was prepared.

11. HCFA Deleted Totals.--This is the total number of bills and reimbursement amounts for bills returned to the intermediary by HCFA for corrections as of the date the batch clearance record was prepared.

12. HCFA Pending Totals.--This is the total number of bills (items) and the total reimbursement amount for bills still pending a final decision by HCFA.

The difference that remains after subtracting "HCFA ACCEPTED TOTALS" plus "HCFA DELETED TOTALS" from "HCFA RECEIPT TOTALS" should equal this total. If the clearance is final, that is, no bills remain to be processed (all bills either accepted or deleted) zeroes will be shown for this total. Pending bills are those bills that cannot be processed either because a bill which is needed to close an earlier open item has not been processed ("in orbit") or it requires extensive investigation ("under investigation").

13. Remarks.--One or more of the following legends can appear under remarks:

a. POSS PREV CERT.--This remark appears on a batch record when the batch may have been erroneously certified in the past. In April 1970, HCFA validated its batch control system and found that some batches which had been certified still had items pending (in orbit or under investigation). If the batch has been reopened for this reason, POSS PREV CERT is shown.

b. *RETURNED PREVIOUSLY.--This remark appears on a final batch record. Each bill which was previously returned or shown as automatically corrected on an earlier batch record has an asterisk (*) next to the sequence number.

c. REC'D OUT OF BALANCE.--This remark appears on a batch record when the intermediary totals (items, money, or both) disagree with HCFA's computed totals.

d. SPECIAL INTERIM/SPECIAL FINAL.—This remark appears to identify the record as a special interim or final batch record requested under the "Letter A" procedure outlined in § 3842.1 - hardcopy interim or final batch records are produced only on the basis of "Letter A" requests.

C. INDIVIDUAL BILLING DATA.—If the special batch record is an interim notice, all bills submitted in the batch are listed in the following order: all bills accepted by HCFA, all bills deleted by HCFA, and all bills which are pending. If the notice is a special final batch record, it lists all bills in the batch accepted by HCFA followed by bills in the batch deleted by HCFA.

14. Sequence Number.—This is a 2-digit number assigned by HCFA for control of each bill in the batch.

15. HI Claim Number.—The HI claim number is entered as shown in the billing data.

16. Surname.—The beneficiary's surname appears as shown in the billing data (six positions only).

17. Billing From Date.—The from date or first date of the billing period is shown as it is shown in the billing data.

18. Reimbursement Amount.—This is the amount of reimbursement reported in the billing data even if the billing data is automatically corrected and reinstated by HCFA. The reimbursement for HCFA corrected bills can be determined as follows:

a. Overapplied Part A cash deductible.—Subtract the adjusted deductible from the original deductible and add the difference to the reimbursement amount originally reflected for this item. The total represents what should have been reimbursed to the provider. Both the original and adjusted Part A cash deductibles are shown with the miscellaneous data. Any overapplied deductible amount must be refunded to the beneficiary or other party that paid the deductible. Make the refund in accordance with §§ 3401ff.

b. Overapplied Part A blood deductible.—Subtract the adjusted blood deductible pints from the original blood deductible pints and multiply the difference by the charge per pint. Add the product to the reimbursement amount originally shown to compute what should have been reimbursed to the provider. Both the original blood deductible pints applied, the adjusted blood deductible pints applied, and the applicable charge per pint are shown with the miscellaneous data. Any overapplied deductible charges must be refunded to the beneficiary or other party that paid the deductible. Make the refund in accordance with SS 3401ff.

c. Underapplied Part A blood deductible.—Subtract the original blood deductible pints from the adjusted blood deductible pints and multiply the difference by the charge per pint. Subtract the product from the reimbursement amount originally shown to compute what should have been reimbursed to the provider. Both the original blood deductible pints applied, the adjusted blood deductible pints applied, and the applicable charge per pint are shown with the miscellaneous data. Recoupment of the difference in blood pint charges should be processed in accordance with SS 3707-3714.4.

d. Overutilization of full reimbursement days.—Subtract the original nonlifetime coinsurance days from the HCFA adjusted nonlifetime coinsurance days and multiply the difference by the coinsurance rate shown with the miscellaneous data when the rate calculated by HCFA is the same as that shown on the bill. Subtract the result from the reimbursement amount originally reflected here to compute what should have been reimbursed to the provider. Both the original coinsurance days, if any, and the adjusted nonlifetime coinsurance days are shown with the miscellaneous data. Recoupment of the undercollected coinsurance amount should be processed in accordance with SS 3707-3714.4. When HCFA shows a rate that is different than that shown on the bill, recalculate the nonlifetime coinsurance amount by using the new rate established by HCFA and then recompute the new reimbursement amount. The refund or recoupment, whichever is applicable, should be made in accordance with SS 3707-3714.4 and S 3401ff.

e. Underutilization of nonlifetime coinsurance days.—Subtract the original nonlifetime coinsurance days from the HCFA adjusted nonlifetime coinsurance days and multiply the difference by the coinsurance rate shown with the miscellaneous data when the coinsurance rate calculated by HCFA agrees with the original rate shown on the bill.

Add the result to the reimbursement amount originally reflected to compute what should have been reimbursed to the provider. Both the original nonlifetime coinsurance days, if any, and the adjusted nonlifetime coinsurance days are shown with the miscellaneous data. Refund any coinsurance amounts overcollected from the beneficiary or other party that paid the deductibles in accordance with SS 3401ff. When HCFA shows a rate that is different than that shown on the bill, recalculate the nonlifetime coinsurance amount by using the new rate established by HCFA, recalculate the new lifetime coinsurance amount for the benefit period, and then recompute the new reimbursement.

f. Not entitled to type (Part A or Part B) of home health visits on billing.—The automatic correction does not affect the amount of reimbursement since the total number of visits are not subject to correction only the type of visits ("A" or "B") applied are subject to change.

19. Process Code.—These codes indicated the status of each bill as follows:

Code	Explanation
AAAA	Accepted
RRRR	Bill is in orbit
HHHH	Bill is under investigation
Blank	REJECTED - TEST CLAIM
7000 SERIES	Bill has been automatically corrected

A list and explanation of error codes for bills deleted and returned to the intermediary and automatic correction codes are shown in §§ 3824-3828ff.

20. Corrected HI Claim Number.—If HCFA processed the bill under a different (corrected) claim number than the number shown by the intermediary, the corrected number appears in this item, preceded by a code which indicates the reason it was changed. The codes are "X" for cross-referred and "C" for correction.

This situation occurs when an intermediary did not correct the claim number on a bill based on the query reply, or when HCFA records a number change after an intermediary has queried an admission. Usually, a number change results from a divorce or remarriage of a beneficiary. Upon receipt of a corrected number, be sure to correct your record.

21. Miscellaneous Billing Data.—The following are possible entries which may appear in this item. The entry applies only to the bill on that line. This field is used in conjunction with the Process Code (Field 10 on the Batch Clearance detail record) to give the intermediary additional information on the disposition of the bill. On the Batch Clearance tape record this data is indicated by codes located in positions 68 through 71. A maximum of four codes can be contained in the tape record for each bill.

NAME/# DIS	When received in conjunction with a consistency edit error code, it alerts the intermediary to the fact that the name and HIC number transmitted do not match any on the Health Insurance Master Record. In addition to correcting the consistency error, the intermediary must also resolve this problem before resubmitting. Otherwise, a utilization error will result. (Code 1 on the tape record.)

NO OPEN ITEM	Given in conjunction with a process code indicating the bill is being rejected for a consistency or utilization error. It signifies no query has been received for the admission date shown on the bill, and no open item is being placed on the Admission Control record as a result of this bill. Therefore, for these bills only, no delete query is required if the intermediary corrects the admission date. However, this rejected bill is placed on the RTI Control file, and a correction or void bill is required. The intermediary should verify that the admission date transmitted to Medicare was correct, query if necessary, and otherwise take appropriate action to transmit correct data to Medicare. This code will not apply to Home Health bills. (Code 2 on the tape record.)
NO PART A	Medicare records show no entitlement to Part A benefits. (Code 3 on the tape record.)
NO PART B	Medicare records show no entitlement to Part B benefits, (Code 4 on the tape record.)
MISBATCHED	An initial bill was submitted in a correction batch or a correction bill was submitted in an initial batch (see entry in "TYPE OF BILL"). This code will not apply for batches submitted after September 1, 1979, inasmuch as correction and initial bills will be in the same batch after that time. (Code 5 on the tape record.)
PURGED	Used in conjunction with process code AAAA. The previously rejected bill has been purged due to age. Beneficiary Utilization record has been updated (see § 3837). (Code 6 on the tape record.)

GEN OPEN ITEM	Used with process codes AAAA, HHHH, or RRRR whenever the hospital of SNF bill received contains an admission date which has not been queried. It is intended to alert the intermediary to a possible error. When this code accompanies a bill which is not the initial bill for a stay (i.e., admission and from dates are not equal), it will indicate that not only was the admission date not queried, but HCFA has not received any earlier bills for this stay. Intermediary should status query to determine whether the admission date transmitted is correct and take appropriate corrective action if required. (See also § 3831.1, Item 110. C and G trailers.) (Code 7 on the tape record.)
TOLERANCE (Money Amount)	- (a) Total covered charges of less than $50 are shown on HCFA-1453, HCFA-1486, HCFA-1483, HCFA-1487, or equivalent tape format and HCFA's records indicate that the deductible has not been met. - (b) Total charges on the bill exceed the deductible applied on the bill, HCFA records show that less than $50 of the inpatient or calendar year deductible, whichever is applicable to the particular billing, remains to be met, and in the case of a HCFA-1453, a code "A" does not appear in location 81 of the tape format (19V of the HCFA-1453) indicating physician charges not includable with the deductible. (See § 3620, Item 19V, example 3.) - (c) The sum of payment distributions (item 25, provider and patient block amounts combined) on a HCFA-1483 are equal to less than $50. The exact amount of the deductible to be met for a bill accepted under (a), (b), or (c) should be obtained from the most recent HCFA response to a query for the involved bill.
(Date of Death Death, Home Health Part A or B or Outpatient)	-(a) The through and discharge dates of a Part A or Part B home health or outpatient bill will be overlaid with the HI date of death, if the home health bill through date is the last day of the month, and the HI date of death is prior to the bill through date, but is equal on month and year, or the outpatient bill through date is equal on month and year.

best copy available

-(b) If the bill fails any subsequent edits, the bill will be returned to the intermediary for the appropriate reason. No automatic adjustment routines will be applied to these bills. The bill through and discharge dates will contain the HI date of death that overlaid the original through and discharge dates submitted by the intermediary.

See § 3930.1E, Batch Clearance Detail Record, fields 18 and 19 for additional details regarding both tolerances.

Missing Batch Report

3844. QUARTERLY MISSING BATCH REPORT

A. HCFA provides intermediaries quarterly, a Missing Batch Report. The report is prepared upon completion of the Batch Status operations in the last month of each quarter.

The report is prepared in conjunction with Part A Statistical Standards. The established performance criteria requires that no more than 2 percent of all missing batches be missing more than 3 months; i.e., the percentage shown on item 4 must be at least 98 in order to be in compliance.

Statistics are provided monthly on the last page of your Batch Status Report in order that you may determine on a current basis whether or not you are in compliance with the performance criteria. See § 3842 for actions you should take when you have missing batches.

B. Description of Items on Missing Batch Report.—The Missing Batch Report is broken down into the following categories:

1. Number of batches missing 1-3 months.
2. Number of batches missing 4 months or more.
3. Total number of missing batches.
4. Percentage of the total missing batches that are missing less than 4 months.

The above four categories will be shown for:

1. Individual intermediary numbers.
2. Regional totals - totals for all intermediary numbers within your Medicare region.
3. National totals - totals for all intermediary numbers.

3845. BILL ERROR REPORT

This report is furnished to all intermediaries on a quarterly basis. Three reports are provided. One for INPATIENT HOSPITAL and SKILLED NURSING FACILITY billings, one for HOME HEALTH and OUTPATIENT billings, and for HOSPICE billings. The report is divided into three distinct parts and the bill processing data is shown for the last four quarters (includes the most recent quarter). Examples of these parts follow:

PART I (TYPE OF BILLING)

	QUARTER	PERCENT	LAST 4 QUARTERS	PERCENT
NATIONAL (9)				
BILLS REVIEWED	2,761,846	100.0	10,750,917	100.0
BILL ERRORS	62,816	2.3	226,577	.2
**CONSISTENCY	3,692	.1	16,230	.2
*UTILIZATION	59,124	2.1	210,347	2.0
INTERMEDIARY (10)				
BILLS REVIEWED	50,263 (1)	100.0 (5)	185,096	100.0
BILL ERRORS	797 (2)	1.6 (6)	2,860	1.5
**CONSISTENCY	4 (3)	.0 (7)	14	.0
*UTILIZATION	793 (4)	1.6 (8)	2,846	1.5

EXPLANATION

(1) - This figure represents the number of bills reviewed (processed by HCFA).
(2) - This figure represents the number of bills returned (deleted).
(3) - Of the bills returned, this represents consistency errors.
(4) - Of the bills returned, this represents utilization errors.
(5) - This is the percentage of bills reviewed.
(6) - This is the percentage (rounded) of returned bills.
(7) - Percentage (rounded) of bills returned for consistency errors.
(8) - Percentage (rounded) of bills returned for utilization errors.
(9) - The figures are the totals for all intermediaries in the United States.
(10)- The figures are the totals for the intermediary for which the report is prepared.

*Includes bills automatically corrected by HCFA.
**Consistency edits performed on the face of the bill only.

PART II CONSISTENCY CODES (SEE §3825.1***)

CODE	QUARTER	PERCENT	LAST 4 QUARTERS	PERCENT
19X2	1 (1)	.0 (2)	4 (3)	.0 (4)
2802	2	.0	5	.0
3211	0	.0	5	.0
MULT	1 (5)	.0	1	.0

EXPLANATION

(1) - This figure represents the number of bills that failed the 19X2 edit.
(2) - Percentage (rounded) of bills returned for this error during the quarter.
(3) - Number of bills that failed the edit during the last 4 quarters.
(4) - Percentage (rounded) of bills that failed the edit during the last 4 quarters.
(5) - If more than 1 error, "MULT" (multiple) appears instead of code.

PART III UTILIZATION CODES (SEE §3828FF***)

CODE	QUARTER	PERCENT	LAST 4 QUARTERS	PERCENT
5052	9	.0	26	.0
5200	2	.0	2	.0
5211	53 (1)	.1 (2)	247 (3)	.1 (4)

EXPLANATION

(1) - This figure represents the number of bills that failed the 5211 edit.
(2) - Percentage (rounded) of bills returned for this error during the quarter.
(3) - Number of bills that failed the edit during the last 4 quarters.
(4) - Percentage (rounded) of bills that failed the edit during the last 4 quarters.

***Section of Medicare Intermediary Manual containing narrative for code.

PART II and III data pertains to the intermediary for which the report is prepared.

```
BILL ERROR REPORT - QUARTER ENDING XX/XX/XX        INTERMEDIARY NO. 00000

PART I         INPATIENT HOSPITAL                                              SKILLED NURSING FACILITY
------------------------------------------------------     ------------------------------------------------------

                QUARTER      PERCENT  LAST 4 QTRS - PERCENT        QUARTER      PERCENT  LAST 4 QTRS   PERCENT

NATIONAL
 BILLS REVIEWED XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X          XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X
 BILL ERRORS    XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X          XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X
**CONSISTENCY   XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X          XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X
 *UTILIZATION   XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X          XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X

INTERMEDIARY
 BILLS REVIEWED XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X          XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X
 BILL ERRORS    XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X          XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X
**CONSISTENCY   XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X          XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X
 *UTILIZATION   XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X          XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X

PART II        CONSISTENCY CODES (SEE 3825.1***)                       CONSISTENCY CODES(SEE 3825.1***)
------------------------------------------------------     ------------------------------------------------------
CODE            QUARTER      PERCENT  LAST 4 QTRS   PERCENT    CODE QUARTER      PERCENT  LAST 4 QTRS   PERCENT

XXXX            XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X      XXXX XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X

         (AN ERROR CODE IS NOT LISTED FOR AN                         (AN ERROR CODE IS NOT LISTED FOR
          ERROR THAT OCCURRED PRIOR TO THE                            AN ERROR THAT OCCURRED PRIOR TO
          LAST 4 QUARTERS)                                            THE LAST 4 QUARTERS)


PART III       UTILIZATION CODES (SEE 3828FF***)                       UTILIZATION CODES(SEE 3828FF***)
------------------------------------------------------     ------------------------------------------------------
CODE            QUARTER      PERCENT  LAST 4 QTRS   PERCENT    CODE QUARTER      PERCENT  LAST 4 QTRS   PERCENT

XXXX            XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X      XXXX XXXXXXXXXX   XXX.X   XXXXXXXXXX    XXX.X

         (AN ERROR CODE IS NOT LISTED FOR AN                         (AN ERROR CODE IS NOT LISTED FOR
          ERROR THAT OCCURRED PRIOR TO THE                            AN ERROR THAT OCCURRED PRIOR TO
          LAST 4 QUARTERS)                                            THE LAST 4 QUARTERS)

*INCLUDES BILLS AUTOMATICALLY CORRECTED BY HCFA            ***SECTION OF MEDICARE INTERMEDIARY MANUAL
**CONSISTENCY EDITS PERFORMED ON THE FACE OF THE BILL ONLY    CONTAINING NARRATIVE FOR CODE
```

```
BILL ERROR REPORT - QUARTER ENDING XX/XX/XX        INTERMEDIARY NO. 00000

PART I        HOME HEALTH (A&B)
----------------------------------------------         ----------------OUTPATIENT--------------------

                   QUARTER    PERCENT LAST 4 QTRS PERCENT        QUARTER     PERCENT LAST 4 QTRS PERCENT
NATIONAL
 BILLS REVIEWED XXXXXXXXXX  XXX.X  XXXXXXXXXX   XXX.X        XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X
 BILL ERRORS    XXXXXXXXXX  XXX.X  XXXXXXXXXX   XXX.X        XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X
**CONSISTENCY   XXXXXXXXXX  XXX.X  XXXXXXXXXX   XXX.X        XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X
 *UTILIZATION   XXXXXXXXXX  XXX.X  XXXXXXXXXX   XXX.X        XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X

INTERMEDIARY
 BILLS REVIEWED XXXXXXXXXX  XXX.X  XXXXXXXXXX   XXX.X        XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X
 BILL ERRORS    XXXXXXXXXX  XXX.X  XXXXXXXXXX   XXX.X        XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X
**CONSISTENCY   XXXXXXXXXX  XXX.X  XXXXXXXXXX   XXX.X        XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X
 *UTILIZATION   XXXXXXXXXX  XXX.X  XXXXXXXXXX   XXX.X        XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X

PART II      CONSISTENCY CODES (SEE 3825.4***)                 ----CONSISTENCY CODES (SEE 3825.2***)----
----------------------------------------------

CODE             QUARTER    PERCENT  LAST 4 QTRS PERCENT      CODE  QUARTER     PERCENT LAST 4 QTRS PERCENT

XXXX             XXXXXXXXXX XXX.X    XXXXXXXXXX   XXX.X       XXXX  XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X

        ( AN ERROR CODE IS NOT LISTED FOR AN                       (AN ERROR CODE IS NOT LISTED FOR
          ERROR THAT OCCURRED PRIOR TO THE                          AN ERROR THAT OCCURRED PRIOR TO
          LAST 4 QUARTERS)                                          THE LAST 4 QUARTERS)

PART III     UTILIZATION CODES (SEE 3828FF***)                 ----UTILIZATION CODES (SEE 3828FF***)----
----------------------------------------------

CODE             QUARTER    PERCENT  LAST 4 QTRS PERCENT      CODE  QUARTER     PERCENT LAST 4 QTRS PERCENT

XXXX             XXXXXXXXXX XXX.X    XXXXXXXXXX   XXX.X       XXXX  XXXXXXXXXX   XXX.X  XXXXXXXXXX   XXX.X

        (AN ERROR CODE IS NOT LISTED FOR AN                        (AN ERROR CODE IS NOT LISTED FOR
         ERROR THAT OCCURRED PRIOR TO THE                           AN ERROR THAT OCCURRED PRIOR TO
         LAST 4 QUARTERS)                                           THE LAST 4 QUARTERS)

*INCLUDES BILLS AUTOMATICALLY CORRECTED BY HCFA              ***SECTION OF MEDICARE INTERMEDIARY MANUAL
**CONSISTENCY EDITS PERFORMED ON THE FACE OF THE BILL ONLY      CONTAINING NARRATIVE FOR CODE
```

```
BILL ERROR REPORT - QUARTER ENDING XX/XX/XX            INTERMEDIARY 00000

PART I          HOSPICE
-------------------------------------------------------------------------

                QUARTER     PERCENT  LAST 4 QTRS  PERCENT
                -------     -------  -----------  -------
NATIONAL
 BILLS REVIEWED XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X
 BILL ERRORS    XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X
**CONSISTENCY   XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X
 *UTILIZATION   XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X

INTERMEDIARY
 BILLS REVIEWED XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X
 BILL ERRORS    XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X
**CONSISTENCY   XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X
 *UTILIZATION   XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X

PART II         CONSISTENCY CODES (SEE 3825.8***)
-------------------------------------------------------------------------

CODE            QUARTER     PERCENT  LAST 4 QTRS  PERCENT
----            -------     -------  -----------  -------
XXXX            XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X

         (AN ERROR CODE IS NOT LISTED FOR AN
          ERROR THAT OCCURRED PRIOR TO THE
          LAST 4 QUARTERS)

PART III        UTILIZATION CODES (SEE 3828FF***)
-------------------------------------------------------------------------

CODE            QUARTER     PERCENT  LAST 4 QTRS  PERCENT
----            -------     -------  -----------  -------

XXXX            XXXXXXXXXX  XXX.X    XXXXXXXXXX    XXX.X

         (AN ERROR CODE IS NOT LISTED FOR AN
          ERROR THAT OCCURRED PRIOR TO THE
          LAST 4 QUARTERS)

*INCLUDES BILLS AUTOMATICALLY CORRECTED BY HCFA           ***SECTION OF MEDICARE INTERMEDIARY MANUAL
**CONSISTENCY EDITS PERFORMED ON THE FACE OF THE BILL ONLY    CONTAINING NARRATIVE FOR CODE
```

3850. PROVIDER SPECIFIC PAYMENT DATA

Submit a file of Provider Specific Payment Data to CO on a quarterly basis within 15 calendar days after the end of the quarter being reported. Submit this file for PPS and non-PPS hospitals, including hospitals in waiver States. Create a new record any time a change occurs for a provider.

A. PPS Hospitals.—Quarterly, submit all records (past and current) for all PPS providers. Duplicate the provider file used in the "Pricer" module of your claims processing system.

B. Non-PPS Hospitals and Exempt Units.—Create a provider specific history file using the listed data elements for each non-PPS hospital and exempt hospital unit. Quarterly, submit only the current and the preceding fiscal years. If you want to maintain the record for non-PPS hospitals and units in your Pricer PROV file, code Y in position 13.

Use magnetic tape to submit the files.

Send a paper listing copy to your RO.

If you service providers outside of your area, submit a hardcopy of the file to the RO in which the facility is located. (For example, Mutual submits hardcopy of the file to Denver, San Francisco, Atlanta, and Dallas ROs.)

Exception: The intermediary servicing Indian Health Facilities need submit a hardcopy of the file only to the Dallas RO.

Send file to:

Health Care Financing Administration
Provider-Specific Data for Quarter Ending xx/xx/xx
Job OCPSF
Data Quality and Documentation Branch, BDMS
G-D-2 Meadows East Bldg.
6325 Security Blvd.
Baltimore, MD 21207

3850.1 Physical File Specifications - Magnetic Tape.—Tape Characteristics -9 Track, 8 1/2" to 10 1/2" reels with silver mylar reflector with write ring removed.

Parity - Odd

Recording Density - 1600 bytes per inch.

Recording Mode - EBCDIC

File Label - None. The first data record on the file contains the acronym PROSPEC in the first seven positions of the record, blanks in the remaining 153 positions, and serves as a file label. The tape must have an end of file mark.

Logical Record Length - 160 characters.
Block Size: 1600 characters, i.e., a blocking factor of 10.
Unfilled Final Block - Fill with nines.

The external label on the reel must appear as follows:

From (Intermediary Number) To HCFA--BSS,OCO,Job#OCPSF
Provider Specific Payment Data Recording Density 1600 BPI
Date Tape Created (MMDDYY)

3850.2 Provider Specific Data Record Layout and Description.--Complete all fields for PPS hospitals by duplicating the PROV file in Pricer. The data requirements are identified. Complete all fields for non-PPS hospitals and distinct part exempt units as below. This instruction does not apply to SNFs and HHAs.

Field	Format	Location	Coding and Edits
1. Provider No.	X(6)	1-6	Alpha/Numeric - Cross check to item 4 provider type. Positions 3 and 4 of:

Provider Number	Type (see field 4.
00-08	Blanks, 00, 01, or 07-11
12	12
20-22	02
30	04
33	05
40-44	03

Codes for special units S, T, U, or V are in the third position of the provider number and should be type 06 (hospital distinct parts).

Field	Format	Location	Coding and Edits
2. Effective Date	9(6)	7-12	Date of latest change(s) YYMMDD (numeric) year greater than 82, but not greater than current year. Month 01-12, Day 01-31. (See §3656.3 for definition.)
3. Waiver Code	X	13	Provider waived from PPS? Must be Y (yes) or N (no).

Field	Format	Location	Coding and Edits
			Y = Hospital is not under PPS N = Hospital is under PPS
4. Provider Type	XX	14-15	Must be blank or 00-12 blanks or 00 = short term facility 01 = Sole Community 02 = Long Term 03 = Psychiatric 04 = Rehabilitation Facility 05 = Pediatric 06 = Hospital Distinct Parts 07 = Referral Center 08 = Indian Health Center 09 = Redesignated rural - year 1 10 = Redesignated rural - year 2 11 = Sole Community/referral center 12 = Alcohol facility
5. Census Division	9	16	Must be numeric (1-9) The census division to which the facility belongs for payment purposes. Use to select the payment rates. See §3656.3 for valid codes.
6. PPS Blend Period	9	17	For PPS hospitals, report the data in position 17 of your Pricer PROV file. For non-PPS hospitals, enter zero. Must be blank or 0-6.
7. Metropolitan Statistical Area	9(4)	18-21	Must be numeric 9999 if rural or MSA # 0040 - 9340.
8. Fiscal Year End	9(6)	22-27	Must be month, day, and year (MMDDYY) (numeric) Month: 01-12 Day: 01-31 Year: Greater than 82, but not more than 1 year greater than the current year.
9. Case Mix Adjusted Cost Per Discharge	9(5)V99	28-34	For PPS hospitals and waiver State nonexcluded hospitals, enter the PPS base year cost per discharge divided by the case mix index. For excluded hospitals enter the cost per

Field	Format	Location	Coding and Edits
			discharge for the preceding cost reporting period shown in item 8. Verify if figure is less than $400 or greater than $10,000.
10. Cost of Living Adjustment	9V999	35-38	For PPS hospitals report the adjustment in these positions of your PROV file. See §3656.3 for non-PPS hospitals. See §3656.3, file positions 35-38 for acceptable values.
11. Intern-bed ratio	9V9(4)	39-43	For PPS hospitals, include the ratio from your Pricer PROV file. For non-PPS hospitals, calculate as you would for PPS hospitals. See §3656.3D for the calculation.
12. Special Provider Update Factor	9V9(5)	44-49	For PPS hospitals, include the factor, if any, from your PROV file. For non-PPS hospitals, enter zero. (See §3656.3)
13. Hospital Beds	9(5)	50-54	Enter the number of hospital beds available. See §3656.3D for definition. Must be greater than zero.
14. Disproportionate Share Percentage	V9(4)	55-58	For PPS hospitals, include the disproportionate share adjustment percentage in position 55-58 in your PROV file. Acceptable range is .0000-.9999. (See §3656.3)
15. Cost to Charge Ratio	9V999	59-62	Derived from latest settled cost report and corresponding charge data from the billing file. Compute this amount by dividing the Medicare Operating Cost (from the cost report) by the Medicare Covered Charge (from the billing file, i.e., the PS&R record). For hospitals

Field	Format	Location	Coding and Edits
			which you are unable to compute a reasonable cost-to-charge ratio, use the appropriate urban or rural statewide average cost-to-charge ratio calculated annually by HCFA. Use these average ratios to calculate cost outlier payments for hospitals where you compute cost-to-charge ratios lower than 0.35 or greater than 1.25. (See §3656.3)
16. Case Mix Index	9V9(4)	63-67	For PPS hospitals, enter the case mix index used to compute field 9. Enter zero for all others.
17. Filler	X	68	Blank
18. Report Date	9(6)	69-74	Must be MMDDYY Date file created.
19. Filler	X	75	Blank
20. Intermediary number	X(5)	76-80	Assigned intermediary number
21. Fiscal Year Beginning Date	9(6)	81-86	Must be numeric (MMDDYY) Month: 01-12 Day: 01-31 Year: Greater than 81 but not greater than the current year.
22. Pass Thru Amount for Capital	9(4)V99	87-92	Per diem amount based on the interim payments to the hospital.
23. Pass Thru Amount For Direct Medical Education	9(4)V99	93-98	Per diem amount based on the interim payments to the hospital.
24. Pass Thru Amount for Organ Acquistion	9(4)V99	99-104	Per diem amount based on the interim payments to the hospital.
25. Total Pass Thru Amount, Including Miscellaneous	9(4)V99	105-110	Per diem amount based on the interim payments to the hospital.

Field	Format	Location	Coding and Edits
26. Supplemental Security Income Ratio	V9(4)	111-114	SSI ratio used to to determine if the hospital qualifies for the disproportionate share adjustment.
27. Medicaid Ratio	V9(4)	115-118	Medicaid ratio used to to determine if the hospital qualifies for the disproportionate share adjustment.
28. Filler	9(42)	119-160	Blank

3850.3 Intermediary Responsibilities.—Create a new record when a change occurs for a provider. You may have multiple records for a single provider within a quarter.

Prior to submitting the file to HCFA, print and review the data. Edit all items for accuracy and correct any errors before submitting the file. Some edit examples:

- Effective date other than YYMMDD.
- Facility has two or more records with different provider numbers for the same month.
- Non-PPS facility with incorrect provider type.
- Incorrect census division for a redesignated facility.
- MSA field with other than 9999 for a rural provider.
- No FYE indicated.
- Questionable pattern of coding, e.g., all provider types in field 4 are identical, all case mix indexes in field 16 are identical.

Provider specific payment data must be received in CO within 15 calendar days of the end of the reporting period. The data will be evaluated based on the following criteria:

- Files conform to tape specifications;
- Files reflect data from all required providers; and
- Files are submitted in the correct record format.

CO will forward an error listing to you for corrections. Submit corrected data files to HCFA within 10 calendar days of notification.

evaluation do not submit another test tape until you are notified of the results of the prior test tape and any reported error situation(s) corrected. Notice that you should continue or discontinue testing is given by telephone, followed by written confirmation from BPO.

HCFA usually processes test tapes within 5 working days of receipt. HCFA will notify you of the results within 3 days after completion of the test. Address testing materials and related correspondence to:

Health Care Financing Administration
Division of Provider Procedures, BPO
Mail Stop 1-H-1
Meadows East Bldg.
Baltimore, MD 21207

3866.1 Number of Test Bills.-- A sufficient test consists of no fewer bills than:

100 Inpatient Hospital,
100 Inpatient SNF,
100 Outpatient Hospital,
100 Hospice,
100 Home Health,
100 CORF,
60 adjustment bills - for each bill type at least 5 of each of the following:
    CANCEL ONLY (all codes)
    DEBIT/CREDIT adjustments
30 RTI VOID claim records with a minimum of five of the bill types listed above,
30 RTI Correction Claim records, five for each bill type listed above,
25 Christian Science bills for intermediaries processing Christian Science claims.

You may submit additional claims of each type, but the length of time required to analyze the test results is directly proportional to the number of test claims submitted. Do not submit parallel production runs for this test.

3866.2 Recording Characteristics.-- 9 track, 1600 or 6250 BPI.

3867. OPERATIONAL PROCEDURES.

Operational billing tapes must comply with this specification. Label them with the prescribed external label (see § 3867.1) and send them to HCFA with a Summary Totals Report (see § 3867.2) for each operational tape reel you submit.

Address inquiries concerning systems operations, procedures, and/or performance of the operational system to HCFA. (See § 3866 for address.)

3867.1 Magnetic Tape Reel External Identification Label.-- Identify each reel of magnetic tape submitted for processing with an external label (form SSA-2589) prepared as follows:

File Code - Enter UNIBILL (Operational Tape)

Enter UNIBILT as appropriate (Test Tape)

Sub Code - Enter Your Identification Number

Oper. Code - Enter Date Created (MMDDYY)

Reel No. - Enter 1 of 1, 1 of 2, 2 of 2, . . . as appropriate (Multi-reel file). Leave blank or enter 1 of 1 (Single-reel file).

Control Identification:

FIRST	Enter first four characters of the batch number. (See § 3879.2.) If it is a multi-batch tape, enter the first four characters of the batch number of the first batch on the reel.
LAST	If it is a multi-batch tape, enter the first four characters of the batch number of the last batch on the reel. Otherwise blank.
MISC. DATA	Enter the reel control number. For test tapes, number the reels in sequential order, i.e., T-1, T-2, etc., for first, second, etc. tests. Number the operational reels produced during any given calendar year in sequential order, i.e., 1,2,....
RECORDING CHARACTERISTICS	Circle applicable recording characteristics (see § 3866.2)- density and number of tracks only. Mode need not be identified. The label does not provide for a density of 6250 BPI. Therefore, if your file is 6250 BPI, indicate that fact by entering "6250" directly above the portion of the label provided for indicating density.

3867.2 The Summary Totals Report.-- You are free to design a Summary Totals Report in a format suited to your equipment and method of operation.

Summary Totals Report must accompany each operational reel of tape submitted to SSA, and contain the following information;

SSA address;

Production date;

Your name, number and address;

Reel Number;

Batch Numbers;

Types of Batches;

Total number of batches;

Total number of bills in each batch;

Total number of bills in all batches;

Reimbursement amount for each batch; and

Total reimbursement amount (for all batches on the tape reel).

3867.3 File Retention.—Retain a copy of the UNIBILL file until receipt of the HCSSACL tape which indicates that the subject UNIBILL file has been received and processed by HCFA. If you have not received the related HCSSACL file within 20 days from the date HCFA received the UNIBILL file, contact the Division of Provider Procedures at the address shown in §3866.

Consistency Edits-Magnetic Tape File

3868. CONSISTENCY EDITS - ALL BILL TYPES.

Records must be in the correct order within the file.

Each record must contain a valid record identification code.

Each bill record must contain a valid action code.

Each bill record must be in the proper batch with batch number entered in the appropriate data block.

Each date must be a valid date in the valid format.

Each money field in file must be numeric and unsigned unless otherwise specified.

A valid Return to Intermediary (RTI) Control Number must be entered on each resubmitted RTI bill. For bills that are not RTIs this field is blank.

3869. CONSISTENCY EDITS - ADJUSTMENT BILLS.

Code each adjustment bill as follows:

It must contain an association code, "Xn" for Debit and Credit, where X equals A thru Z, and n equals 1 thru 9.

Both bills in a Debit-Credit adjustment action must be together in the same batch, and the patient's name, HICN, and association code the same on both bills.

NOTE: Both bills will be deleted if either is not present in the batch or is returned for correction.

A "Cancel Only" adjustment bill must contain a reason code of "C", "P", "S", "D", or "H".

The positions allocated for the adjustment bill codes must be blank for nonadjustment bill.

3870 ALPHABETIC GLOSSARY OF DATA ELEMENTS.

Data Element	Definition
Action Code	Indicates the type of action to take: 1 - Original Debit Action (Includes nonadjustment RTI correction items) 2 - Cancel by Credit Adjustment 3 - Secondary Debit Adjustment 4 - Cancel Only Adjustment 8 - Benefits Refused (For inpatient bills, an "R" nonpayment code must also be present.) 9 - Payment Requested (Used on bills that replace previously submitted benefits refused bills, Action Code 8. In such cases a debit/credit pair is not required. For inpatient bills, enter a "P" in the nonpayment code.)
Adjustment Code	
a. Cancel Only	Reason for cancelling previously submitted bill.
b. Filler	
c. Association Code	Code to associate debit/credit adjustments. A1=Credit, A1=Debit
Admission Date	The date the patient was admitted for inpatient care, outpatient service, or start of care. For an admission notice for hospice care, enter the effective date of election of hospice benefits.
Admitting Diagnosis Code	Code indicating patient's diagnosis at admission.
Attending Physician Number	Number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.
Batch Number	Number of the batch in which this bill was submitted.
Batch Date	Date you batched this bill.
Birth Date	The patient's date of birth.
Blood Deductible Charge Per Pint	Average charge per pint for the blood pints used to satisfy the Medicare blood deductible.
Blood-Deductible Pints	The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible.
Blood-Furnished Pints	Total number of pints of whole blood or units of packed red cells furnished to the patient.

Data Element	Definition.
Blood-Replaced Pints	The total number of pints of whole blood or units of packed red cells furnished to the patient that have been replaced by, or on behalf of, the patient.
Blood-Unreplaced Pints	The number of pints of whole blood or units of packed red cells furnished to the patient that have not been replaced by, or on behalf of, the patient.
Charges	Charges pertaining to the related revenue code.
Condition Codes	Code(s) used to identify conditions relating to this bill that may affect payer processing. (Addendum C.)
Cost Report Days	Days credited to provider's PS&R Report as Medicare Days.
Date Approved	Date you adjudicated an initial bill or, for adjustment bills, date you processed the adjustment.
Date Care Started	For Home Health Claim, the first date the beneficiary used benefits for the current approved period of Home Health services.
Date of Service (Ancillaries Only)	The date the associated ancillary service as identified by the UB-82 revenue center code was delivered.
Date Received	Date you received the bill or the bill passed your edits if received via an interactive terminal for initial bills. For PRO adjustments, this is the later of the date you received the adjustment or the date you received a batch clearance notice on the original bill.
Diagnosis Code	The first of these codes is the ICD-9-CM diagnosis code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization.) The remaining codes are the ICD-9-CM diagnosis codes corresponding to additional conditions that co-existed at the time of admission, or developed subsequently, and which had an effect on the treatment received or the length of stay.
Diagnosis Related Grouping	Code assigned to indicate the DRG to which this claim belongs for payment purposes. Applicable to hospital bills.
ESRD Method of Reimbursement	Code indicating whether ESRD covered services are reimbursed under Method 1 or Method 2. 1=Method 1, 2=Method 2, 0=Not ESRD

Data Element	Definition
First Year Coinsurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness. If bill spans two calendar years, this field contains the coinsurance days that occur in the first calendar year, otherwise it contains the total coinsurance days for the stay.
HCPCS Code	HCPCS stands for HCFA Common Procedure Coding System. It is an extention of the CPT-4 procedure coding system maintained by the AMA and used by Carriers to pay SMI claims and by Intermediaries to indicate diagnostic clinical laboratory tests. The diagnostic clinical laboratory codes that must be billed by hospitals are contained within the CPT-4 subset of HCPCS. Not required for inpatient bills.
HICN	Beneficiary's unique identification number assigned by Medicare. Enter the patient's Medicare number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.
HMO Identification	A five position number identifying the HMO.
HMO Option Code	Code identifying the HMO option selected by the HMO. See §3555.1. If the "R" trailer is a "1" or a "2", the HMO is a cost basis HMO. If the "R" trailer is an "A", "B", or "C", the HMO is a risk basis HMO.
HMO Election Date	The effective date of the beneficiary's membership in the HMO.
HMO Termination Date	The effective date of the beneficiary's termination of membership in the HMO.
HMO Paid Code	A "1" in this position indicates an HMO paid this bill. Only required on inpatient bills.
Intermediary Number	Your Medicare identifying number.
Kron Indicator	Presence of a "1" in this field indicates that this bill starts a new spell of illness regardless of the contents of HCFA's utilization record.
Medicaid Provider Number	The number assigned to the provider by Medicaid.
Medical Record Number	Number assigned by the provider to the patient's records to assist in retrieval.

Data Element	Definition
Medicare Provider Number	The number assigned to the provider by Medicare.
Medicare Reimbursement Amount	Amount paid to the provider by Medicare for this claim. For non-DRG bills e.g., outpatient, SNF, HHA, and exempt hospitals, this is the amount determined from the bill regardless whether PIP is used for interim payment. For DRG bills, this is the amount paid (DRG and any blended rate). Do not include pass through per diem amounts related to DRG bills, such as capital expenditures or medical education that are paid separately.
NOTE:	The reimbursement amount is the amount after any deductions because Medicare is not the primary payer, or made to satisfy deductible or coinsurance. Set minus amounts to zero.
Noncovered Charges	Charges pertaining to the related UB-82 revenue code that are not covered by Medicare.
Nonpayment Code	Code indicating reason that no Medicare payment is made.
Non-Utilization Days	Days of care not chargeable to Medicare utilization.
NOU Code	1=Do Not Send NOU; 0=Send NOU
Number of Grace Days	Following the date of the PRO/UR denial determination, this is the number of days determined by the PRO/UR to be necessary to arrange for the patient's post discharge care.
Occurrence Code	A code defining a significant event relating to this bill that may affect processing.
Occurrence Date	Date associated with the Occurrence Code in the preceding field.
Occurrence Span Code	A code that identifies an event that relates to the payment of the claim.
Occurrence Span Date	The date related to the Occurrence Span Code shown in the preceding field.
Operating Physician Number	Number used by the provider to identify the operating physician in it's records.

Data Element	Definition
Over-ride Code	Code indicating special handling for a specific revenue center code.
Pass Thru Per Diem Rate	The pass thru per diem rate consists of the established reimbursable costs for the current year divided by the estimated Medicare days for the current year (all PPS bills). See Provider Reimbursement Manual §2405.2 for types of costs to include.
Patient Control Number	Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual case records and posting of payment.
Patient Paid Excluding Blood	Amount provider reports that patient has paid toward the bill excluding payment for blood.
Patient Paid Toward Blood Deductible	Amount provider reports that patient has paid toward the blood deductible.
Patient Name	Patient's last name, first name, and middle initial.
Patient Status (At Thru Date)	A code indicating the patient's status as of the statement covers thru date.
Patient ZIP Code	ZIP code of patient's residence.
Payment Distribution	A breakout of the amount of reimbursement you paid to a. Provider, and b. Patient.
Prior Psych Days Used	The number of days the beneficiary used in a psychiatric facility in the 150 days immediately prior to Medicare entitlement and beyond.
Procedure Code	The first procedure code identifies the principal procedure performed during the period covered by this bill. The remaining codes, if any, identify the other procedures performed during the billing period.
Procedure Date	Date that each procedure indicated by the related code (preceding field) was performed.
PRO Processing Date	The processing date the PRO enters in field 18 of the PRO-Report (Pro Adjustment Record). (See §3674.5 D.)
PRO Control Number	The control number the PRO enters in field 19 of the PRO-Report (PRO Adjustment Record). (See §3674.5 D.)

Data Element	Definition
PRO Approval Indicator	An indicator describing the PRO determination.
PRO Approved Stay Dates	The first and last days approved where part of the stay had not been approved.
Rate	Rate for related inpatient accommodation. For clinical diagnostic laboratory services rendered to outpatients or non-patients, show the amount paid from the fee schedule.
ReAdmit Code	Indicates whether a hospital inpatient was admitted to this stay within seven days of discharge from an inpatient hospital. Y=Yes N=No
Record Identification Code (RIC)	Code you use to identify bill type e.g., inpatient hospital, outpatient hospital, SNF. See §3875.1 for a definition of valid codes.
Revenue Center Code	UB-82 revenue center code for the accommodation or service provided.
RTI Control Number	Number reported to you on bills returned by HCFA because an error on the bill record caused it to be not useable by the HCFA system. This number is used by HCFA to monitor your RTI bill processing.
Scheduled Payment Date	Date the check you issued is mailed, deposited by you in the provider's account or transferred electronically. For PIP claims and no payment bills, enter the scheduled payment date for payment bills in the same adjudication batch. For adjustments (action code 3 in position 2 of the record) enter the date you forward UNIBILL to HCFA.
Second Year Coinsurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness. If the bill spans two calendar years, this field contains the coinsurance days that occurred in the second calendar year, otherwise it contains zeroes.
Second Year Lifetime Reserve Days	Each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of services during a spell of illness. If the bill spans two calendar years, this field contains the Lifetime Reserve Days that fall in the second year.

Data Element	Definition
Sex	The sex of the patient as recorded at date of admission, outpatient service, or start of care.
Source of Admission	A code indicating the source of this admission.
Statement Covers	The beginning and ending service dates of the period covered by this bill.
Total Lifetime Reserve Days	Each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days during a spell of illness. This item refers to the number of lifetime reserve days used by the beneficiary.
Treatment Authorization Code	A number or other indicator that designates that the treatment covered by this bill had been authorized by the payer.
Type of Admission	A code indicating the priority of this admission.
Type of Bill	A code reported by the provider indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)
Units (Days for Accommodations)	A quantitative measure of services rendered by revenue center category to, or for, the patient to include such items as accommodation days for accommodation revenue center codes and pints of blood, number of renal dialysis treatments, etc. for ancillary revenue center codes.
UB Code	Code indicating the means by which this bill was reported to you.
Utilization Days	Days of care chargeable to Medicare utilization.
Value Amount	Amount of money related to the associated value code.
Value Code	A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization.
Verified Patient Liability	Amount of money for which you determined the patient is liable involving Blood Deductible, Cash Deductible, Part B Coinsurance.

3871. CODING STRUCTURES

Data Element: Condition Codes

Data Definition: A code(s) used to identify conditions relating to this bill that may affect payer processing.

Code Structure:

Code	Code Title	Definition
02	Employment Related	Patient alleged that the medical condition causing this episode of care was due to environment/events resulting from employment.
04	HMO Enrollee	Medicare beneficiary is enrolled in an HMO.
07	Treatment of Non-terminal Condition for Hospice Patient.	The patient is a hospice enrollee, but the provider is not treating a terminal condition and is therefore requesting Medicare reimbursement.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Indicates that the beneficiary would not provide information concerning other insurance coverage.
09	Neither Patient nor Spouse is Employed	Indicates that in response to provider development questions, the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Indicates that in response to provider development questions, the patient and spouse have indicated that they are employed but hold no group coverage from an EGHP.
11	Disabled Beneficiary but no LGHP	Indicates that in response to provider development questions, the disabled beneficiary and/or family member has no group coverage from a LGHP.
17	Patient is Over 100 Years Old	Indicates that the patient is over 100 years old at date of admission or date of first service for outpatient services. Not used for electronic billing.
20	Beneficiary Requested Billing	The provider realizes the services on this bill are for a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination of coverage by Medicare (or other primary payer).

21	Billing for Denial Notice	Code indicates that services are at a noncovered level of care or excluded, but the SNF or HHA is requesting a denial notice from Medicare in order to bill Medicaid or other insurances.
36	General Care Patient in a Special Unit	Patient temporarily placed in special care unit bed because no general care beds were available.
37	Ward Accommodation-Patient's Request	Patient assigned to ward accommodations at patient's request.
38	Semi-Private Room Not Available	Indicates that either private or ward accommodations assigned because semi-private accommodations were not available.
39	Private Room Medically Necessary	Patient needed a private room for medical reasons.
40	Same Day Transfer	Patient transferred to another facility before midnight of the day of admission.
55	SNF Bed Not Available	The patient's SNF admission was delayed more than 30 days after hospital discharge because an SNF bed was not available.
56	Medical Appropriateness	Patient's SNF admission was delayed more than 30 days after hospital discharge because the physical condition made it inappropriate to begin active care within that period.
57	SNF Readmission	Patient previously received Medicare covered SNF care within 30 days of the current SNF admission.

Codes 60-65 are not reported by providers. You must enter the code where applicable.

60	Day Outlier	This bill meets the Pricer criteria for day outlier.
61	Cost Outlier	This bill meets the Pricer criteria for cost outlier.
62	PIP Bill	This bill is a PIP bill.
63	PRO Denial Received Before Batch Clearance Report	The "Date Received" on a PRO adjustment bill is the date the HCSSACL file was received that reports acceptance of the original bill by HCFA. The HCSSACL receipt date is used if the PRO's notification is earlier than the acceptance report of the original bill.
64	Other Than Clean Claim	The claim is not a "clean claim."
65	Non-PPS Code	This bill is not a PPS bill.

66	Outlier Not Claimed	Bill may meet the criteria for cost outlier, but the hospital did not claim the cost outlier.
67-70		Reserved.

RENAL DIALYSIS SETTING

71	Full Care In Unit	Billing is for a patient who received staff assisted dialysis services in a hospital or renal dialysis facility.
72	Self Care in Unit	Billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self Care Training	Billing is for special dialysis services where the patient and helper (if necessary) were learning to perform dialysis.
74	Home	Billing is for a patient who received dialysis services at home but where code 75 below does not apply.
75	Home - 100-Percent Reimbursement	Billing is for a patient who received dialysis services at home using a dialysis machine payed for by Medicare under the 100 percent program.
76	Back-up Facility	Billing is for a patient who received dialysis services in a back-up facility.
77	Provider Accepts or is Obligated/ Required due to Contractual Agreement or Law to Accept Payment by a Primary Payer as Payment in Full	Indicates the provider has accepted or is obligated/required due to a contractual agreement or law to accept payment as payment in full.
79	CORF Services Provided Off Site	Indicates that physical therapy, occupational therapy, or speech pathology services were provided off site.

Data Element: Nonpayment Codes

Definition: Code indicating the reason for nonpayment.

B	Benefits exhausted.
E	HMO out-of-plan services not emergency or urgently needed.
C	Noncovered Care (includes all "bene at fault" waiver cases).
N	All other reasons for nonpayment.
R	Benefits Refused, or evidence not submitted.
P	Payment Requested.

Data Element: Occurrence codes

Definition: A code defining a significant event relating to this bill that may affect payer processing.

ACCIDENT RELATED CODES

01	Auto Accident	The date of an auto accident.
02	Auto Accident/ No Fault Insurance Involved	The date of an accident where the State has applicable no fault liability laws, (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability	The date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no fault liability.
04	Accident/Employment Related	The date of an accident relating to the patient's employment.
05	Other Accident	The date of an accident not described by the above codes.
11	Onset of Symptoms/Illness	The date the patient first became aware of symptoms/illness.

INSURANCE RELATED CODES

18	Date of Retirement Patient/Beneficiary	The date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	The date of retirement for the patient's spouse.
20	Guarantee of Payment Began	The date on which the provider began claiming Medicare payment under the guarantee of payment provision.
21	PRO Notice Received	The date of receipt by the hospital or SNF of the PRO's finding that an admission or further stay was not medically necessary.
22	Active Care Ended	The date on which a covered level of care ended in a SNF or general hospital, or date active care ended in a psychiatric or tuberculosis hospital.

		Code not required where PRO approval indicator (Field 62 of the Inpatient UNIBILL record) contains a code.
23	Benefits Exhausted	The last date for which benefits can be paid.
24	Date Insurance Denied	The date the insurer's denial of coverage was received by the provider.
26	Date SNF Bed Available	The date on which a SNF bed became available to a hospital inpatient who required only SNF level of care.
27	Date HHA Plan established or last reviewed	The date a home health plan of treatment was established or last reviewed for home health care.
28	Date CORF Plan established or last reviewed	The date a CORF plan of treatment was established or last reviewed.
29	Date OPT Plan established or last reviewed	The date a plan of treatment was established or last reviewed for OPT.
30	Date Speech Pathology Plan established or last reviewed	The date a Speech Pathology Plan plan of treatment was established or last reviewed.
31	Date Beneficiary Notified of intent to bill (Accommodations)	The date of the notice provided to the patient by the hospital stating that he no longer required a covered level of inpatient care.

32	Date Beneficiary Notified of intent to bill (procedures or treatment)	The date of the notice provided to the patient by the hospital stating that requested care (diagnostic procedures or treatments) is not considered reasonable or necessary by Medicare.

SERVICE RELATED CODES

33	First Month of the 12 Month Coordination Period for ESRD Beneficiaries Covered by EGHP	Code indicates the first day of the first month of the 12 month period, as defined in S3490.2D, during which Medicare benefits are secondary to benefits payable under an EGHP. Required only for ESRD beneficiaries.
34	Date of Election of Extended Care Services	The date the guest elected to receive extended care services (used by Christian Science Sanatoria only).
35	Date Treatment Started	Code indicates the date treatment began for the therapies.
36	Date of Inpatient Hospital Discharge for Transplant Procedure	Code indicates the date of discharge for the inpatient hospital stay in which the patient received a transplant procedure when the hospital is billing for immunosuppressive drugs.
42	Date of Discharge	For the final bill for hospice care, enter the date the Medicare beneficiary terminated his election of hospice care.

Data Element:	Occurrence Span Codes
Data Definition:	A code that identifies an event that relates to the payment of the claim.

Code Structure

70	Qualifying Stay Dates (Medicare)	The from/thru date of at least a 3-day hospital stay that qualifies the patient for Medicare payment of SNF services billed. Code can be used only by SNF for billing.
71	Hospital Prior Stay Dates	The from/thru dates of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	The dates of the first and last visits occurring in this billing period if the dates are different from those in the Statement Covers Period.

74	Noncovered Level of Care	The from/through dates of a period at a noncovered level of care in an otherwise covered stay, excluding any period reported with Occurrence Span Code 76 or 77.
75	SNF Level of Care	The from/through dates of a period of SNF level of care during an inpatient hospital stay. Used to show PRO approval of patient's remaining in hospital because SNF bed not available. Code is not applicable to swing bed cases. Hospitals under PPS use this code in day outlier cases only.
76	Patient Liability	The from/through dates of a period of noncovered care for which the hospital is permitted to charge the Medicare beneficiary. Used only where you, or the PRO, have approved such charges in advance, and the patient has been notified in writing 3 days prior to the "from" date of the noncovered period.
77	Provider Liability	The from/through dates of a period of noncovered care for which the provider is liable.
78	SNF Prior Stay Dates	The from/through dates of any SNF stay that ended within 60 days of this hospital or SNF admission.

Data Element: Override Codes

Definition: Code indicating special action regarding deductible/coinsurance at a revenue center code level.

Codes:	
0	Both deductible and coinsurance apply.
1	Deductible does not apply.
2	Coinsurance does not apply.
3	Neither deductible nor coinsurance applies.
4	This revenue center code contains no associated charge.

Data Element: Patient Status

Definition: A code indicating the patient's status as of statement covers thru date:

Codes:

01	Discharged to home or self care (routine discharge).
02	Discharged/transferred to another short-term general hospital.
03	Discharged/transferred to SNF.
04	Discharged/transferred to an ICF.
05	Discharged/transferred to another type of institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice.

20	Expired - (or did not recover - Christian Science Patient).
30	Still patient.
40	Expired at home-Hospice beneficiary.
41	Expired in a hospital, SNF, or ICF-Hospice beneficiary.
42	Expired - place unknown-Hospice beneficiary.

Data Element: PRO Approval Indicator

Definition: An indicator describing the PRO's determination.

Code:	1	Approved by the PRO	Code indicates claim has been reviewed by the PRO and has been fully approved including any day or cost outlier.
	2	Automatic Approval (Focused Review)	Code does not apply to Medicare claims.
	3	Partial Approval	Code indicates the bill has been reviewed by the PRO, and some portion (days or services) has been denied. The from/thru dates of the approved portion of the stay, excluding grace days and any period at a noncovered level of care (code "77" in item 33), are shown in items 88 and 89.
	4	Admission Denied	Code indicates patient's need for inpatient services was reviewed upon admission and the PRO found that none of the stay was medically necessary.
	5	Post-payment Review Applicable	Code indicates that any medical review will be completed after the claim is paid. The bill may be a day outlier; part of the sample review; reviewed for other reasons; or may not be reviewed.
	6	Pre-admission Authorization	Pre-admission authorization obtained, but services not reviewed by the PRO.
	7-9		Reserved.

Data Element: Revenue Code

Definition: A Code which identifies a specific accommodation, ancillary service or billing calculation.

Code: See Addendum C

Data Element: Source of Admission

Definition: A code indicating the source of this admission.

Code:

1 - Physician Referral	The patient was admitted upon the recommendation of a personal physician.
2 - Clinic Referral	The patient was admitted upon the recommendation of this facility's clinic physician.
3 - HMO Referral	The patient was admitted upon the recommendation of an HMO physician.
4 - Transfer from a Hospital	The patient was admitted as an inpatient transfer from an acute care facility.
5 - Transfer from a Skilled Nursing Facility	The patient was admitted as an inpatient transfer from a SNF.
6 - Transfer from Another Health Care Facility	The patient was admitted as a transfer from a health care facility other than an acute care facility or SNF.
7 - Emergency Room	The patient was admitted upon the recommendation of this facility's emergency room physician.
8 - Court/Law Enforcement	The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative.
9 - Information Not Available	The means by which the patient was admitted to this facility is not known.

Code Structure (Newborn):

1 - Normal Delivery	A baby delivered without complications.
2 - Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
3 - Sick Baby	A baby delivered with medical complications other than those relating to premature status.
4 - Extra Mural Birth	A newborn born in a non-sterile environment.
5 -8	Reserved
9	Information not available.

Data Element: Type of Admission

Definition: A Code indicating the priority of this admission.

1 = Emergency	The patient required immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2 = Urgent	The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally the patient was admitted to the first available and suitable accommodation.
3 = Elective	The patient's condition permitted adequate time to schedule the availability of suitable accommodations.
4 = Newborn	Necessitates the use of special source of admission codes.
5-8	Reserved.
9	Information not available

Data Element: Type of Bill

Definition: A code indicating the specific type of bill (inpatient, outpatient, adjustments, voids, etc.)

Code Structure

Type of Facility - 1st Digit

Hospital	1
SNF	2
HHA	3
Christian Science (Hospital)	4
Christian Science (Extended Care)	5
Clinic	7
Special Facility	8
Reserved	9

Bill Classification (Except Clinics and Special Facilities) - 2nd Digit

Inpatient (Including Part A)	1
Inpatient (Part B only) or Home Health Visits under B	2
Outpatient	3
Other (for Part B use only)	4
Swing Beds	8
Reserved	9

Bill Classification (Clinics) 2nd digit		Bill Classification - Special Facilities - 2nd digit
Rural Health	1	Hospice (non-hospital based)
Free Standing Renal Dialysis Center	2	Hospice (hospital based)
	3	Ambulatory Surgical Center
CORF	4	

Frequency - 3rd Digit

Non-Payment/Zero claim	0
Admit thru Discharge Claim	1
Interim - First claim	2
Interim - Continuing claim	3
Interim - Last claim	4
Late Charge(s) Only Claim	5
Adjustment of prior claim	6 - not used by Medicare in UNIBILL
Replacement of prior claim	7
Void/cancel prior claim	8
Reserved	9
Adjustment Required by PRO	P
Adjustment Required by Intermediary	I

Data Element: UB Codes

Data Definition: Code indicating the means by which the bill was reported to you.

Code Structure

0	Unknown
1	EMC Tape/UB-82/HCFA Format
2	EMC Tape/UB-82/Other Format
3	EMC Tape/Other
4	EMC Telecom/UB-82
5	EMC Telecom/Not UB-82
6	Other EMC/UB-82
7	Other EMC/Not UB-82
8	UB-82 hard copy
9	Other hard copy

Data Element: Value Codes

Data Definition: A code that identifies data of a monetary nature that is necessary for processing this claim as qualified by the payer organization.

Code Structure

05	Professional Component included in Charges and also billed separately to Carrier	For use on Medicare and Medicaid bills if the State requests this information.
06	Medicare Blood Deductible	Total cash blood deductible.
07	Medicare Cash Deductible	Medicare cash deductible.
08	Medicare Lifetime Reserve Amount in the First Calendar Year.	Medicare lifetime reserve amount charged in the year of admission.
09	Medicare Coinsurance Amount in the First Calendar Year.	Medicare coinsurance amount charged in the year of admission.
10	Medicare Lifetime Reserve Amount in the Second Calendar Year.	Medicare lifetime reserve amount charged in the year of discharge where the bill spans two calendar years.
11	Medicare Coinsurance Amount in the Second Calendar Year	Medicare coinsurance amount charged in the year of discharge where the bill spans two calendar years.

12	Working Aged Beneficiary/ Spouse with EGHP	Amount shown is that portion of a payment from a higher priority EGHP insurance made on behalf of an aged beneficiary that the provider is applying to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
13	ESRD Beneficiary in the 12 Month Coordination Period with EGHP	Amount shown is that portion of a payment from a higher priority EGHP insurance made on behalf of an ESRD beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
14	Automobile, No Fault or any Liability Insurance	Amount shown is that portion of a payment from a higher priority automobile, no fault or liability insurance made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
15	WC	Amount shown is that portion of a payment from a higher priority WC plan made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
16	PHS, Other Federal Agency	Amount shown is that portion of a payment from a higher priority PHS or other Federal Agency made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
17	Outlier Amount	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of day or cost outlier payment to be made.
18	Disproportionate Share Amount	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the disproportionate share amount applicable to the bill.
19	Indirect Medical Education Amount	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the medical education amount applicable to the bill.

31	Patient Liability Amount	Amount shown is that which you or the PRO approved to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
41	BL	Amount shown is that portion of a payment from a higher priority BL program made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
42	VA	Amount shown is that portion of a payment from a higher priority VA made on behalf of a Medicare beneficiary that the provider applied to Medicare covered services on this bill. If six zeroes were entered, the provider claimed conditional Medicare payment.
43	Disabled Beneficiary Under Age 65 With LGHP	Amount shown is that portion of a payment from a higher priority LGHP made on behalf of a disabled Medicare beneficiary that the provider applied to Medicare covered services on this bill.
50	Physical Therapy Visit	Number of physical therapy visits from onset (at the billing provider) through billing period.
70	Interest Amount	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Indicates the amount of interest to be applied.
71	Funding ESRD Networks	PROVIDERS DO NOT REPORT THIS. FOR PAYER INTERNAL USE ONLY. Report the amount by which the Medicare payment was reduced to help fund the ESRD networks.
72-79	Payer Codes	Codes reserved for internal use only by third party payers. HCFA will assign as needed.

3872. UNIBILL SERVICE CODES

Roll up for UNIBILL in the same manner as for PS&R. If you have more than 27 revenue line items, make the following additional roll-ups before preparing UNIBILL. On outpatient surgery do not roll up to code 270 revenue codes 271 or 273-279. See Addendum C §3600 for revenue codes and definitions.

	I/P	SNF	O/P	HOSP	HH	CORF	RHC	UB	REV CODE
Total	X	X	X	X	X	X	X	51	001
1-bed	X	X						51	110, 140,
2-4 bed	X	X						51	100, 120, 130, 160, 170, 180, 190
5 or more bed (ward)	X	X						51	150
Intensive Care	X							51	200
Coronary Care	X							51	210
Blood	X	X	X				X	51	380
Operating Room	X	X	X					51	360, 710, 720
Anesthesia	X		X					51	370
O/P Services	X							51	500
Blood Admin.	X	X	X				X	51	390
Pharmacy	X	X	X		X 1/	X	X	51	250, 260
Radiology	X	X	X				X	51	280, 320, 330, 340, 350, 400
Laboratory	X	X	X				X	51	300,310
Medical/Surgical Supplies	X	X	X		X	X	X	51	270
Durable Medical Equipment	X	X	X		X	X	X	51	290, 291, 292
Used DME	X	X	X		X	X		51	293
Physical Therapy	X	X	X		X	X	X	51	420
Occupational Therapy	X	X	X		X	X	X	51	430

1/ RIC F and Bill Type Code 34X only

	I/P	SNF	O/P	HOSP	HH	CORF	RHC	UB	REV CODE
Speech Pathology	X	X	X		X	X	X	51	440, 470
Inhalation Therapy	X	X	X			X	X	51	410, 460
Clinic Visit	X	X	X				X	51	510
Free Standing Clinic			X			X	X	51	520
Emergency Room	X		X				X	51	450
Ambulance	X	X	X					51	540
Skilled Nursing Care					X	X	X	51	550
Medical Social Services	X	X	X		X	X	X	51	560
Home Health Aide					X		X	51	570
Other Visits					X	X	X	51	580
Routine Care				X				51	651
Continuous Care				X				51	652
Inpatient Care				X				51	655
General Inpatient Care (Non Respite)				X				51	656
Physician Services				X				51	657
Other Hospice				X				51	659
Other	X	X	X		X	X	X	51	All Other

ESRD SPECIFIC REVENUE CODES

ESRD revenue codes must be billed at detail level.

Dialysis Type:	Hemodialysis	Peritoneal Dialysis	CAPD	CCPD	Other
Inpatient	801	802	803	804	809
Outpatient	821	831	841	851	
Home Supplies	822	832	842	852	
Home Equipment	823	833	843	853	

	I/P	SNF	O/P	HOSP	HH	CORF	RHC	UB	REV CODE
Maintenance/100%	824			834		844		854	
Support Services	825			835		845		855	

	Living	Cadaver	Unknown
Type of Donor	811	812	813

3872.1 Deductions and Coinsurance for Selected Revenue Center Codes—

Revenue Center Code	0 Deductible & Coinsurance	1 Deductible Does not Apply	2 Coinsurance Does not Apply	3 Neither Applies
001	X			
100	X			
110	X			
120	X			
130	X			
140	X			
160	X			
170	X			
180	X			
190	X			
200	X			
210	X			
250	X			X (Pneumococcal Vaccine)
260	X			
280	X			
290-292	X	X 1/		
293			X 2/	X 1 & 2/
294-299	X	X 1/		
300	X (Therapeutic)			X (Diagnostic)
310	X (Therapeutic)			X (Diagnostic)
320	X			
330	X			
340	X			
350	X			
360	X			
370	X			
380	X			
390	X			
400	X			
410	X			
420	X			
430	X			
440	X			
450	X			
460	X			
470	X			

1/ DME supplied under a home health plan of treatment (Bill Type Codes 33X and 34X)
2/ Used DME

Revenue Center Code	0 Deductible & Coinsurance	1 Deductible Does not Apply	2 Coinsurance Does not Apply	3 Neither Applies
500	X			
510	X			
520	X			
540	X			
550	X			
560				X
570				X
580				X
651				X
652				X
655				X
656				X
657				X
659				X
710	X			
720	X			

3873 SERVICE CODES CROSS REFERENCE

NEW UNIBILL	OLD 1453 PATBILL	NEW UNIBILL	OLD 1483 PATBILL	NEW UNIBILL	OLD 1487 PATBILL
100-9	18a	510-9	17a	550-9	18A
200-9	18a	450-9	17b	420-9	18B
300-9	18a	300-9	17c	440-9	18C
400-9	18a	320-9	17d	430-9	18D
500-9	18a	250-9	17e	560-9	18E
380-9	18b	380-9	17f	570-9	18F
360-9	18c1	540-9	17g	380-9	18G
370-9	18c.2	420-9	17h	990-9	18K
500-9,	18c.3	990-9	17i		
390-9	18c.4	910-9	17j		
250-9	18c.5	920-9	17k		
320-9	18c.6	930-9	17l		
300-9	18c.7	940-9	17m		
270-9	18c.8				
420-9	18c.9				
430-9	18c.10				
440-9	18c.11				
410-9	18c.12				
990-9	18c.13 (Other)				

3873.1 Type of Bill Code—Relationship of HCFA-1450 Item 4 to HCFA-1483 Item 9

Item 4 of HCFA-1450		
First Digit	Second Digit	Item 9 of HCFA-1483
1	2	A
2	2	A
1	3	B
2	3	B
1	4	C
2	4	C
7	2	B
3	4	B
7	1	C

3873.2 Bill Type Codes and Allowable Provider Numbers (See §§3876.1 and 3878 for the Codes Listed by Record Layout).—

Bill Type Code	Provider Number Range(s) 1/
11X Hospital Inpatient (Part A)	0001-0999, 1200-1299, 2000-2299, 3025-3099, 3300-3399, 4000-4499, S001-S999, T001-T999, V001-V999
12X Hospital Inpatient Part B	Same as 11X
13X Hospital Outpatient	Same as 11X
14X Hospital Other Part B	Same as 11X
18X Hospital Swing Bed	U001-U999
21X SNF Inpatient	5000-6499
22X SNF Inpatient Part B	5000-6499
23X SNF Outpatient	5000-6499
24X SNF Outpatient (Other Part B)	5000-6499
28X SNF Swing Bed	5000-6499/U001-U999
33X Home Health	7000-7999
34X Home Health (Part B Only)	7000-7999
41X Christian Science Hospital	1990-1999
51X Christian Science SNF	6990-6999
71X Clinic Rural Health	3800-3999
72X Clinic ESRD	2300-2999, 3500-3799
74X Clinic CORF, or Clinic OPT	4500-4599 6500-6899 1800-1899
81X Nonhospital based hospice	1500-1799
82X Hospital based hospice	1500-1799
83X Hospital Outpatient (ASC)	Same as 11X

The Bills Tape Data File

3874. THE BILLS TAPE INTERNAL LABEL.

The label identifies the process, the responsible intermediary, and the sequence number of the specific reel in the file. If a multi-reel file see § 3874.1.

3874.1 The Reel Number.--The reel number is a required internal and external data entry for multi-reel files only. For the multi-reel file, enter the reel number in locations 10 through 12 of the Bills Tape Internal Label (see § 3874.2), and as indicated on the External Label. (See § 3867.1.) The reel number is a numeric field beginning with 001 for the first reel of a given file, increasing by one in sequence for each additional reel. For single reel files, leave blank, or enter 001 in the above locations.

3874.2 The Internal Label Record Description-- Operational

1.	Identification	7	X	1-7	UNIBILL
2.	Blank	2	X	8-9	
3.	Reel Number	3	X	10-12	See §3874.1
4.	Blank	7	X	13-19	
5.	Intermediary	5	N	20-24	Intermediary Submitting File
6.	Blank Number	7	X	25-31	
7.	Date of File Creation	6	N	32-37	MMDDYY
8.	Blank	1963	X	38-2000	

3874.3 The Internal Label Record Description.-- Test Tape

FIELD	SIZE	FMT	LOC	REMARKS
1. Identification	7	X	1-7	UNIBILT
2. Blank	2	XX	8-9	
3. Reel Number	3	X	10-12	See § 3874.1
4. Blank	7	X	13-19	
5. Intermediary Number	5	N	20-24	Intermediary Submitting File
6. Blank	7	X	25-31	
7. Date of File Creation	6	N	32-37	MMDDYY
8. Blank	1963	X	38-2000	

3875. THE BILL TAPE BATCH CONTROL RECORD.

A Bill Tape Batch Control Record precedes the detail bill-type data records comprising each batch of bills in the file. Identify it by the entry of the letter "B" in position 1 of the batch control record and identify each batch by the entry of a batch number and a batch-type code. Descriptions of each of the above data items as well as the batch control record follow.

3875.1 Record Identification Code.-- Location 1 of all control and data records must contain a valid record identification code as follows:

A - Home Health Plan P Record Identification;
B - The Bills Tape Batch Control Record Identification;
C - Inpatient Hospital Record Identification;
D - Outpatient Record Identification;
E - Christian Science Record Identification (Form HCFA-1486);
F - Home Health Plan M Record Identification;
H - RTI Void Record Identification;
I - Inpatient SNF Record Identification;
J - HOSPICE;
M - Comprehensive Outpatient Rehabilitation Facility (CORF);
Pure "-" - The Bills Tape Batch Summary Record Identification.

3875.2 The Batch Number.-- Enter the batch number in positions 7-14 of the Batch Control and Batch Summary Records, and positions 1993-2000 of all detailed bill records in each batch. The batch number consists of a four-position number assigned sequentially in the order of batch creation running from A000 to Z999 and repeating if required . . . immediately followed by the four-position Julian date (YDAY) of batch creation (i.e., numeric "0" to 9 for the year in the given decade, followed by the Julian number of the appropriate DAY).

3875.3 The Batch-Type Code.-- Enter the Batch-Type Code in position 19 of the Batch Control Record. The valid batch-type codes are:

L - Inpatient hospital/SNF;
P - Outpatient, CORF, and Hospice;
(Hospice, CORF, and Outpatient claims may not be mixed in the same batch.)
Q - HHA;
N - Christian Science (Form HCFA-1486);
M - RTI (VOID Action).

3875.4 The Batch Control Record Layout and Description.--

FIELD		SIZE	FMT	LOC	REMARKS
1.	Identification (Batch Control)	1	X	1	Fixed "B"
2.	Intermediary Number	5	N	2-6	Intermediary submitting file
3.	Batch Number	8		7-14	See § 3875.1
	a. Sequence number	4	X	7-10	
	b. Julian date	4	N	11-14	YDAY
4.	Blank	4	X	15-18	
5.	The Bill-Type Code	1	X	19	See § 3875.3
6.	Blank	1981	X	20-2000	

3875.5 The Action Code.—Location 2 of all bill-type data records must contain a valid action code. The valid codes are:

1 - Original Debit Action (Includes nonadjustment RTI correction items.)
2 - Cancel by Credit Adjustment
3 - Cancel by Debit Adjustment
4 - Cancel Only Adjustment
8 - Nonadjustment Benefit Payment Refused (Code R bills)
9 - Payment Requested Adjustment (Code P bills)

3876 INPATIENT HOSPITAL/SNF RECORD LAYOUT AND DESCRIPTION.

(See § 3876.1 for bill types included.)

Fld	Description	Psn.	Picture	Just.	From	Thru
1.	Record Identification (RIC)	1	X		1	1
2.	Action Code	1	9		2	2
3.	Adjustment Codes					
	a. Cancel Only Code	1	X		3	3
	b. Filler	1	X		4	4
	c. Association Code	2	XX	L	5	6
4.	HICN	12	X(12)	L	7	18
5.	Medical Record Number	17	X(17)	L	19	35
6.	Patient Control Number	17	X(17)	L	36	52
7.	Type of Bill	3	XXX		53	55
8.	Medicare Provider Number	6	X(6)		56	61
9.	Filler	4	XXXX		62	65
10.	Medicaid Provider Number	12	X(12)	L	66	77
11.	Filler (Medicaid Use)	4	XXXX		78	81
12.	Treatment Authorization Code	10	X(10)	L	82	91
13.	Patient Name					
	a. Last	6	X(6)	L	92	97
	b. First Initial	1	X		98	98
	c. Middle Initial	1	X		99	99
14.	Patient's Zip Code	9	X(9)	L	100	108
15.	Birthdate (MMDDYY)	6	9(6)		109	114
16.	Sex	1	X		115	115
17.	Admission Date (MMDDYY)	6	9(6)		116	121
18.	Type of Admission	1	X		122	122
19.	Source of Admission	1	X		123	123
20.	Patient Status (At Thru Date)	2	XX		124	125
21.	Statement Covers					
	a. From (MMDDYY)	6	9(6)		126	131
	b. Thru (MMDDYY)	6	9(6)		132	137
22.	Utilization Days	3	999	R	138	140
23.	Non-utilization Days	4	9999	R	141	144
24.	Cost Report Days	3	999	R	145	147
25.	First Year Coinsurance Days	2	99	R	148	149
26.	Second Year Coinsurance Days	2	99	R	150	151
27.	Total Lifetime Reserve Days	2	99	R	152	153
28.	Second Yr. Lifetime Reserve Days	2	99	R	154	155
	Claim Related Occurrences Related to a Specific Date (Occurs 7 Times)				156	211
29.	Occurrence Code	2	99			
30.	Occurrence Date	6	9(6)			

Fld	Description	Psn.	Picture	Just.	From	Thru
	Claim Related Occurrences Related to a Span of Dates (Occurs 10 Times)				212	351
31.	Occurrence Span Code	2	99			
32.	Occurrence Span Dates					
	a. From	6	9(6)			
	b. Thru	6	9(6)			
	Claim Related Conditions Related to no Specific Date (Occurs 7 Times)				352	365
33.	Condition Code	2	99	L		
	Blood Record					
34.	Blood - Furnished Pints	3	999	R	366	368
35.	Blood - Replaced Pints	3	999	R	369	371
36.	Blood - Unreplaced Pints	3	999	R	372	374
37.	Blood - Deductible Pints	2	99	R	375	376
38	Filler	2	XX		377	378
	Claim Related Values (Occurs 10 Times)				379	478
39.	Value Code	2	99			
40.	Value Amount	8	9(6)V99	R		
	Financial Data (Occurs 28 Times)				479	1682
41.	Revenue Center Code	3	999	R		
42.	HCPCS	5	X(5)	R		
43.	Filler	4	X(4)			
44.	Units	3	9(3)			
45.	Date of Service (MMDD) If Applicable	4	9(4)			
46.	Rate	7	9(5)V99	R		
47.	Charges	8	9(6)V99	R		
48.	Noncovered Charges	8	9(6)V99	R		
49.	Over-ride Code	1	9			
	Medical Data					
50.	HMO Identification	5	X(5)	L	1683	1687
50a.	HMO Option Code	1	X		1688	1688
50b.	HMO Election Date (MMYY)	4	XXXX	L	1689	1692
50c.	HMO Termination Date (MMYY)	4	XXXX	L	1693	1696
50d.	Filler	4	XXXX		1697	1700
51.	Diagnosis Related Grouping (DRG)	3	999		1701	1703
52.	Filler	3	XXX		1704	1706
53.	Medicare Reimbursement Amount	9	9(7)V99	R	1707	1715
54.	Diagnosis Code (Occurs 5 Times)	5	X(5)	L	1716	1740
55.	Filler	1	X		1741	1741

Fld	Description	Psn.	Picture	Just.	From	Thru
	Procedure Codes and Dates (Occurs 3 Times)				1742	1786
56.	Procedure Code	4	X(4)	L		
57.	Filler	5	X(5)			
58.	Procedure Date (MMDDYY)	6	9(6)			
59.	Admitting Diagnosis Code	5	X(5)	L	1787	1791
60.	Attending Physician Number	16	X(16)	L	1792	1807
61.	Operating Physician Number	16	X(16)	L	1808	1823
62.	PRO/UR Approval Indicator	1	9		1824	1824
63.	PRO/UR Approved Stay Dates					
	a. From (MMDDYY)	6	9(6)	L	1825	1830
	b. Thru (MMDDYY)	6	9(6)	L	1831	1836
64.	Number of Grace Days	1	9		1837	1837
65.	Inpatient Hospital Deductible Override Code. ("A" in this position overrides cash ded. edits.)	1	X		1838	1838
66.	Filler	1	X		1839	1839
67.	HMO Paid Code	1	9		1840	1840
68.	UB Code	1	9		1841	1841
69.	Kron Indicator	1	X		1842	1842
70.	Prior Psych Days Used	3	999	R	1843	1845
71.	Pass Thru Per Diem Rate	6	9(4)V99	R	1846	1851
72.	ReAdmit Code (Readmitted to short-term hospital from another short-term hospital within 7 days.)	1	X		1852	1852
73.	Nonpayment Code	1	X		1853	1853
74.	Patient Filed Bill Code E=Patient Filed, else blank	1	X		1854	1854
75	Filler	45	X(45)		1855	1899
75a.	PRO Processing Date	6	X(6)		1900	1905
75b.	PRO Control Number	12	X(12)	L	1906	1917
75c.	Filler	14	X(14)		1918	1931
76.	NOU Code (1=Do Not Send NOU)	1	X		1932	1932
77.	Verified Noncovered Stay Dates					
	a. From Date	6	X(6)	L	1933	1938
	b. Thru Date	6	X(6)	L	1939	1944
78.	RTI Control Number	10	X(10)	L	1945	1954
79.	Date Received	6	9(6)	L	1955	1960
80.	Date Approved	6	9(6)	L	1961	1966
81.	Scheduled Payment Date	6	9(6)	L	1967	1972
82.	Filler (Intermediary Use)	15	X(15)		1973	1987
83.	Intermediary Number	5	X(5)	L	1988	1992
84.	Batch Number	4	XXXX	L	1993	1996
85.	Batch Date (YDDD)	4	9(4)	L	1997	2000

3876.1 Bill Type Codes Billed on the INPATIENT HOSPITAL/SNF Record

110	Hospital Inpatient Nopay
111	Hospital Inpatient Admission to Discharge
112	Hospital Inpatient First Claim
113	Hospital Inpatient Continuing Claim
114	Hospital Inpatient Last Claim
117	Hospital Inpatient Adjustment
118	Hospital Inpatient VOID/CANCEL
11P	Hospital Inpatient Adjustment initiated by PRO
11I	Hospital Inpatient Adjustment initiated by You
180	Hospital Swing Bed Nopay
181	Hospital Swing Bed Admission to Discharge
182	Hospital Swing Bed First Claim
183	Hospital Swing Bed Continuing Claim
184	Hospital Swing Bed Last Claim
187	Hospital Swing Bed Adjustment
188	Hospital Swing Bed VOID/CANCEL
18P	Hospital Swing Bed Adjustment Initiated by PRO
18I	Hospital Swing Bed Adjustment Initiated by You
210	SNF Inpatient Nopay
211	SNF Inpatient Admission to Discharge
212	SNF Inpatient First Claim
213	SNF Inpatient Continuing Claim
214	SNF Inpatient Last Claim
217	SNF Inpatient Adjustment
218	SNF Inpatient VOID/CANCEL
280	SNF Swing Bed Nopay
281	SNF Swing Bed Admission to Discharge
282	SNF Swing Bed First Claim
283	SNF Swing Bed Continuing Claim
284	SNF Swing Bed Last Claim
287	SNF Swing Bed Adjustment
288	SNF Swing Bed VOID/CANCEL
410	Christian Science Hospital Nopay
411	Christian Science Hospital Admission to Discharge
412	Christian Science Hospital First Claim
413	Christian Science Hospital Continuing Claim
414	Christian Science Hospital Last Claim
417	Christian Science Hospital Adjustment
418	Christian Science Hospital VOID/CANCEL
510	Christian Science SNF Nopay
511	Christian Science SNF Admission to Discharge
512	Christian Science SNF First Claim
513	Christian Science SNF Continuing Claim
514	Christian Science SNF Last Claim
517	Christian Science SNF Adjustment
518	Christian Science SNF VOID/CANCEL

3877 OUTPATIENT/HOSPICE/HOME HEALTH/CORF RECORD LAYOUT AND DESCRIPTION. (See § 3878 for bill types included.)

Fld	Description	Pan.	Picture	Just.	From	Thru
1.	Record Identification (RIC)	1	X		1	1
2.	Action Code	1	9		2	2
3.	Adjustment Codes					
	a. Cancel Only Code	1	X		3	3
	b. Filler	1	X		4	4
	c. Association Code	2	XX	L	5	6
4.	HICN	12	X(12)	L	7	18
5.	Medical Record Number	17	X(17)	L	19	35
5a.	Patient Control Number	17	X(17)	L	36	52
6.	Type of Bill	3	XXX		53	55
7.	Medicare Provider Number	6	X(6)		56	61
8.	Filler	4	XXXX		62	65
9.	Medicaid Provider Number	12	X(12)	L	66	77
10.	Filler (Medicaid Use)	4	XXXX		78	81
11.	Filler	10	X(10)	L	82	91
12.	Patient Name					
	a. Last	6	X(6)	L	92	97
	b. First Initial	1	X		98	98
	c. Middle Initial	1	X		99	99
13.	Filler	9	X(9)	L	100	108
14.	Birthdate (MMDDYY)	6	9(6)		109	114
15.	Sex	1	X		115	115
16.	Filler	8	X(8)		116	123
17.	Patient Status (At last serv. dt.)	2	XX	L	124	125
18.	Statement Covers					
	a. 1st svc. date (MMDDYY)	6	9(6)	L	126	131
	b. last svc. date (MMDDYY)	6	9(6)	L	132	137
19.	Filler	18	X(18)		138	155
	Claim Related Occurrences Related to a Specific Date (Occurs 7 Times)				156	211
20.	Occurrence Code	2	99			
21.	Occurrence Date	6	9(6)			
	Claim Related Occurrences Related to a Span of Dates (Occurs 10 Times)				212	351
22.	Occurrence Span Code	2	99			
23.	Occurrence Span Dates					
	a. From	6	9(6)			
	b. Thru	6	9(6)			
	Claim Related Conditions Related to no Specific Date (Occurs 7 Times)				352	365
24.	Condition Code	2	99	L		

Fld	Description	Psn.	Picture	Just.	From	Thru
	Blood Record					
25.	Blood - Furnished Pints	3	999	R	366	368
26.	Blood - Replaced Pints	3	999	R	369	371
27.	Blood - Unreplaced Pints	3	999	R	372	374
28.	Blood - Deductible Pints	2	99	R	375	376
29.	Filler	2	XX		377	378
	Claim Related Values (Occurs 10 Times)				379	478
30.	Value Code	2	99			
31.	Value Amount	8	9(6)V99	R		
	Financial Data (Occurs 28 Times)				479	1682
32.	Revenue Center Code	3	999	R		
33.	HCPCS	5	X(5)	R		
34.	Filler	4	X(4)			
35.	Units	3	9(3)			
36.	Date of Service (MMDD) If Applicable	4	9(4)			
37.	Rate	7	9(5)V99	R		
38.	Covered Charges	8	9(6)V99	R		
39.	Filler	8	X(8)			
40.	Over-ride Code	1	9			
	Medical Data					
41.	HMO Identification	5	X(5)	L	1683	1687
41a.	HMO Option Code	1	X		1688	1688
41b.	HMO Election Date (MMYY)	4	XXXX	L	1689	1692
41c.	HMO Termination Date (MMYY)	4	XXXX	L	1693	1696
41d.	Filler	11	X(11)		1697	1700
42.	Medicare Reimbursement Amount	9	9(7)V99	R	1707	1715
43.	Diagnosis Code (Occurs 5 Times)	5	X(5)	L	1716	1740
44.	Filler	1	X		1741	1741
	Procedure Codes and Dates (Occurs 3 Times)				1742	1786
45.	Procedure Code	4	X(4)	L		
46.	Filler	5	X(5)			
47.	Procedure Date (MMDDYY)	6	9(6)			
48.	Filler	5	X(5)		1787	1791
48a.	Attending Physician Number	16	X(16)	L	1792	1807
48b.	Operating Physician Number	16	X(16)	L	1808	1823
48c.	Filler	14	X(14)		1824	1837
49.	ESRD Method of Reimbursement	1	9		1838	1838
50.	Filler	1	X		1839	1839
51.	Filler	1	X		1840	1840
52.	UB Code	1	9		1841	1841
53.	Filler	11	X(11)		1842	1852

Fld	Description	Psn.	Picture	Just.	From	Thru
54.	Patient Paid Toward Blood Ded.	7	9(5)V99	R	1853	1859
55.	Patient Paid Excl. Blood	7	9(5)V99	R	1860	1866
56.	Verified Patient Liability					
	a. Blood Deductible	7	9(5)V99	R	1867	1873
	b. Cash Deductible	6	9(4)V99	R	1874	1879
	c. Coinsurance	7	9(5)V99	R	1880	1886
57.	Payment Distribution					
	a. Provider	7	S9(5)V99	R	1887	1893
	b. Patient	6	9(4)V99	R	1894	1899
58.	PRO Processing Date	6	X(6)		1900	1905
58a.	PRO Control Number	12	X(12)	L	1906	1917
58b.	Filler	27	X(27)		1918	1944
59.	RTI Control Number	10	X(10)	L	1945	1954
60.	Date Received	6	9(6)	L	1955	1960
61.	Date Approved	6	9(6)	L	1961	1966
62.	Scheduled Payment Date	6	9(6)	L	1967	1972
63.	Filler (Intermediary Use)	15	X(15)		1973	1987
64.	Intermediary Number	5	X(5)	L	1988	1992
65.	Batch Number	4	XXXX	L	1993	1996
66.	Batch Date (YDDD)	4	9(4)	L	1997	2000

3878. BILL TYPE CODE COMBINATIONS BILLED ON THE OUTPATIENT/HOSPICE/ HOME HEALTH/CORF RECORD LAYOUT AND DESCRIPTION

121 Hospital Inpatient Part B Admission to Discharge
122 Hospital Inpatient (Part B Only) Interim - first claim
123 Hospital Inpatient (Part B Only) Interim - continuing claim
124 Hospital Inpatient (Part B Only) Interim - last claim
125 Hospital Inpatient Part B Late Charge
127 Hospital Inpatient Part B Adjustment
128 Hospital Inpatient Part B VOID/CANCEL

131 Hospital Outpatient First Service to Last Service
132 Hospital Outpatient Interim - first claim
133 Hospital Outpatient Interim - continuing claim
134 Hospital Outpatient Interim - last claim
135 Hospital Outpatient Late Charge
137 Hospital Outpatient Adjustment
138 Hospital Outpatient VOID/CANCEL
13P Hospital Outpatient Adjustment initiated by the PRO
13I Hospital Outpatient Adjustment initiated by the intermediary

141 Hospital Other Part B Admission to Discharge
145 Hospital Other Part B Late Charge
147 Hospital Other Part B Adjustment
148 Hospital Other Part B VOID/CANCEL

221 SNF Inpatient Part B Admission to Discharge
222 SNF Inpatient (Part B Only) Interim - first claim
223 SNF Inpatient (Part B Only) Interim - continuing claim
224 SNF Inpatient (Part B Only) Interim - last claim
225 SNF Inpatient Part B Late Charge
227 SNF Inpatient Part B Adjustment
228 SNF Inpatient Part B VOID/CANCEL

231 SNF Outpatient First Service to Last Service
235 SNF Outpatient Late Charge
237 SNF Outpatient Adjustment
238 SNF Outpatient VOID/CANCEL

241 SNF Other Part B Admission to Discharge
245 SNF Other Part B Late Charge
247 SNF Other Part B Adjustment
248 SNF Other Part B VOID/CANCEL

321 Home Health First Service Through Last Service, no Part A entitlement
322 Home Health Interim - first claim, no Part A entitlement
323 Home Health Interim - continuing claim, no Part A entitlement
324 Home Health Interim - last claim, no Part A entitlement
325 Home Health Late Charge, no Part A entitlement
327 Home Health Adjustment, no Part A entitlement
328 Home Health VOID/CANCEL, no Part A entitlement

331 Home Health First Service Through Last Service
332 Home Health Interim - first claim
333 Home Health Interim - continuing claim
334 Home Health Interim - last claim
335 Home Health Late Charge
337 Home Health Adjustment
338 Home Health VOID/CANCEL

341 Home Health (Part B Only) First Service Through Last Service
342 Home Health (Part B Only) Interim - first claim
343 Home Health (Part B Only) Interim - continuing claim
344 Home Health (Part B Only) Interim - last claim
345 Home Health (Part B Only) Late Charge
347 Home Health (Part B Only) Adjustment
348 Home Health (Part B Only) VOID/CANCEL

711 Clinic Rural Health First Service to Last Service
712 Clinic Rural Health Interim - first claim
713 Clinic Rural Health Interim - continuing claim
714 Clinic Rural Health Interim - last claim
715 Clinic Rural Health Late Charge
717 Clinic Rural Health Adjustment
718 Clinic Rural Health VOID/CANCEL

721 Clinic ESRD First Service to Last Service
722 Clinic ESRD Interim - first claim
723 Clinic ESRD Interim - continuing claim
724 Clinic ESRD Interim - last claim
725 Clinic ESRD Late Charge
727 Clinic ESRD Adjustment
728 Clinic ESRD VOID/CANCEL

741 Clinic CORF First Service to Last Service
742 Clinic CORF Interim - first claim
743 Clinic CORF Interim - continuing claim
744 Clinic CORF Interim - last claim
745 Clinic CORF Late Charge
747 Clinic CORF Adjustment
748 Clinic CORF VOID/CANCEL

811 Non-hospital based hospice First Service to Last Service
812 Non-hospital based hospice Interim - first claim
813 Non-hospital based hospice Interim - continuing claim
814 Non-hospital based hospice Interim - last claim
815 Non-hospital based hospice Late Charge
817 Non-hospital based hospice Adjustment
818 Non-hospital based hospice VOID/CANCEL

821 Hospital based hospice First Service to Last Service
822 Hospital based hospice Interim - first claim

823 Hospital based hospice Interim - continuing claim
824 Hospital based hospice Interim - last claim
825 Hospital based hospice Late Charge
827 Hospital based hospice Adjustment
828 Hospital based hospice VOID/CANCEL

831 Ambulatory Surgical Center First Service to Last Service
832 Ambulatory Surgical Center Interim - first claim
833 Ambulatory Surgical Center Interim - continuing claim
834 Ambulatory Surgical Center Interim - last claim
835 Ambulatory Surgical Center Late Charge
837 Ambulatory Surgical Center Adjustment
838 Ambulatory Surgical Center VOID/CANCEL

3879 RTI VOID RECORD LAYOUT AND DESCRIPTION.
(Bill Type Code XX8.)

Fld	Description	Psn.	Picture	Just.	From	Thru
1	Record Identification (RIC)	1	X		1	1
2.	Filler	5	X(5)		2	6
3.	HICN	12	X(12)	L	7	18
4.	Filler	34	X(34)		19	52
5.	Type of Bill	3	XXX		53	55
6.	Medicare Provider Number	6	X(6)		56	61
7.	Filler	30	X(30)		62	91
8.	Patient Name					
	a. Last	6	X(6)	L	92	97
	b. First Initial	1	X		98	98
	c. Middle Initial	1	X		99	99
9.	Filler	9	X(9)		100	108
10.	Birthdate (MMDDYY)	6	9(6)		109	114
11.	Sex	1	X		115	115
12.	Date of Admission	6	9(6)		116	121
13.	Filler	2	XX		122	123
14.	Patient Status (At Thru Date)	2	XX		124	125
15.	Statement Covers					
	a. From (MMDDYY)	6	9(6)		126	131
	b. Thru (MMDDYY)	6	9(6)		132	137
16.	Filler	1703	X(1703)		138	1840
17.	UB Code	1	9		1841	1841
18.	Filler	103	X(103)		1842	1944
19.	RTI Control Number	10	X(10)		1945	1954
20.	Filler	18	X(18)		1955	1972
21.	Filler (Intermediary Use)	15	X(15)		1973	1987
22.	Intermediary Number	5	X(5)		1988	1992
23.	Batch Number	4	XXXX		1993	1996
24.	Batch Date (YDDD)	4	9(4)		1997	2000

3880. THE BATCH SUMMARY RECORD DESCRIPTION.

The Bills Tape Batch Summary Record closes a given batch record by summarizing the preceding batch totals (i.e., Items in Batch, Total Reimbursement Amount, and Reimbursement Subtotal for all adjustment bills in the batch) and passing control to the next batch on the tape, or to the end of file (Trailer Record - § 3881). The Batch Summary Record is:

FIELD	SIZE	FMT	LOC	REMARKS
1. Identification (Batch Summary)	1	X	1	Pure "-"
2. Intermediary Number	5	N	2-6	Intermediary submitting file.
3. Batch Number	8		7-14	See § 3875.2
a. Sequence Number	4	N	7-10	
b. Julian Date	4	N	11-14	YDAY
4. Batch Totals	29		15-43	See Note Below.
a. Number of Items in Batch	2	X	15-16	
b. Reimbursement Amount (total)	9	N	17-25	All bills in batch
c. Reimbursement Sub-total	9	N	26-34	All adjustment bills in batch
d. Blank	9	N	35-43	
5. Batch Deletion	4	X	44-47	Enter VOID for a deleted batch.
6. Blank	1953	X	48-2000	

NOTE: Both reimbursement entries are net amounts that may be unsigned, signed "minus," or signed "plus" in the units positions of their respective fields. The appropriate signs ensue from the cumulative algebraic effect of the individual bill action codes on both the total reimbursement amount and the reimbursement sub-total amount for adjustment bills only. When the batch contains adjustment bills only, the entries in the reimbursement total and sub-total fields must be the same.

3881. THE TRAILER RECORD LAYOUT AND DESCRIPTION.

The Bills Tape Trailer Record closes the reel or file. A Tape Mark preceding the Trailer Record is optional. However, the Trailer Record must always be followed by two Tape Marks. Trailer identification consists of a numeric 1 immediately followed by the letters END in locations 1 through 4. An R or F in location 6 indicates end of reel or file, as the case may be. The Trailer Record includes the total number of items in the reel and file (including the PIP bill count), the total reimbursement for both the reel and file, and the "total number of batches" in the reel and file. The file and reel totals must be the same for a single reel file. For a multi-reel file, the file totals are the cumulative totals following in sequence from first to last reel comprising the file. The end of reel and file totals (i.e., items and batches) are signed "plus" in the units position. Do not split a batch between reels for a multi-reel file. The trailer record follows:

FIELD	SIZE	FMT	LOC	REMARKS
1. Identification (Trailer Record)	4	X	1-4	1END
2. Blank	1	X	5	
3. End of Reel/File Indicator	1	N	6	R or F
4. File Totals	21		7-27	
a. Number of Items in File	6	N	7-12	
b. Reimbursement Amount	12	N	13-24	
c. Number of Batches in File	3	N	25-27	
5. Reel Totals	21		28-48	
a. Number of Items in Reel	6	X	28-33	
b. Reimbursement Amount	12	X	34-45	
c. Number of Batches	3	X	46-48	
6. Blank	1952	X	49-2000	

3882. UNIBILL CONSISTENCY RETURN CODES

Codes (Derived from Record Identification Code - see §3875.1):

H=Hospital
S=Skilled Nursing Facility
CH=Christian Science Hospital
CS=Christian Science SNF
HOSP=Hospice
O/P=Outpatient
CORF=Comprehensive Outpatient Rehabilitation Facility
HHA=Home Health Agency

Error Code	Applicable to	Explanation
		Item 4—Type of Bill
0401	General	The Type of Bill, item 4, is impossible, incomplete, or missing, or is inconsistent with the provider number shown in Item 7. (See §3873.2).
		Item 7—Medicare Provider Number
0701	General	Provider number does not match the provider number in HCFA's Intermediary/Provider file.
0702	General	The entry is not consistent with the type of bill.
		Item 15—Admission Date (Start of Care Date for Home Health) Date of Qualifying Stay for Christian Science SNF
1501	H, S, CH, CS & HHA	Date of Admission is impossible or incomplete.
1502	H, S, CH, CS & HHA	Date of Admission is later than "From Date".
1503	S	The date of admission is more than 30 days after the "Thru" date of the qualifying hospital stay and there is no Condition Code 55, 56, or 57. One of these must be present.
		Item 21—Patient Status
2101	H, S CH, CS & HOSP	Patient Status omitted or code impossible.
2102	H, S, CH, CS & HOSP	Patient Status Code is not correct. Code is 40, 41, or 42 and bill is not a Hospice bill, or code is 20, and bill is a Hospice bill.

Item 22--Statement covers period.

Error Code	Applicable To	Explanation
2201	General	This entry is an impossible or incomplete "From" date.
2202	General	The "From" date is later than the "Thru" date.
2203	General	The "Thru" date is an impossible or incomplete entry.
2204	General	The "From" date on this bill is prior to the effective date of this aspect of the Medicare program: 1. EGHP a. Working Aged: 1/1/83 b. ESRD Beneficiary in 12 month coordination period 10/1/81 2. CORF 7/1/81 3. Hospice 11/1/83 4. PPS 10/1/83
2205	O/P CORF	Date of Last Service is not in the same year as Date of First Service.

Item 23 - Utilization Days

Error Code	Applicable To	Explanation
2301	H, S CH & CS	A hospital bill contains an entry other than a number or a number that exceeds 150. A SNF bill contains an entry other than a number between 0 and 101 (between 0 and 31 for SNF Christian Science).
2302	H, S CH & CS	The sum of utilization days (Field 22), plus nonutilization days (Field 23), must equal the difference between the Thru Date minus the From Date in the Statement Covers Period (Field 21). Exception: If the Patient Status code (Field 20), is 30, or if the From Date is equal to the Thru Date, the sum of utilization days plus nonutilization days must equal the difference between the Thru Date minus the From Date in the Statement Covers Period, plus 1.
2303	H, S CH & CS	The number of "Utilization Days" exceeds the number of "Accommodation Days," but the dates of admission and discharge are not the same.
2304	H	No Utilization Days are shown on patient filed bill.
2306	H & S	Utilization Days are shown as "0," the "Statement Covers Period From Date" is not the same as the "Thru date", a nonpayment code is present, and some reimbursement is being made. (Does not apply to a credit or cancel only adjustment bill.)

Item 24—Nonutilization Days

Error Code	Applicable To	Explanation
2401	H, S CH & CS	This entry contains an entry other than a number.

Error Code	Applicable To	Explanation
		Item 25—Coinsurance Days
2501	H, S CH & CS	The Coinsurance Days entry is incomplete or is other than a number. If a hospital bill, "Coinsurance days" exceed 30. If a SNF bill, "Coinsurance days" exceed 80.
2502	H, S CH & CS	"Coinsurance days" exceed the number of "Utilization Days".
2503	H & S	If hospital, "Utilization Days" (Field 23) less the sum of "First Year Coinsurance Days" (Field 25), "Second Year Coinsurance Days" (Field 26), and 'Total Lifetime Reserve Days" (Field 27) exceed 60. If SNF, "Utilization Days" (Field 23) less the sum of "First Year Coinsurance Days" (Field 25), and "Second Year Coinsurance Days" (Field 26) exceed 20.
2504	H, S CH & CS	The coinsurance rate (coinsurance amount divided by coinsurance days) exceeds the rate that applies to the calendar year in which the coinsurance days occur.
2505	H, S CH & CS	In a hospital bill the nonlifetime and/or lifetime coinsurance rate applicable to the calendar year in which the coinsurance days and lifetime reserve days occurred exceed the average daily rate for this bill. In a SNF bill, the coinsurance rate applicable to the calendar year in which the coinsurance days occurred exceeds the average daily rate for this bill. This edit will be overridden on bills containing occurrence span code 77 (provider liable).
2506	H, S CH & CS	Coinsurance days are shown, but no amount is shown for either Value Code 09, or Value Code 11.
2507	H & CH	The sum of coinsurance days plus lifetime reserve days in either the year of admission or the year of discharge in a bill that spans calendar year end is greater than the number of days in the statement covers period for that portion of the bill. That is, the difference between December 31 of the year of admission (plus 1) and the From Date (Field 21a) is less than the number of first year coinsurance days (Field 25) plus the difference between total lifetime reserve days (Field 27) minus second year lifetime reserve days (Field 28), or the difference between the thru date (Field 21b.) of the bill and January 1 of the year of the thru date is less than the sum of second year coinsurance days (Field 26) plus Second Year Lifetime Reserve Days. If the patient status code is 30, add one to the difference between the statement covers thru date and January 1 of the year of discharge before making the comparison.

Error Code	Applicable To	Explanation
		Item 26—Lifetime Reserve Days
2601	H, S CH & CS	In a hospital bill this item contains an entry other than a number or a number that exceeds 60. An entry for a SNF bill is inappropriate as lifetime reserve days apply only to hospital stays.
2602	H & CH	Lifetime Reserve days are shown, but no amount is shown for either Value Code 08, or Value Code 10.
2603	H & CH	The lifetime reserve rate (lifetime reserve amount divided by lifetime reserve days) exceeds the rate that applies to the calendar year in which the lifetime reserve days occurred.
2604	H	PPS Bills only - This bill contains both Lifetime Reserve Days (Field 27) and Covered Days other than Lifetime Reserve Days (Field 22 is greater than Field 27), but does not involve a day outlier. PPS bills may not include Lifetime Reserve Days unless all days used are Lifetime Reserve Days or the bill contains a Day Outlier (Value Code 17, and Condition Code 60).
		Item 28--Occurrence
		The third digit of the following return codes reflects the sequence in which the code occurred. The sequence is 1 through 0, with 0 representing the 10th code.
28X1	General	The date associated with the indicated occurrence code is impossible, incomplete, or missing.
28X2	S & CS	Date Guarantee of Payment Began—Entry is inappropriate as this item applies only to hospital bills.
28X3	H & CH	Date Guarantee of Payment Began—Hospital bill: date is earlier than the Admission date or later than the "Statement Covers Thru" date.
28X4	H & CH	Date Guarantee of Payment Began—Utilization Days cannot exceed 12 days beyond the admission date, if admission date and the Statement covers Period "From" date are the same, unless the billing dates cover the period 12/24 through 1/2, in which case 13 days cannot be exceeded.
28X5	H & CH	If the guarantee of payment date is shown and the admission date and from date are not equal, Utilization Days cannot exceed 12 days unless the billing dates cover the period 12/24 thru 1/2 in which case 13 days cannot be exceeded.

Error Code	Applicable To	Explanation
28X6	H & CH	The "Date Guarantee of Payment Began" is earlier than the "Date Benefits Exhausted " (Occurrence Code 23).
28X7	H & CH	The "Date Guarantee of Payment Began" plus "Utilization Days (less "Coinsurance and Nonutilization days") cannot exceed the "Statement Covers Period Thru" date unless the Patient Status Code is 30 (Still Patient) in which case the "Thru" date cannot be exceeded by more than 1 day.
28X8	H, S CH & CS	Date Active Care Ended—This date is outside the "Statement covers period" dates.
28X9	H, S CH & CS	"Utilization Days" exceed the number of days from the "From" date through the "Date active care ended", Occurrence Code 22, minus the days for any Noncovered Level of Care (Occurrence Span Code 76) reported on this bill.
28X0	H, S CH & CS	Benefits Exhausted—This date is outside the "Statement Covers Period" dates.
28XA	H, S CH & CS	"Utilization Days" are greater than the number of days from the "From Date" through the "Date Benefits Exhausted" and in a hospital bill, "Date Guarantee of Payment Began" is not present.
28XB	O/P	Date Benefits Exhausted—This date is later than the "Date of First Service" on the bill.
28XC	O/P	Date Benefits Exhausted—A date is shown for a bill other than a Part B Inpatient bill.

Item 33—Occurence Span Codes and Dates Required

The third digit of the following error codes represents the location of the Occurrence Span code that failed a HCFA edit.

Error Code	Applicable To	Explanation
33X1	S	Qualifying Stay Dates—The "From" or "Thru" date is an impossible or incomplete entry.
33X2	S	Qualifying Stay Dates—The "Thru" date is the same as, or prior to, the "From" date.
33X3	S	Qualifying Stay Dates—The 3-day stay requirement is not met. (The "Thru" date is not 3 or more days later than the "From" date.)
33X4	S	Qualifying Stay Dates—The "Thru" date is later than the "Date of Current Admission".

Items 35-39—Condition Codes

The second and third digit of the following error codes represent the condition code reported on the bill.

Error Code	Applicable To	Explanation
35X1	H	Condition Code 60 cannot be present with Condition Code 61 or Condition Code 65. Condition Code 61 cannot be present with Condition Code 60 or Condition Code 65. Condition Code 65 cannot be present with any one of the following Condition Codes: 60, 61, 62, or 66.
35X2	H	Either Condition Code 60 (Length of Stay Outlier) or 61 (Cost Outlier) is present but Value Code 17 is not present in Item 46-49.

Item 40—Blood Record (Pints) Furnished

Error Code	Applicable To	Explanation
4001	H, S, & O/P	Blood Pints Furnished—The entry is other than a number.
4002	H, S, & O/P	"Blood Pints Furnished" is not equal to "Pints Replaced" plus "Pints Not Replaced".
4003	H, S & O/P	"Blood Pints Furnished" is zero with charges shown for Value Code 06. For outpatient, "Blood - Unreplaced Pints" is zero with charges shown in field 56a., "Verified Patient Liability, Blood Deductible."

Item 42—Blood Record (Pints) Not Replaced

Error Code	Applicable To	Explanation
4201	H, S, & O/P	"Not Replaced" is invalid or is an entry other than a number.
4202	H, S & O/P	"Not Replaced" is zero with charges shown in Value Code 06; that is all pints have been replaced and no charges should be shown. For outpatient, "Blood - Unreplaced Pints" is zero, with charges shown in field 56a., "Verified Patient Liability, Blood Deductible."

Item 43--Blood Record (Pints) Deductible

Error Code	Applicable To	Explanation
4301	H, S, & O/P	Blood Deductible—This entry is other than a number, or the number of pints is greater than 3.
4302	H, S, & O/P	Blood Deductible—A number of pints is entered but no blood usage is shown in Blood Pints Furnished.

Error Code	Applicable To	Explanation
4303	H, S, & O/P	Blood Deductible—The number of pints exceeds the number of pints not replaced.
4304	H, S, & O/P	Blood Deductible—The number of pints is more than the number left after subtracting the number of pints replaced from the number 3.
		Item 46--Value Code
		The third digit of the following error codes represents the location of the rejected Value Code.
46X1	General	Valid Value Code Contains an impossible amount.
46X2	H & S	Value Code 06—Medicare Blood Deductible is shown in value code; but no entry in Blood Record (Pints) deductible (item 43).
46X3	H & S	Value Code 06—Medicare Blood Deductible is completed in Value Code; but the total charges for revenue center code 001 (Totals) equals noncovered charges for revenue center code 001, indicating that blood cannot be applied toward the deductible.
46X4	H & CH	Value Code 07—Inpatient deductible amount shown exceeds inpatient deductible for the year.
46X5	S & CS	Value Code 07—Inpatient Deductible is present on a SNF bill.
46X6	H	Value Code 17, outlier amount, is present, but neither a day outlier (Condition Code 60), nor a cost outlier (Condition Code 61) is reported in the condition codes.
46X7	H	Value Code 17—outlier amount is greater than the reimbursement amount plus the sum of Value Amounts for Value Codes 06 through 16. This edit is not applicable if the Admission Date is earlier than the From Date.

Error Code	Applicable To	Explanation
		Item 51—Revenue Code
		For error codes involving the Revenue code and associated items (items 51-54), X=1-R; where 1 is the 1st revenue code, 2 is the 2nd revenue code, ..., 0 is the 10th revenue code, A is the 11th revenue code, Q is the 27th revenue code and R is the 28th revenue code.
51X1	General	Impossible or incomplete Revenue Code.
51X2	General	The revenue code cannot be present for this bill type:

Bill Type	Revenue Center Codes Not Allowed
11X	52X, 55X, 57X, 58X, 59X, 65X, 82X, 83X, 84X, 85X
12X	10X-17X, 20X-23X, 28X, 36X-39X, 45X, 47X-59X, 61X, 65X, 72X, 75X, 80X-85X, 88X-92X, 94X
13X	10X-18X, 20X-21X, 23X, 50X, 52X, 55X, 57X-59X, 65X, 72X, 80X, 81X, 99X
18X	56X-59X, 80X, 82X-85X, 88X, 89X
21X	17X, 20X-21X, 36X-37X, 45X, 50X-52X, 56X-59X, 65X, 71X, 72X, 80X-85X, 88X, 89X
22X	10X-23X, 28X, 36X-39X, 45X, 47X-59X, 61X, 65X, 72X, 75X, 80X-85X, 88X-92X, 94X
23X	10X-24X, 28X-29X, 32X, 38X, 39X, 41X, 45X, 53X, 55X-74X, 85X-99X
32X	10X-24X, 28X, 30X, 41X, 44X-53X, 60X, 87X
33X	10X-24X, 28X, 30X, 41X, 44X-53X, 60X, 87X
34X	10X-24X, 28X, 41X, 44X-53X, 60X, 87X
41X	002-109, 111-139, 141-223, 225-229, 231-269, 271-989, 991-999
51X	002-109, 111-139, 141-223, 225-229, 231-269, 271-989, 991-999
71X	10X-24X, 34X-37X, 40X, 45X, 46X, 48X, 49X-51X, 53X, 54X, 70X-72X, 80X-90X, 99X
72X	10X-24X, 26X, 28X, 29X, 33X-37X, 40X-72X, 74X-81X
74X	10X-24X

Bill Type	Revenue Center Codes Not Allowed
81X	002-650, 653-654, 658-999
82X	002-650, 653-654, 658-999
83X	10X-18X, 20X, 21X, 23X, 50X, 52X, 55X, 57X-59X, 65X, 72X, 80X-89X, 99X

51X3 General Units entry is missing or invalid; units required for this revenue code. HCFA bypasses this edit for accommodation revenue center codes (100-169, 200-219) if the inpatient bill contains zero utilization days or involves a payer primary to Medicare.

Bill Type	Revenue Center Codes Requiring Units
11X	100-169, 200-219, 381, 382, 801-804
12X	None
13X	300-319, 381, 382, 450, 459, 510-519, 821
18X	100-169, 381, 382
21X	100-169, 381, 382
22X	None
23X	300-319, 381, 382
32X	10X-24X, 28X, 30X, 41X, 44X-53X, 60X, 87X
33X	42X-44X, 472, 55X-57X
34X	42X-44X, 472, 55X-57X
41X	100-1169, 200-219
51X	100-1169, 200-219
71X	300-319, 381, 382, 42X-44X, 472, 51X, 55X-57X
72X	300-319, 381, 382, 821, 831, 841, 851, 881
74X	410-449, 472, 550-569
81X	650-659
82X	650-659
83X	300-319, 381, 382, 450, 459, 510-519, 821

L

Error Code	Applicable	Explanation
51X4	General	Total Charges or Noncovered Charges is invalid
51X5	General	Noncovered Charges exceed Total Charges.
51X6	General	A revenue center code is shown, but total charges for the revenue center is zero. For a nonpayment SNF bill, a revenue center of 001 may be shown with zero shown for both total charges and noncovered charges.
6101	General	Total Charges for revenue code 001 are not equal to the sum of the Total charges for all other revenue codes.
6102	H & S CH & CS	Noncovered Charges for revenue code 001 are not equal to the sum of the noncovered charges for all other revenue center codes.
6201	H & S CH & CS	Total Deductions (the sum of Value Codes 06 through 11) is greater than the difference between "charges" for revenue code 001 and "noncovered charges" for revenue code 001. This edit will be overridden when occurrence span code 77 (provider liable) is present on the bill.
6901	H	This bill is identified as a Kron bill, but contains no covered days.
6902	H	This bill is identified as a Kron bill, but contains a non-payment code of "N" or "B".

RETURN CODES BETWEEN 9401 AND 9409 RESULT FROM THE HCFA GROUPER PROGRAM

9401	H	Invalid principal diagnosis (item 77).
9402	H	Bill does not meet the criteria for any DRG in a Major Diagnostic Category (MDC) based on Principal Diagnosis Code.
9403	H	Invalid Beneficiary Age (not between 0 and 124).
9404	H	Sex (item 13) is not male or female.
9405	H	Invalid patient status.

Error Code	Applicable To	Explanation
9408	H	DRG is not between 001 and 468.
9409	H	DRG calculated by HCFA does not match DRG.
		Verified Noncovered Stays - UNIBILL Field 77
94A1	H & S CH & CS	Verified Noncovered Stays—The "FROM" date is impossible or incomplete.
94A2	H & S CH & CS	Verified Noncovered Stays—The "FROM" date is later than the "THRU" date.
94A3	H & S CH & CS	Verified noncovered Stays—The "THRU" date is an impossible or incomplete entry.
94A4	H & S CH & CS	The "THRU" date is later than the admission date (item 15).
94A5	H & S CH & CS	The "THRU" date shown is more than 60 days prior to the admission date (item 15).
		Prior Psychiatric Days - UNIBILL Field 70
94C1	H	This item contains an entry other than a number.
94C3	H	"Utilization Days" plus "Days used" exceed 150.
		Amount Reimbursed
94F1	General	Amount Reimbursed—This amount contains an entry other than a number.
94F2	H	Amount Reimbursed—The HMO Paid Code indicates that an HMO paid on behalf of Medicare, but a reimbursement amount greater than zero is shown.
		Nonpayment Code
94G1	H & S CH & CS	Nonpayment Code—The code entered is other than "N," "C," "B," "R," "P," or "E".
94G2	H & S CH & CS	Nonpayment Code—No code is entered in this item but the totals of Noncovered Charges are equal to the total charges.
94G3	H & S CH & CS	Nonpayment Code—Code "N," "C," "E," or "B" is shown in this item with total deductions or reimbursement present. A nonpayment

Error Code	Applicable To	Explanation
		bill may not contain Value Codes 06 through 17 (Deductibles, coinsurances, MSP amounts, and Outlier amounts) and may not contain a reimbursement amount.
94G4	H & S CH & CS	Nonpayment Code—Code "R" is shown in this item with reimbursement present.
		Missing Values
9901	General	No detail revenue code shown on this bill.
9902	H & S CH & CS	The inpatient bill contains no accommodation charge, that is, the bill does not contain a revenue code between 100 and 219 (between 100 and 169 for SNF bill) and FROM and THRU dates are not equal.
9903	O/P	No clinic visits shown for independent RHC.
9904	S	Occurrence Span Code 70, Qualifying Stay Dates, is not present on an initial SNF bill.
	O/P	Verified Patient Liability - UNIBILL Field 56
		Blood Deductible
9910	O/P	This item contains an entry other than a number.
9911	O/P	A deductible amount is shown in this item, with no pints furnished shown in item 40.
		Cash Deductible
9920	O/P	This item contains an entry other than a number or the number exceeds $75.
		Coinsurance
9930	O/P	This item contains an entry other than a number.
9931	O/P	This amount, positions 1880-1886, is not equal to 20 percent of the total of field 38, Covered Charges for each revenue center code with an override code of 0 or 1, minus the amount shown in Value Code 5, physician component reported separately to the carrier.

HCFA does not perform this edit if either of the following conditions is present:

1. The ESRD Method of Reimbursement Code, Field 49, is "1", or
2. At least one revenue center code has an Override Code other than "0" or "1" and one of the following Value Codes is present: 14, 15, 16, 41, or 42.

Payment Distribution - UNIBILL Field 57

9940	O/P	The Provider portion contains an entry other than a number.
9942	O/P	The Patient portion contains an entry other than a number.
9944	O/P	The Patient portion is not equal to the sum of patient payments minus the sum of the verified deductibles for cash and blood and the verified coinsurance.

3882.1 Identifying and Editing Final Nonpayment Bills.— Final Nonpayment Bills are identified by the presence of a valid nonpayment code of "N", "C", "B", or "E" in field 73 (Inpatient Hospital and SNF, including Christian Science). Editing of final nonpayment bills is limited to the edits described by return codes 0401, 0701, 0702, 1501, 1502, 2101, 2102, 2201, 2202, 2203, 2401, 33X1, 33X2, 33X3, 33X4, 51X4, 51X5, 6902, 94G1, 94G2, 94G3, and 9904.

3882.2 Adjustment Bill Return Codes

Error Code	Explanation
0010	This code is used on a "CREDIT" or "DEBIT" bill which passes the consistency edits but which must be deleted because the related "CREDIT" or "DEBIT" contains a consistency error. Does not apply to SPIDER.
0011	Invalid action code.
0020	The "CANCEL ONLY" adjustment bill does not contain the reason code or contains a code other than C, P, S, D, or H.
0040	This code is used to delete bills if the "DEBIT" is submitted without a corresponding "CREDIT" or vice versa. Does not apply to SPIDER.
0041	A "DEBIT" and/or "CREDIT" is submitted without a matching Association Code. Does not apply to SPIDER.
0300	A "DEBIT" and "CREDIT" has been submitted with the same matching code but the bills do not agree on the name and/or claim number. Does not apply to SPIDER.

3882.3 MCE Error Codes.—These codes are returned to you to locate and correct the source of the error.

Error Code		Explanation
7601	H	Invalid diagnosis or procedure code.
7602	H	Invalid fourth or fifth digit.
7603	H	E-code as principal diagnosis.
7604	H	Duplicate of principal diagnosis.
7605	H	Age conflict with diagnosis.
7606	H	Sex conflict with diagnosis.
7607	H	Manifestation code as principal diagnosis.
7608	H	Unacceptable principal diagnosis.

Special Billing Procedures

3883. SAMPLE BILLS.

Sample bill data is required for all final and interim bills on the tape record with the exception of adjustment (i.e., Cancel Only and Debit/Credit) bills, and RTI (i.e., Correction and VOID) bills. Narrative or coded diagnostic and surgical procedures data, when applicable, must be entered on the data record for all sample bills. The narrative data entries will consist of the first 41 characters of the surgical procedures appearing in the appropriate block on each of the billing forms and/or the first 45 characters of the diagnoses appearing in the appropriate block on each of the billing records. The coded data must be the full ICD-9-CM diagnosis or surgical procedure codes as reported by the provider. (See §§ 3880.2-3880.6 for specifics.) Sample size and selection criteria for each of the bill types follow:

INPATIENT HOSPITAL CLAIMS (HCFA-1453)--100 percent of all claims. For renal claims the number and type of dialysis sessions rendered must be shown in item 19T of the HCFA-1453 or in the appropriate blocks in the PATBILL format. To insure proper routing of these claims a special effort should be made to insure that the renal indicator is correctly set in the tape record. (See location 823 of § 3880.2 for detailed information on the format of this data.)

SKILLED NURSING FACILITY CLAIMS (HCFA-1453)-- 100 percent of all claims.

OUTPATIENT CLAIMS (HCFA-1483)--5 percent sample-- all claims with HI claim numbers ending in 05, 20, 45, 70, or 95.

HOME HEALTH AGENCY CLAIMS (HCFA-1487)-- 40 percent sample--all claims ending in 0, 4, 5, or 8.

3883.1 Inpatient Hospital Bills Involving End Stage Renal Disease Services.—A renal indicator is needed on all inpatient hospital bills (HCFA-1453) regardless of diagnosis where the beneficiary is identified as an ESRD patient (by the appropriate S-trailer in the query response or any other means available). For purposes of entitlement tracking, data for all kidney transplants and transplant nephrectomies are required. The transplant or transplant nephrectomy must be specifically identified as such using the full ICD-9-CM diagnosis and procedure codes. The type of kidney transplant, living or cadaveric donor, must also be shown.

This information is required from initial, interim, and final bills. See location 823 of §3880.2 for detailed information on the format of this data.

3884. THE BATCHING OF BILLS.

A batch control and batch summary record must be present for each batch of bills recorded on magnetic tape. No batch should exceed 90 bills in number. Different batch types (see S 3879.3) may be recorded on the same tape reel and may be sequenced in any order.

There are six batch types identified by the entry of the Batch-Type Code (see § 3879.3) in location 19 of the Batch Control Record (see § 3979.6). All inpatient hospital/SNF bills, outpatient bills, Christian Science bills, and Home Health Agency bills, with the exception of Final Nonpayment and RTI VOID bills are to be batched according to billing form of origin, i.e., HCFA-1453, HCFA-1483, HCFA-1486, HCFA-1487. All Final Nonpayment bills (Forms HCFA-1453 and HCFA-1486) are to be batched in a Final Nonpayment bill batch with detail records in abbreviated format as delineated in § 3880.6. All RTI VOID bills are to be batched in a VOID batch independent of billing form of origin and with detail record in abbreviated format as delineated in § 3880.7. When applicable, special bill types must be designated on the individual bill data records by entry of a special bill type code (E - Patient Filed bill or N - PIP bills) in location 937 on the Inpatient hospital/SNF and Christian Science bill data records, and (N - PIP bills) in location 371 on the Home Health Agency bill data record. See § 3885 and § 3886 for coding of Adjustment and RTI bills.

3885. ADJUSTMENT BILLS

Adjustment bills must conform to all the edit specifications contained herein and are identified by the action codes (see & 3880.1), i.e., 2 - cancel by credit adjustment; 3 - secondary debit adjustment; 4 - cancel only adjustment; 9 - payment requested adjustment (Code P). See § 3884 for batching instructions.

3885.1 The Association Adjustment Code.--All adjustment bills must have an association code you assigned. The association code is to be entered for adjustment bills only in locations 5-6 of the data records. The code is to consist of an alpha (A through J) in location 5 of the data record followed by a numeric (1 through 9) in location 6. For example, the first adjustment bill or bill pair (if "Debit/Credit" adjustment) in any given batch would be identified by an "A" followed by a numeric "1", i.e., "A1." Subsequent bills or bill pairs (if "Debit/Credit" adjustment) in the same batch would be identified by A2, A3, . . . , A9, B1, . . . , J9.

3885.2 The Cancel Only Adjustment Code (Action Code 4).--A Cancel Only Adjustment bill is used to delete a bill which has been accepted by SSA. This code is described in § 3816. The code is to be given in location 3 of the bill data detail record. The valid codes follow:

C - Coverage Only Code
P - Plan Transfer
S - Scramble
D - Duplicate Billing
H - Other

3885.3 The Credit/Debit Adjustment Action (Action Codes 2 and 3).--In a credit cancel, debit adjustment action, both bills must be in the same batch and must be identified as companion bills by the same association adjustment code (see § 3885.1). All adjustment bills may be batched together in the same batch, however, according to bill type (see § 3879.3).

3885.4 Code R and Code P Adjustment Bills.--For a Cancel Only or Credit/Debit Adjustment of a Code R or Code P adjustment, action codes 8 and 9 can no longer be used to identify the action as well as the bill type. Consequently, the required adjustment of a Code R or Code P type bill is to be effécted by (1) the proper entry of the required action code (Code 2, 3, or 4) on the applicable bill record; (2) the entry of R or P in the R/P bill-type adjustment bill code location on the applicable record (viz., position 600 on the Hospital/ SNF or 339 on the HHA data record). Code R and Code P adjustment bills are to be batched on adjustment batches.

3885.5 RTI Adjustment Bills.--Adjustment bills are not currently under RTI control at SSA. Consequently, for the present, RTI adjustment bills returned to SSA need not contain an RTI control number. However, when an adjustment bill is returned to you for corrective action, an RTI number is assigned for your use only, e.g., in the case of a "Credit/Debit" adjustment requiring RTI action both bills are returned, each with its own RTI control number. Currently you should not submit an RTI VOID bill for an RTI adjustment bill not returned to SSA.

3885.6 Adjustment Batch Balancing.--Adjustment bills are identified by the action code in location 2 of the Bills Tape Bill-Type Records. Although all "reimbursement amounts" are unsigned, credit actions are considered negative, the units position of the "total reimbursement amount" of the Bills Tape Batch Summary Record must be zoned "minus." Otherwise, the units position of the "total reimbursement amount" must be zoned "plus."

3886. THE BILLS TAPE RTI ACTION

RTI (Returned to Intermediary) bills may require either a correction or a VOID action.

3886.1 The RTI Control Number.--The RTI control number is the primary means for the identification of the RTI action and the ensuing purge from SSA's pending RTI control file. The 10 character RTI control number assigned by SSA shall consist of the following two items in tandem in the order given:

1. Batch number (see § 3879.2).
2. A two digit SSA-assigned sequence number.

3886.2 RTI Correction Action Bills.--Correction action requires (1) the correction of the error; (2) the return to SSA of all data originally submitted with correction; and (3) the addition of SSA's RTI control number to the bill data detail record. RTI correction items must be batched (maximum 90 items per batch) by batch-type designated for bills with the required billing form of origin. RTI control is achieved by the entry of the RTI control number (§ 3886.1) on the appropriate data records.

3886.3 RTI VOID Action Bills.--See § 3880.7 for description of the VOID action data record, explanation of usage, and batching requirements.

3887. TAPE DELETIONS--BATCHES, ITEMS, BATCH NUMBERS

To delete bill detail records from a prepared tape prior to submission to SSA, delete the desired bill and adjust the item and reimbursement amounts in the batch summary record.

To delete an entire batch from a prepared tape prior to submission to SSA, you may delete all the bill items from the batch in question and forward to SSA the batch control and batch summary records for the deleted batch. The batch summary record should be adjusted to show zero items and zero reimbursement with the constant VOID entered in positions 44-47 of the batch summary record.

To delete one or more batch numbers from the system, you should forward to SSA the batch control and batch summary records for the deleted batch(es). The batch summary record for each batch number deleted from the system should be adjusted to show zero items and zero reimbursement with constant VOID entered in locations 44-47 of the batch summary record.

When one or more of the above deletions have been made, the tape trailer and summary totals for the tape must be adjusted.

Each batch of bills you submit is assigned a batch number for control purposes (see § 3879.2). The four position batch control portion of the batch number should be countably sequenced in order of batch creation to ensure coverage of all permissable numbers.

(Ultimately all batch numbers within the coverage must be accounted for by each intermediary). Should you inadvertently skip one or several batch numbers on a given tape, the skipped numbers should be accounted for on a subsequent tape submission. If more than one intermediary reports via the same tape, each must ultimately account for all batch numbers falling within his range of coverage.

3890. EXHIBITS

1 - Transmittal and Report Form
2 - Summary Totals Report

EXHIBIT 1

TEST TAPES ONLY
TRANSMITTAL AND REPORT FORM
(See § 3866)

INTERMEDIARY: ______________________________
Headquarters City State Number

T-Number: __________; Date posted: __________; Configuration: __________
(See 3867.1-Misc. Data) (Track & Density)

Number of Bills: Hospital Reg.* Adj. Cor. __________; SNF Reg.* Adj. Cor. __________;

Outpatient Reg.* Adj. Cor. __________; HHA: Reg.* Adj. Cor. __________ Part A, Reg.* Adj. Cor. __________ Part B;

Final Non-Payment Reg.* Adj. Cor. __________; RTI Void __________.

Intermediary Contact: ____________________, Phone __________ (Include Area Code) EXT. ____

*Regular, Adjustment, RTI Correction - Cross out non-applicable classification.

(For Medicare Bureau/SSA Use Only)

Date Received: __________; Date Processed: __________.

Test Results:

EVALUATOR: ____________________

EXHIBIT 2

SUMMARY TOTALS REPORT

PAGE 001

TO

SOCIAL SECURITY ADMINISTRATION
BUREAU OF DATA PROCESSING
TAPE LIBRARY AND CONTROL SECTION
2-A-5 OPERATIONS BUILDING
6401 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21235

06/16/77

FROM

INTERMEDIARY AND ADDRESS NUMBER

REEL NUMBER 001

TYPE OF BATCH	BATCH NUMBER	TOTAL CLAIMS	TOTAL REIMBURSEMENT AMOUNT
INPATIENT	X129	84	39,021.00
	X130	45	25,659.00
	X131	62	32,274.00
	X132	67	41,560.00
	X133	09	4,380.00
	X134	26	13,039.00
FINAL NON-PAYMENT	X135	90	60,559.44
	X136	43	47,599.59
HOME HEALTH	X137	14	1,584.45
	X138	06	516.40
OUTPATIENT	X139	47	1,247.95
	X140	50	1,437.36
	X141	44	1,429.76
	X142	13	961.20
	X143	22	1,647.92
	X144	16	818.84
	X145	34	585.08
RTI VOID	X146	11	298.24

TOTAL CLAIMS 683
TOTAL BATCHES 18
TOTAL REIMBURSEMENT $ 274,619.23

Monthly Statistical Report on Status of Intermediary Workloads

3892. MONTHLY INTERMEDIARY WORKLOAD REPORT (FORM HCFA-1566)—GENERAL

Prepare and submit to HCFA each month a Intermediary Workload Report--Form HCFA-1566—showing your workload under the health insurance program. A separate report is required for each office assigned a separate intermediary number. When your service area covers more than one State, a separate report for each State is not required.

3892.1 Purpose and Scope.—The monthly Intermediary Workload Report is the source of current information on the status of your workloads. The data derived from the report, together with information from other sources, are used by HCFA for such purposes as:

- Estimating workloads,
- Analyzing manpower and material requirements,
- Establishing operating norms and pars,
- Comparing the performance of individual intermediaries. and
- Identifying problem areas for resolution by the intermediary and/or HCFA.

The workload report is designed to serve as a basic management tool for individual intermediaries. The workload report provides some of the data needed for budgeting, financing, work-planning, progress evaluation, and identification of operating problems.

Submit HCFA-1566, Intermediary Workload Report, in accordance with the following instructions.

3892.2 Due Date.—Transmit Form HCFA-1566 to HCFA CO via PC or terminal as soon as possible after the end of the month being reported but no later than the 10th of the following month using instructions contained in the Medicare Contractor Workload System User's Guide. Transmission of the data to the CO will be measured under the CPEP program.

3893. COMPLETING PAGE ONE OF THE MONTHLY INTERMEDIARY WORKLOAD REPORT

3893.1 Heading.—Enter your name and assigned number in the indicated spaces. In the space labeled "Reporting Period," enter the calendar month and year (e.g., 11/85) being reported. In the space labeled "Number of Working Days in Period," enter the number of working days scheduled for the reporting period, less any days where no claims were processed as a result of a strike, snow storm, etc.

3893.2 Checking Reports.—Before sending page one of the report to HCFA, check its completeness and arithmetical correctness. This check not only ensures accuracy but also uncovers other errors and inconsistencies. Use the following checklist:

For each column:

- Line 1 + 2 = 3.
- Line 7 + 8 = 6.
- Line 6 + 9 = 10.
- Line 3 + 4 - 10 = 12.
- Line 5 must be equal to or less than line 4.
- Line 13 must be equal to or less than line 12.
- Line 14 must be equal to or less than line 13.
- Line 17 + 18 + 19 + 20 = 16.
- Line 22 + 23 + 24 + 25 = 21.
- Line 27 must be equal to or less than line 26.
- Line 29 + 30 + 31 = 28.
- Columns ii + iii + iv + v + vi = i for lines 1-27.
- Columns ii + iii = i for lines 28-31.

Base all data reported on the HCFA-1566 on actual counts and not on any types of estimates or samples.

3893.3 Type of Bill.—Provider bills fall into the following columns of the report:

column (i) Total—All provider bills.

column (ii) Inpatient Hospital—HCFA-1450s submitted by hospitals for inpatient services, with the following two-digit classification codes in item 4: 1-1 (inpatient hospital); and 4-1 (Christian Science Hospital-inpatient).

column (iii) Outpatient—HCFA-1450s submitted by hospitals or SNFs for outpatient services, with the following two-digit classification codes in item 4: 1-3 (Hospital-outpatient); 2-3 (SNF-outpatient); 4-3 (Christian Science Hospital-outpatient); and 5-3 (Christian Science-SNF-outpatient); and 8-3 (hospital-outpatient-surgical procedures-ASC).

column (iv) SNF—HCFA-1450s with the following two-digit classification codes in item 4; 1-8 (hospital swing-bed); 2-1 (SNF-inpatient);2-8 (SNF-swing bed); and 5-1 (Christian Science-SNF-inpatient).

column (v) HHA—HCFA-1450s submitted by HHAs, with the following two-digit classification codes in item 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); 3-4 (HHA-Other-Part B benefits).

column (vi) Other—HCFA-1450s with the following two-digit classification codes in item 4:

1-2 (hospital inpatient-Part B benefits),
1-4 (hospital-Other-Part B benefits),
2-2 (SNF-inpatient-Part B benefits),
2-4 (SNF-Other-Part B benefits),
4-2 (Christian Science-inpatient-Part B benefits),
4-4 (Christian Science-inpatient-other),
5-2 (Christian Science-SNF inpatient-Part B benefits),
5-4 (Christian Science-SNF inpatient-other),
7-1, 7-2, 7-3, 7-4 (Clinics-provider rural health clinics-ESRD, CORFs, etc.), and
8-1 and 8-2 (Hospices).

NOTE: Do not count "independent" rural health clinic bills. Report them separately on the Monthly Intermediary Report on Independent Rural Health Clinic Bill Workloads. (See § 3895.)

best copy available

3893.4 Body of Report.

SECTION A: INITIAL BILL PROCESSING OPERATION

Complete every type of bill column (i through vi) for each reporting item as described below. Include data on all bills received for initial processing from providers (including provider rural health clinics) directly or indirectly through a RO, another Part A intermediary, etc. Do not include:

- Bills received from institutional providers if those bills are incomplete, incorrect, or inconsistent and consequently returned for clarification. Individual controls are no longer required for these bills,
- Adjustment bills,
- Bills previously submitted to central office but returned for correction—RTIs,
- Bills submitted by independent rural health clinics,
- Misdirected bills transferred to a Part B carrier or another Part A intermediary, and
- HHA bills where no utilization is chargeable and no payment has been made, but which intermediaries have requested only in order to facilitate recordkeeping processes.

Opening Pending

Line 1—Pending End of Last Month.—Enter in this line the number of bills reported as pending on line "12" on the previous month's report.

Line 2—Adjustments.—If it is necessary to revise the pending figure for the close of the previous month because of inventories, reporting errors, etc., enter the adjustment on this line. Report bills received near the end of the reporting month and placed under computer control sometime after the reporting month as bills received in the reporting month and not as bills received in the following month. In the event that some bills may have not been counted in the proper month's receipts, count them as adjustments to the opening pending in the subsequent month.

If line "3" differs from the entry in line "12" of the report for the previous month, there must be an entry in this line. The entry is preceded by a plus or minus sign, as appropriate. Explain the reason for any adjustment in the Remarks section.

Line 3—Adjusted Opening Pending.—Enter the result of line "1" + line "2."

Receipts

Line 4—Received During Month.—Enter the total number of bills received for initial processing during the month.

Count all bills immediately upon receipt regardless of whether or not they are put into the processing operation with the exception of those discussed below.

NOTE: Count bills submitted by providers electronically after they have passed intermediary consistency edits. Prior to that time these bills or entire tape reel (where magnetic tape is the medium of submission) may be returned by you without being counted as "received."

Do not count as new receipts the following:

- o Bills received which are to be returned to providers for additional development or information,
- o Adjustment bills,
- o Bills returned by central office for correction (RTIs),
- o Bills submitted by independent rural health clinics,
- o Misdirected bills which will be transferred to a Part B carrier or another Part A intermediary, and
- o HHA bills where no utilization is chargeable and where no payment is made, but which intermediaries have requested for recordkeeping purposes.

If any bill belonging to one of these exclusion categories is inadvertently counted as an initial bill received (e.g., certain adjustment bills unidentifiable at the time of receipt), subtract it from the receipt count at the time the bill is correctly identified.

Line 5—Electronic Media Bills.—Report the number of bills included in line "4" which were received via electronic media.

Clearances

Line 6--Total Batched (7 + 8).--Report the number of initial bills (described in lines 7 and 8 below) processed and batched. Make the counts for these items at the time processing activity is completed.

Line 7--Payment Made.-- Enter the number of initial bills approved for payment and batched for submittal to central office during the month. Count all batched bills for which you approved some payment. Include bills for which you made reimbursement in full or in part as a result of a determination that both the beneficiary and the provider were without fault (liability waiver). (See § 3445.)

Line 8--No Reimbursement Made.--Enter the number of initial bills processed and batched for submittal to central office during the month for which you made no reimbursement.

Line 9--Total Not Batched.--Report the number of initial bills processed during the month for which batching is not required and therefore will not be batched for submittal to central office. Report these items during the month in which you made the determination as to their final disposition. Include interim (nondischarge) bills not required to be submitted in those cases where the provider submits an interim payment bill but you determine it is a no-payment bill. (See § 3610)

Include Part B bills for which no payment was made because: (1) all services rendered were noncovered, (2) the individual was either not eligible for hospital insurance or not entitled to supplementary medical insurance, or (3) the bill duplicated a previously-received bill.

Do not include home health bills where no utilization is chargeable and no payment has been made, but you have requested only to facilitate recordkeeping processes.

Line 10—Total Processed.—Report the sum of lines 6 and 9.

Line 11—HMO Bills.—Enter the number of bills included in line 10 which represent bills paid by HMOs and batched by you during the reporting month.

NOTE: Count HMO bills paid by you on line 10, but not on line 11.

Closing Pending

Line 12—Pending End of Month.—Enter the number of bills received in the reporting month or prior that have not been processed by the end of the reporting month.

Line 13--Pending Longer Than 1 Month.— Report the number of bills included in line "12" pending longer than 1 month, i.e., those received prior to the reporting month but not processed to completion by the end of the reporting month. For example, for the reporting month of January 1986, report the number of bills pending at the end of January 1986 which had been received prior to January 1, 1986. Exclude bills received in the reporting month.

Line 14—Pending Longer Than 2 Months.—Report the number of bills included in line 12 pending longer than 2 months, i.e., those received prior to the month preceding the reporting month but not processed to completion by the end of the reporting month. For example, for the reporting month of January 1986, report the number of bills pending at the end of January 1986 which had been received prior to December 1, 1985. Exclude bills received in the reporting month and one month prior to the reporting month.

Bill Investigations

Line 15--Bill Investigations Initiated.--Enter the number of initial bills that, for purposes of processing the claim to completion, required outside contact (via telephone, correspondence, or on-site visit) with providers, social security offices, beneficiaries, etc., during the month. This includes contacting outside parties to resolve problems with covered level of care determinations, insufficient medical information or missing, inconsistent, or incorrect items on the bill. Do not count routine submissions by providers of additional medical evidence with bills as investigations in themselves. Count only the number of bills requiring investigation, not the number of contacts made. Bills reported as investigated in a prior month should be excluded from this count even if the investigation continued into the reporting month. Do not count as bills investigated those returned to providers because they were incomplete, incorrect or inconsistent and consequently were not counted as "receipts."

SECTION B: ADJUSTMENT BILLS

This section of the report includes data on the number of adjustment bills processed and pending for the reporting month, including those generated by providers, PROs, or as a result of MSP or other activity. In the reporting of adjustment bills, count only the number of original bills requiring adjustment, not both the debit and credit.

The final action taken on an adjustment bill depends on the situation.

- If a provider submits an adjustment bill which is received by the intermediary at a time when the original bill is still in its possession, the final adjustment action is taken on the original bill before it is submitted to HCFA.
- If an adjustment bill involves only money adjustments (no utilization changes) and will not be submitted to HCFA, count it as cleared after review and adjustment in payment.
- If an adjustment bill involves utilization changes and the original bill was rejected by HCFA, count it when it is resubmitted to HCFA in the form of a correction bill (RTI). (However, if the sole purpose of the adjustment bill is to correct an RTI, do not count it on the HCFA-1566.)
- If an adjustment bill involves utilization changes and the original bill was accepted by HCFA, count it when it is batched for submittal to HCFA. (Since § 3816 precludes the processing of a utilization adjustment bill until the bill upon which the adjustment action is based is accepted by HCFA, no utilization adjustment billing action may be processed until a batch clearance or query reply indicates that HCFA has accepted the original bill.)

Clearances

Line 16—Total Processed.— Report the number of adjustment bills processed during the month. Count adjustment bills as processed in final only when no further action is required.

Line 17—PRO Generated.—Report the number of adjustment bills included in line 16 which were generated by PROs.

Line 18—Provider Generated.—Report the number of adjustment bills included in line 16 which were generated by providers.

Line 19—MSP— Report the number of adjustment bills included in line 16 which were generated as a result of Medicare Secondary Payor (MSP) activity.

Line 20—Other—Report the number of adjustment bills included in line 16 which were generated by other than PROs, providers, or MSP activity. Include HMO adjustments where the HMO acted as an intermediary and made payment on the initial bill.

Pending

Line 21—Total Pending.—Report the number of adjustment bills which were not processed to completion by the end of the reporting month.

Line 22—PRO Generated—Report the number of adjustment bills included in line 21 which were not processed to completion by the end of the reporting month and which were generated by PROs.

Line 23—Provider Generated.—Report the number of adjustment bills included in line 21 which were not processed to completion by the end of the reporting month and which were generated by providers.

Line 24—MSP.—Report the number of adjustment bills included in line 21 which were not processed to completion by the end of the reporting month and which were generated by MSP activity.

Line 25—Other.—Report the number of adjustment bills included in line 21 which were not processed to completion by the end of the reporting month and which were generated by other than PROs, providers or MSP activity. Include HMO adjustments not processed to completion where the HMO acted as an intermediary and made payment on the initial bill.

SECTION C: MEDICAID CROSSOVER BILLS

This section of the report presents data on the volume of Medicaid crossover bills sent to Medicaid State agencies or their fiscal agents.

Clearances

Line 26—Transmitted to State Agencies.—Enter the total number of Medicaid crossover bills transmitted to State agencies or their fiscal agents in the reporting month.

Line 27—Electronic Media Bills.—Enter the number of bills included in line 26 which were transmitted via electronic media to State agencies or their fiscal agents.

SECTION D: INQUIRIES

This portion of the report presents data on the volume of provider or beneficiary inquiries which were processed during the reporting month. Include only processed inquiries dealing with Medicare bill processing issues. These issues would correspond to the workload budgeted under line 1 of the HCFA-1523 budget form.

Count inquiries as follows:

Beneficiary-Count one per contact (telephone, walk-in, or written), regardless of the number of bills being questioned. For example, if a letter from a beneficiary requests information on the status of one or more bills, count the response (interim or final) as one written beneficiary inquiry. Count each completed reply, terminated telephone conversation, or in-person discussion as processed, regardless of the need for subsequent contact on the same issue. Responses resulting from additional intermediary followup or analysis, or from recontacts by the beneficiary, are considered separate inquiries. Beneficiary inquiries include those made by anyone on behalf of the beneficiary, except by a provider.

Provider-Count one per contact (telephone, walk-in, or written). For example, if a provider calls or writes to obtain the status of 3, 6, or 10 separate bills, count the response as 1 provider telephone or written inquiry.

Include or exclude beneficiary and provider inquiries as follows:

- Count as inquiries those requests for Medicare bill information from beneficiaries or providers or their representatives which are directed to you for response.

- Do not count processed inquiries which are concerned solely with the intermediary's private line of business.

- Do not count inquiries concerned with professional relations activities.

- Do not count inquiries related solely to reimbursement issues, medical review or utilization review, MSP, audits, etc.. These are areas for which intermediaries receive distinctively separate Medicare funding. This exclusion achieves comparability with the HCFA-1523 budget form.

- Count electronic inquiries only if the response is provided by telephone or in writing and requires intermediary involvement. Do not count electronic inquiries if the provider can directly access the contractor's system to determine bill status.

- Count congressional inquiries according to whether they were made on behalf of a beneficiary or provider.

- Count inquiries made by HCFA ROs or SSA district offices only if concerning a Medicare bill and made on behalf of a beneficiary or provider.

- Count misdirected telephone inquiries which are referred to another source for a final response. Do not count misdirected written inquiries.

- Do not count inquiries which are, in fact, explicit or implicit requests for reconsiderations or hearing. Consult Part 3, §§ 3780ff. for specifics on what is a request for reconsideration or review.

Report the number of inquiries, from beneficiaries (column ii) and providers (column iii) processed during the reporting month, as follows:

Line 28—Total.—Report in the appropriate column the total number of inquiries processed.

Line 29—Telephone Inquiries.—Report in the appropriate column the total number of telephone inquiries processed.

Line 30—Walk-in Inquiries.—Report in the appropriate column the total number of walk-in contacts processed.

Line 31—Written Inquiries.—Report in the appropriate column the total number of written inquiries responded to.

REMARKS.--Enter an explanation of adjustments shown in line 2 as well as any comments relevant to the interpretation and analysis of the report.

SIGNATURE.--Space for signature of official responsible for report.

TITLE.--Space for title of official responsible for report.

DATE.--Date report is completed.

3894. COMPLETING PAGES TWO THROUGH ELEVEN OF THE INTERMEDIARY WORKLOAD REPORT

3894.1 Heading.--Enter your name and assigned number in the indicated space. In the space labeled "Report Month," enter the calendar month and year (e.g., 0187) being reported.

3894.2 Checking Reports.--Before transmitting pages two-eleven of the report to HCFA, check for completeness and arithmetical accuracy. Use the following checklist:

- For each column, line 20 must equal the sum of lines 1-19.
- For each column, line 39 must equal the sum of lines 21-38.
- For lines 1-39, column 1 must equal the sum of columns 2-7.
- For each of lines 1-39, column 8 must be less than or equal to column 1.
- The "All Claims" page (page 11) must equal the sum of all the bill types (total of nine) for each data element on the page, except line 40.

3894.3 Body of Report

SECTION E: CLAIMS PROCESSING TIMELINESS

Pages two-eleven of the HCFA-1566 include data on your activity in processing bills to completion during the reporting period. Count the bill as processed to completion on the "scheduled payment date." The "schedule payment date" is the date the check you issued is mailed, deposited by you in the provider's account, or transferred electronically. For PIP bills and no payment bills, the "scheduled payment date" is the date for payment bills in the same adjudication batch. Base data shown on reliable counts of all bill processing activity. Do not estimate bill counts. Report data on initial bills only. Do not include:

- Bills received from institutional providers if they are incomplete, incorrect, or inconsistent and consequently returned for clarification. Individual controls are not required for these bills;

- Adjustment bills;

- Bills previously submitted to CO but returned for correction—RTIs;

- Bills submitted by independent RHCs (separate reporting instructions will be issued for these);

- Misdirected bills transferred to a carrier or another intermediary; and

- HHA bills where no utilization is chargeable and no payment has been made, but which you have requested only in order to facilitate recordkeeping processes. (There is no HCFA requirement for HHAs to submit no payment non-utilization chargeable bills.)

Apart from these exceptions, include in the report all bills (including PIP and EMC) processed to completion (e.g., paid bills, complete denials, no payment bills) in the reporting month. Report bills in the month the scheduled date of payment falls. See §3600.1 for the definition of scheduled payment date for all bills, including PIP and no payment bills. "Clean" bills are those bills which do not require investigation or development external to your operation on a prepayment basis. Bills which do not meet the definition of "clean" are "other" bills. See § 3600.1 for examples of "clean" and "other." Bills paid are those for which some payment was made (i.e., reimbursement greater than zero). Bills not paid are those for which no payment was made (i.e., bill charges applied completely toward deductible or fully denied).

On each page two-eleven (there is a separate page for each type of bill category listed below), report:

- In column 1, the total number of bills processed to completion;

- In column 2, the number of "non-PIP clean" bills paid;

- In column 3, the number of "non-PIP other" bills paid;

- In column 4, the number of "PIP clean" bills paid;

- In column 5, the number of "PIP other" bills paid;

- In column 6, the number of "clean" bills not paid;

- In column 7, the number of "other" bills not paid; and

- In column 8, the number of bills processed to completion which were received via electronic media, whether "clean" or "other."

For each category, show the number processed to completion on the line corresponding to the number of days from receipt by you to the scheduled date of payment or other final action, if a no-pay bill. See §3600.1C for definition of receipt date.

To calculate the processing time for a claim, subtract the Julian receipt date from the processed to completion Julian date. When the processed to completion date falls in the year following the year of receipt, add to the Julian date of completion 365 (or 366 if the year of receipt is a leap year). If a claim is processed to completion on the same day it is received, the processing time is one day. This definition applies to all lines of the report, including line 40.

On line 40 report the mean processing time (PT) to one decimal place for each column. To calculate the mean PT, add the processing times for all the bills shown in lines 20 and 39 of that column and divide by the sum of lines 20 and 39. You cannot use the categories on the report to calculate the mean PT. Because of the aggregation of claims in lines 35-39 you must use the processing times for the individual claims as explained below to make this calculation.

Mean Processing Time Calculation for All Claims

- Subtract the Julian date of receipt from the Julian date of payment (or equivalent action for those not paid) for each claim.
- Accumulate the result to cell counter for number of days for all claims.
- Divide this result by the total number of claims.
- Round to one decimal place.

EXAMPLE:

Claim	Julian Date		Counter by Days	Counter by Claims
	Receipt	Paid		
A	87103	87133	30	1
B	87105	87206	101	2
C	87115	87177	62	3
D	87120	87213	93	4
E	87122	87215	93	5
F	87130	87223	93	6

Total Days = 30 + 101 + 62 + 93 + 93 + 93 = 472

Mean = 472/6 = 78.6666 = 78.7

Complete the report for each bill type:

- Inpatient Hospital—Of the bills reported on the "All Claims" page, show on page 2 data on the number of HCFA-1450s submitted by hospitals for inpatient services with the following two-digit classification codes in item 4: 1-1 (inpatient hospital); and 4-1 (Christian Science Hospital-inpatient),

- Outpatient—Of the bills reported on the "All Claims" page, show on page 3 data on the number of HCFA-1450s submitted by hospitals and SNFs for outpatient services with the following two-digit classification codes in item 4: 1-3 (hospital-outpatient); 2-3 (SNF-outpatient); 4-3 (Christian Science Hospital-outpatient); 5-3 (Christian Science SNF-outpatient); and 8-3 (hospital-outpatient surgical procedures - ASC),

- SNF—Of the bills reported on the "All Claims" page, show on page 4 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 1-8 (hospital swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF-swing-bed); and 5-1 (Christian Science SNF-inpatient),

- HHA—Of the bills reported on the "All Claims" page, show on page 5 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); and 3-4 (HHA-other-Part B benefits),

- Hospice—Of the bills reported on the "All Claims" page, show on page 6 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 8-1 and 8-2 (Hospice),

- CORF—Of the bills reported on the "All Claims" page, show on page 7 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 7-4 (Comprehensive Outpatient Rehabilitation Facility or Other Rehabilitation Facility),

- ESRD—Of the bills reported on the "All Claims" page, show on page 8 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 7-2 (Free Standing Renal Dialysis Center),

- Lab—Of the bills reported on the "All Claims" page, show on page 9 data on the number of HCFA-1450s with the following two-digit classification codes in item 4: 1-4 (Hospital-Other-Part B benefits); and 2-4 (SNF-Other-Part B benefits),

- Other—Of the bills reported on the "All Claims" page, show on page 10 data on the number of HCFA-1450s not included in the previous eight bill categories, and

- All Claims—On page 11 include all bills processed to completion during the reporting month.

3894.4 COMPLETING PAGE TWELVE OF THE INTERMEDIARY WORKLOAD REPORT

3894.5 Heading.—Enter your name and assigned number in the indicated space. In the space labeled "Report Month," enter the calendar month and year (e.g., 0587) being reported.

3894.6 Checking Reports.—Before transmitting page twelve to HCFA, check its completeness and arithmetical accuracy. Use the following checklist:

- For each column, line 1 must equal the sum of lines 2-10.
- For each column, line 11 must equal the sum of lines 12-20.
- For each line, column 1 must equal the sum of columns 2-6.

3894.7 Body of Report

SECTION F: INTEREST PAYMENT DATA

Page twelve of the HCFA-1566 includes data on your payment of interest on bills because of your failure to meet the required payment date of Section 9311 of the Omnibus Budget Reconciliation Act of 1986. Counts of bills processed reflect their status as of the last workday of the reporting calendar month. Base data shown on reliable counts of all bill processing activity and not on estimates. Report data on initial bills only. Include all bills requiring interest payments in the month. Report bills in the month the scheduled date of payment falls. See § 3600.1 for a discussion of interest payments and the definition of scheduled payment date.

Complete the report for each column as follows:

- Column 1 - Total—Include data for all bills for which interest payments were made in the reporting month.

- Column 2 - Hospital—Of the bills reported in column 1, show in column 2 data for HCFA-1450s submitted by hospitals for inpatient or outpatient services with the following two-digit classification codes in item 4:

1-1 (inpatient hospital)
1-2 (inpatient hospital - Part B benefits)
1-3 (outpatient hospital)
1-4 (hospital - other Part B benefits)
4-1 (Christian Science Hospital - inpatient)
4-2 (Christian Science Hospital - inpatient Part B benefits)
4-3 (Christian Science Hospital - outpatient)
4-4 (Christian Science Hospital - inpatient other)
8-3 (Outpatient hospital surgical procedures - ASC)

- Column 3 - SNF—Of the bills reported in column 1, show in column 3 data for HCFA-1450s submitted with the following two-digit classification codes in item 4:

1-8 (hospital swing-bed)
2-1 (SNF - inpatient)
2-2 (SNF - inpatient Part B benefits)
2-3 (SNF - outpatient)
2-4 (SNF - other Part B benefits)
2-8 (SNF-swing-bed)
5-1 (Christian Science SNF - inpatient)
5-2 (Christian Science SNF - inpatient Part B benefits)
5-3 (Christian Science SNF - outpatient)
5-4 (Christian Science SNF - inpatient other)

- Column 4 - HHA—Of the bills reported in column 1, show in column 4 data for HCFA-1450s with the following two-digit classification codes in item 4: 3-2, 3-3 and 3-4.

- Column 5 - Hospice—Of the bills reported in column 1, show in column 5 data for HCFA-1450s with the following two-digit classification codes in item 4: 8-1 and 8-2,

- Column 6 - Remainder—Of the bills reported in column 1 show in column 6 data for all HCFA-1450s not included in columns 2-5.

On line 1, show the number of claims on which you paid interest in the reporting month. Report on line 2 the number of claims included in line 1 for which you made payment one day after the required payment date (e.g., the required payment date is 30 days in FY 1987). Data for lines 3-10 are similar to those for line 2. Calculate the number of days late by subtracting the Julian date of receipt of the bill from the Julian scheduled payment date and then subtracting the required payment date (i.e., 30 in FY 1987). If the bill is paid in the year following the year of receipt, add 365 or 366 (if the year of receipt is a leap year) to the result, as appropriate.

On line 11, show the amount paid in interest on those bills reported in line 1. See § 3600.1 on how to calculate interest payments. On lines 12-20 show the amounts paid in interest for bills reported in lines 2-10, respectively. Show payment amounts on lines 11-20 to the nearest penny, including the decimal point.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE PROGRAM
INTERMEDIARY WORKLOAD REPORT

INTERMEDIARY NAME

REPORTING PERIOD (MONTH AND YEAR)

INTERMEDIARY NUMBER

NUMBER OF WORKING DAYS IN A PERIOD

SECTION A: INITIAL BILL PROCESSING OPERATION		TOTAL (i)	INPATIENT HOSPITAL (ii)	OUT-PATIENT (iii)	SNF (iv)	HHA (v)	OTHER (vi)
OPENING PENDING	1. PENDING END OF LAST MONTH						
	2. ADJUSTMENTS (SHOW + or −)						
	3. ADJUSTED OPENING PENDING						
RECEIPTS	4. RECEIVED DURING MONTH						
	5. ELECTRONIC MEDIA BILLS						
CLEARANCES	6. TOTAL BATCHED (7 + 8)						
	7. PAYMENT MADE						
	8. NO REIMBURSEMENT MADE						
	9. TOTAL NOT BATCHED						
	10. TOTAL PROCESSED (6 + 9)						
	11. HMO BILLS						
CLOSING PENDING	12. PENDING END OF MONTH						
	13. LONGER THAN 1 MONTH						
	14. LONGER THAN 2 MONTHS						
BILL INVESTIGATION	15. BILL INVESTIGATIONS INITIATED						
SECTION B: ADJUSTMENT BILLS							
CLEARANCES	16. TOTAL PROCESSED						
	17. PRO GENERATED						
	18. PROVIDER GENERATED						
	19. MSP						
	20. OTHER						
PENDING	21. TOTAL PENDING						
	22. PRO GENERATED						
	23. PROVIDER GENERATED						
	24. MSP						
	25. OTHER						
SECTION C: MEDICAID CROSSOVER BILLS							
CLEARANCES	26. TRANSMITTED TO STATE AGENCIES						
	27. ELECTRONIC MEDIA BILLS						

SECTION D: INQUIRIES		TOTAL	BENEFICIARY	PROVIDER	REMARKS
	28. TOTAL				
	29. TELEPHONE				
	30. WALK-IN				
	31. WRITTEN				

SIGNATURE	TITLE	DATE

Form HCFA-1566 (11-86)

INTERMEDIARY WORKLOAD REPORT - PAGE _*_
SECTION E - CLAIMS PROCESSING TIMELINESS

INTERMEDIARY ID ______ TYPE OF CLAIM _____*______ REPORT MONTH _______

			************ PAID	*************			** NOT PAID ***		
			*** NON-PIP ***		***** PIP *****				
LINE NUMBER/	DAYS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
1.	1								
2.	2								
3.	3								
4.	4								
5.	5								
6.	6								
7.	7								
8.	8								
9.	9								
10.	10								
11.	11								
12.	12								
13.	13								
14.	14								
15.	15								
16.	16								
17.	17								
18.	18								
19.	19								
20.	Total 1-19								

HCFA-1566 Page _*_

* PAGE NUMBER AND TYPE OF CLAIM ARE TO BE REPORTED AS FOLLOWS:

Page 2-	Inpatient Hospital
Page 3-	Outpatient
Page 4-	SNF
Page 5-	HHA
Page 6-	Hospice
Page 7-	CORF
Page 8-	ESRD
Page 9-	Lab
Page 10-	Other
Page 11-	All Claims

INTERMEDIARY WORKLOAD REPORT PAGE _*_
SECTION E - CLAIMS PROCESSING TIMELINESS

INTERMEDIARY ID ______ TYPE OF CLAIM _____*______ REPORT MONTH _______

		************ PAID	*************			** NOT PAID ***		
		*** NON-PIP ***		***** PIP *****				
LINE NUMBER/ DAYS	TOTAL (1)	CLEAN (2)	OTHER (3)	CLEAN (4)	OTHER (5)	CLEAN (6)	OTHER (7)	EMC (8)
21. 20								
22. 21								
23. 22								
24. 23								
25. 24								
26. 25								
27. 26								
28. 27								
29. 28								
30. 29								
31. 30								
32. 31								
33. 32								
34. 33								
35. 34-45								
36. 46-60								
37. 61-90								
38. 91+								
39. Total 20+								
40. MEAN PT								

HCFA-1566 Page _*_

* PAGE NUMBER AND TYPE OF CLAIM ARE TO BE REPORTED AS FOLLOWS:

Page 2- Inpatient Hospital
Page 3- Outpatient
Page 4- SNF
Page 5- HHA
Page 6- Hospice
Page 7- CORF
Page 8- ESRD
Page 9- Lab
Page 10- Other
Page 11- All Claims

INTERMEDIARY WORKLOAD REPORT
SECTION F - INTEREST PAYMENT DATA

INTERMEDIARY ID ______

REPORT MONTH ________

LINE NUMBER/ CLAIM/PAYMENT INTERVAL	TOTAL (1)	HOSPITAL (2)	SNF (3)	HHA (4)	HOSPICE (5)	REMAINDER (6)
1. No. of Claims						
2. 1 DAY LATE						
3. 2 DAYS LATE						
4. 3 DAYS LATE						
5. 4 DAYS LATE						
6. 5 DAYS LATE						
7. 6-15 DAYS LATE						
8. 16-30 DAYS LATE						
9. 31-60 DAYS LATE						
10. 61+ DAYS LATE						
11. Amount Paid						
12. 1 DAY LATE						
13. 2 DAYS LATE						
14. 3 DAYS LATE						
15. 4 DAYS LATE						
16. 5 DAYS LATE						
17. 6-15 DAYS LATE						
18. 16-30 DAYS LATE						
19. 31-60 DAYS LATE						
20. 61+ DAYS LATE						

HCFA-1566 Page 12

Monthly Statistical Report on Status of Independent Rural Health Clinic Bill Workloads

3895. MONTHLY INTERMEDIARY REPORT ON INDEPENDENT RURAL HEALTH CLINIC BILL WORKLOADS--GENERAL.

Prepare and transmit to HCFA each month a report showing your independent rural health clinic (RHC) billing workloads. A separate report is required for each intermediary office assigned a separate intermediary number which services independent RHCs.

Do not include workload counts for bills submitted by provider RHCs in this report. Bills of this type are reflected and reported on your Monthly Intermediary Workload Report. (See §§ 3892ff.)

3895.1 Purpose and Scope.-- The monthly Intermediary Report on Independent Rural Health Clinic Bill Workloads is the source of current information on the status of your independent RHC bill workloads. The data derived from the report, together with information from other sources, are used by HCFA for:

- Estimating workloads,
- Analyzing manpower and material requirements,
- Providing base information for use in making determinations on possible realignment or expansion of service areas,
- Establishing operating norms and pars,
- Comparing the performance of individual intermediaries, and
- Identifying problem areas for resolution by you and/or HCFA.

This report is also designed to serve as a basic management tool for individual intermediaries. It provides some of the basic data needed for budgeting, financing, workplanning, progress evaluation, and identification of problems in handling independent RHC bills.

3895.2 Due Date.--Transmit the report on independent RHC workloads to HCFA CO via PC or terminal as soon as possible after the end of the month being reported but no later than the 10th of the succeeding month. Use instructions contained in the Medicare Contractor Workload System User's Guide. Nonreceipt of the report by the 10th of the succeeding month will result in contact with you to obtain the required information by telephone.

3895.3 Reporting Definitions.--For Section A of the report, use the same definitions of the terms "received, processed, and pending" as in § 3893.4 under lines 4, 10 and 12, respectively, of the monthly Intermediary Workload Report (HCFA-1566). Bills denied are those bills for which no reimbursement was made for reasons other than deductible was not met. For Section B of the report use the same definitions for processing and payment time given in § 3894.3—monthly Intermediary Workload Report (HCFA-1566 -Pages 2-11). For Section C of the report, use the same definitions as in § 3894.7 (Interest Payment Data).

3895.4 Reporting Instructions.—Report each month, using the format shown in § 3895.6, data on independent rural health clinic (RHC) bills. Do not report data on provider-based RHC bills here. Such bills are reported on the HCFA-1566. Report in Section A the number of independent RHC bills received, adjudicated (processed) and denied during the month, as well as the number of independent RHC bills pending at the end of the month. In addition, report on lines 2A-2M for each State in which you service an independent RHC, the number of such bills processed during the month. Show the two-digit Medicare numeric State code under the column marked "State Code." Show "00" for line 2 under "State Code" to represent the total of all States. If you process bills for only one State show that State code on line 2 with no further breakouts in lines 2A-2M. The counts for lines 2A-2M summed must equal the total number of independent RHC bills reported on line 2.

Report in Section B the claims processing time data for those independent RHC bills for which payment was mailed during the reporting month or equivalent action taken for those not paid. Note that the definition for when a bill is processed in Section B is different from Section A. See § 3894.3 for definitions on "paid" and "clean" bills. "Remainder" in this section refers to all bills (paid and not paid) with the exception of the "clean non-PIP bills" in column 2. Please note that when calculating the "mean" processing time, bills paid on the same day as received are counted as processed in 1.0 days (the same as bills processed the day after receipt).

Report in Section C the number of independent RHC bills for which interest payments were made as well as the amount of interest paid in the reporting month. See § 3600.1 on how to calculate interest.

3895.5 Checking Reports.—Before transmitting the report, check for completeness and accuracy. Use the following checklist:

o The sum of lines 2A + 2M = line 2.
o Line 2 State code must be "00" if lines 2A-2M are used.
o Line 2 State code cannot be "00" if only one State is shown in Section A, line 2.
o The sum of lines 6 - 12 = line 5 for all columns.
o Columns 2 + 3 = column 1 for lines 5 - 12.
o Line 13 must be greater than 0.0 and must contain a decimal point.

Use the following form in reporting independent RHC information:

3895.6 Reporting Form.—

INTERMEDIARY REPORT ON INDEPENDENT RURAL HEALTH CLINIC BILL WORKLOADS

INTERMEDIARY NAME	INTERMEDIARY NUMBER	REPORT PERIOD (MONTH AND YEAR)

SECTION A: WORKLOAD DATA	************************	************************	************************	************************
1. NUMBER RECEIVED		************************	************************	************************
	STATE 1	NUMBER 2	STATE 1	NUMBER 2
2. NUMBER ADJUDICATED			G	
	A.		H	
	B.		I	
	C.		J	
	D.		K	
	E.		L	
	F.		M	
3. NUMBER DENIED		************************	************************	************************
4. NUMBER PENDING		************************	************************	************************

SECTION B: PROCESSING AND PAYMENT TIME DATA	TOTAL PROCESSED 1	PAID CLEAN NON-PIP 2	REMAINDER 3	********************
5. TOTAL				********************
6. 0-24 DAYS				********************
7. 25 DAYS				********************
8. 26 DAYS				********************
9. 27-30 DAYS				********************
10. 31-60 DAYS				********************
11. 61-90 DAYS				********************
12. OVER 90 DAYS				********************
13. MEAN		********************	********************	********************

SECTION C: INTEREST DATA	NUMBER OF CLAIMS 1	AMOUNT PAID 2	******************************
14. TOTAL			******************************

SIGNATURE	DATE	PHONE NUMBER

Quarterly Statistical Report on Selected Intermediary Workload Activities

3896. QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT — GENERAL

In addition to the monthly workload report, prepare and transmit to HCFA a Quarterly Supplement to the Intermediary Workload Report showing the status and disposition of selected workloads. Complete a separate report for each office assigned a separate intermediary number.

3896.1 Purpose and Scope.—The Quarterly Supplement to Intermediary Workload Report - Pages 1 and 2, supplies HCFA with current data on the number of bills processed for each State for which you service one or more providers. The Quarterly Supplement to the Intermediary Workload Report - Page 3, provides data on denials, HHA visits and waivers of liability.

3896.2 Due Date.—Transmit the Quarterly Supplement to HCFA CO via PC or terminal as soon as possible after the reporting quarter but no later than the 15th of the following month. Use instructions contained in the Medicare Contractor Workload System User's Guide. Transmission of the data to CO will be measured under CPEP.

3898. COMPLETING QUARTERLY SUPPLEMENT TO THE INTERMEDIARY WORKLOAD REPORT, PAGES 1 AND 2

3898.1 Heading.—Enter your name and assigned intermediary number. In the space labeled "Reporting Period," enter the fiscal quarter and year for which the report is prepared; e.g., show your 0188 for the quarter October 1987 through December 1987; show 0288 for the January-March 1988 quarter.

3892.2 Checking Reports.--Before transmitting reports to Baltimore, check their completeness and arithmetical accuracy. Use the following checklist:

- Line 1 equals the sum of the number of bills processed reported on line 10 for each corresponding type of bill on the intermediary's monthly workload report (HCFA-1566) - Page 1, for the 3 months of the reporting period.
- Line 1 equals the sum of lines for each column (i.e., items A-LL).
- For all lines of the report, column 1 (Total) equals the sum of the items in columns 2 + 3 + 4 + 5 + 6.
- The State code must be a two-digit numeric Medicare State code.
- The State code on line 1 must be "00" if you service providers in more than one State.
- The State code on line 1 cannot be "00" if you service providers in only one State. (It must be the code for that State.)

3898.3 Type of Bill.--Report counts in total and by type of bill as shown below:

column (1) Total—All provider bills.

column (2) Inpatient Hospital—HCFA-1450s submitted by hospitals for inpatient services, with the following two-digit classification codes in item 4: 1-1 (inpatient hospital); and 4-1 (Christian Science Hospital-inpatient).

column (3) Outpatient—HCFA-1450s submitted by hospitals or SNFs for outpatient services with the following two-digit classification codes in item 4: 1-3 (hospital-outpatient); 2-3 (SNF-outpatient); 4-3 (Christian Science Hospital-outpatient); 5-3 (Christian Science SNF-outpatient); and 8-3 (hospital-outpatient surgical procedures - ASC).

column (4) SNF—HCFA-1450s with the following two-digit classification codes in item 4: 1-8 (hospital-swing-bed); 2-1 (SNF-inpatient); 2-8 (SNF swing-bed); and 5-1 (Christian Science-SNF-inpatient).

column (5) HHA—HCFA-1450s submitted by HHAs with the following two-digit classification codes in item 4: 3-2 (HHA-Part B visits and use of DME); 3-3 (HHA-Part A visits and DME); 3-4 (HHA-other-Part B-benefits).

column (6) Other—HCFA-1450s with the following two-digit classification codes in item 4:

1-2 (hospital inpatient-Part B benefits);
1-4 (hospital-other-Part B benefits)
2-2 (SNF-inpatient-Part B benefits);
2-4 (SNF-other-Part B benefits);
4-2 (Christian Science- inpatient-Part B benefits);
4-4 (Christian Science-inpatient- other);
5-2 (Christian Science-SNF inpatient-Part B benefits);
5-4 (Christian Science-SNF inpatient-other);
7-1, 7-2, 7-3, 7-4 (Clinics-provider rural health clinics-ESRD, CORFs, etc.); and
8-1 and 8-2 (Hospices)

NOTE: Do not count "independent" rural health clinic bills here. Report them separately on the Monthly Intermediary Report on Independent Rural Health Clinic Bill Workloads. (See § 3895.)

3898.4 Body of Report.—

Section A: Bills Processed by State of Provider.-- This section is concerned with the reporting of the claims workload for each State for which you service one or more providers. Record the number of initial bills processed and reported on the monthly Intermediary Workload Report (HCFA-1566) - Page 1 on line 10, Total Processed, (see § 3893.4) over the 3 months of the reporting quarter and broken down by State.

If you service providers located in more than one State, show the total for all States (00) on line 1 of page 1 of the Quarterly Supplement as well as a breakout for each State on lines A-R (Page 1) and continue S-LL (Page 2).

NOTE: The information reported in Section A is to reflect the State of the provider, not the home office, if it is part of a chain organization.

Line 1--Total for All States.-- Report the total number of initial bills processed during the reporting quarter. For each respective column (1 through 6) the number shown equals the sum of the numbers reported on line 10 of the Intermediary Workload Report (HCFA-1566) - page 1, for the 3 months of the reporting quarter.

Lines 1A through 1LL--State.-- In the column just left of column (1), enter the two-digit Medicare State code of each State which includes at least one provider you service. Enter "00" on line 2 for the total of all States. If you service providers located in only one State, do not complete line 1A. Show the State code on line 1—total for all States.

Enter opposite each listed State the number of initial bills processed during the reporting quarter for providers located in the State. Report the data in total in column (1), and by type of bill in columns (2) through (6).

3898.5 COMPLETING QUARTERLY SUPPLEMENT TO THE INTERMEDIARY WORKLOAD REPORT, PAGE 3

3898.6 Heading.—Enter your assigned intermediary number. Under "Report Period"; enter the fiscal quarter and year for which the report is being prepared; e.g., show 0188 for October-December 1987; 0288 for January-March 1988; etc.

3898.7 Checking Reports.—Before transmitting report to CO check for completeness and arithmetical accuracy. Use the following checklist:

- o For all columns, line 2a + 2b must equal line 2.
- o For all columns, line 3a must be equal to or less than line 3.
- o Column 1 must equal the sum of columns 2 + 3 + 4 + 5 + 7 for lines 2-4. (Note: Column 6 is excluded.)
- o Column 6 must be equal to or greater than column 5 for lines 2-3.

- Column 6, line 1, must be equal to or greater than column 5, line 1 of Page 1 for the same reporting quarter.
- Line 4 must be rounded to whole dollars. (NOTE: This may cause you to force column 1 to equal the sum of columns 2+3+4+5+7.)
- For columns 1 through 5 and 7, line 4 must be equal to or greater than line 3 unless line 3 is zero in which case line 4 must also be zero.

3898.8 Type of Bill.—Report counts in total end by type of bill as outlined in § 3898.3 for page 1.

3898.9 Body of Report.—

Section B: Visit Data.—Report under column 6, line 1, the number of billed visits for HHA bills shown as processed in column 5, line 1, of the Quarterly Supplement, page 1, for the same reporting period.

Section C: Denial Determinations.-- This section includes data on full and partial denial determinations you made. Report information on only those denial determinations resulting in your preparing and sending a notice to the beneficiary. Include denials for no-pay bills where you send a denial notice to the beneficiary. Some examples of these various types of beneficiary notices are HCFA-1954, HCFA-1955, and EOMB. (See §§ 3719ff. for further discussion of the types of notices and their content.)

Do not count denial notices sent for the sole purpose of informing the beneficiary that future services will be denied.

Do not include denial notices sent by PROs . Do not include in this section counts of those situations where services were considered not reasonable and necessary or custodial care, but because both the beneficiary and provider were found to be without fault under § 213 of P.L. 92-603, liability was waived in full, excluding deductibles and coinsurance. (See §§ 3430ff.) However, include counts of those situations involving waiver of beneficiary liability only, i.e., provider found to be at fault.

Report the total number of denials according to whether they were medical or nonmedical. "Medical" denials include those where:

- Services were determined to be not reasonable or necessary, i.e., denials based on § 1862(a)(1) of the Act (see § 3151), such as noncovered medical social worker services,
- Services were determined to be custodial in nature i.e., denials based on § 1862(a)(9) of the Act (see § 3159), such as maintenance care,
- Denials based on medical statutory exclusions, e.g., noncovered foot care and cosmetic surgery performed in an outpatient setting, or dental services,
- No skilled services were rendered, e.g., home health aide services,

- Level of care was not skilled,
- Patient was not homebound for HHA services,
- Daily visits were denied (HHA services must be intermittent),
- Condition was not one for which Vitamin B12 is allowed,
- No documentation was available to substantiate patient under care of physician, or
- Services rendered were not consistent with certification.

Some examples of "nonmedical" denials are those where:

- Beneficiary was not entitled to benefits,
- Beneficiary's benefits were exhausted,
- Beneficiary had not met the 3-day inpatient hospital stay requirement for SNF services,
- Beneficiary had not met the 30-day transfer from hospital requirement (statutory provisions not applicable),
- There was a workers' compensation offset,
- Physician refused to certify,
- Services were furnished prior to entitlement or after termination of entitlement,
- Provider refused to submit evidence,
- Supervisory visits should have been included as administrative cost (see NOTE below),
- Duplicate services were rendered (see NOTE below),
- Noncovered supplies were provided (see NOTE below), or
- Undocumented services were billed (see NOTE below).

NOTE: Examine "noncovered" services individually to determine whether they are medical or nonmedical denials. If a service is routinely denied without medical review, count it as a nonmedical denial. However, if a medical review determination must be made, count it as a medical denial, even if it is listed as a nonmedical denial.

In selecting a reason for denial where both medical and nonmedical denials are involved, select the one which denied payment for the largest amount of total charges.

Line 2--Total Denial Determinations.--For columns 1-5 and 7 report the total number of denial notices sent to beneficiaries during the quarter. Count all denial notices, whether the patient stay, HHA plan of treatment, or Part B services were denied in full or in part. Report in column 6 the number of HHA visits denied for those HHA denials reported in column 5.

Line 2A--Medical.--Report the number of beneficiary notices (visits for column 6) included in line 2 above where payment was denied either in full or in part for medical reasons.

Line 2B--Non-medical.--Report the number of beneficiary notices (visits for column 6) included in line 2 above where payment was denied either in full or in part for non-medical reasons.

Section D: Waiver of Liability Activities.-- This section focuses on your activity with respect to the "waiver of liability" provision (§ 213 of P.L. 92-603). Beneficiaries and providers are protected from liability for services that are considered (1) not reasonable and necessary, or (2) custodial care, if you determine that the beneficiary and provider did not know or have reason to know that the services were not covered. (See §§3430-3446ff.)

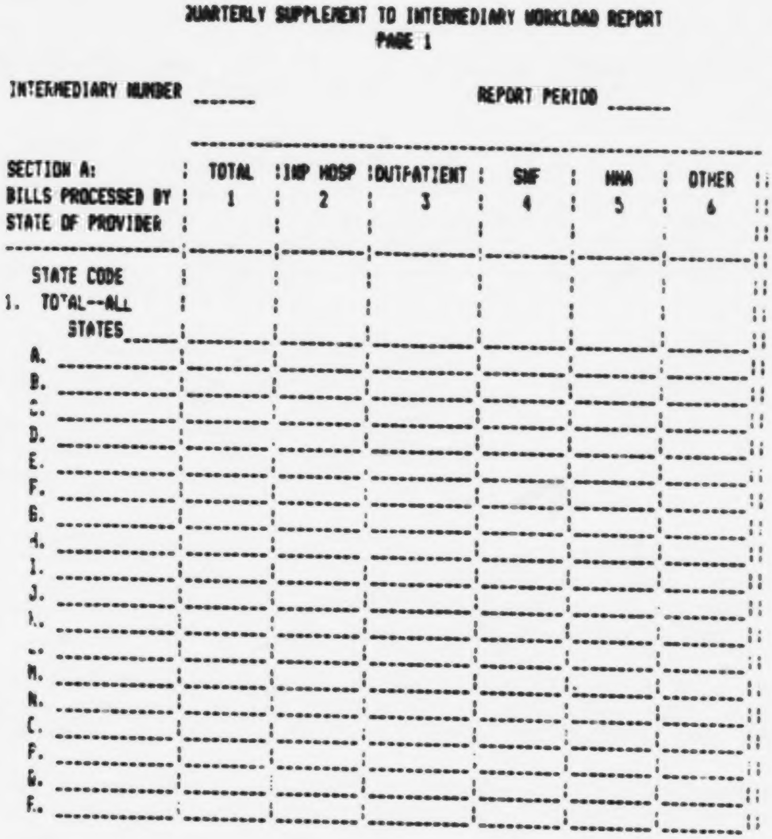
Lines "3" and "4" refer to your determinations to waive the liability of both the beneficiary and the provider and make payment in full or in part or apply charges toward the deductible for services determined to be noncovered because they are not reasonable or necessary or constitute custodial care. These determinations are made on one of the following levels: (1) Initial bill processing, (2) appeals process, or (3) at any other time, such as when an you decides to reopen your determination. Do not count waiver determinations made by PROs.

Line 3--Total Number of Determinations.--For columns 1-5 and 7 report the total number of cases where you made a determination to waive the liability of both the beneficiary and provider during the current reporting quarter. Report in column 6 the number of HHA visits for which liability was waived for those cases reported in column 5.

Line 3A--Initial.--For columns 1-5 and 7 report the number of determinations included in line 3 which were made during adjudication of the initial bill. Report in column 6 the number of HHA visits for which liability was waived during adjudication of the initial bill.

Line 4--Total Amount Reimbursed.--Enter the amounts paid (to the nearest dollar) under the waiver provision for the cases enumerated in line "3". The amount of reimbursement does not include coinsurance amounts, charges applied toward the deductible, or reimbursements for services not under consideration with respect to the waiver provision. Where services on a bill are totally paid (excluding applicable deductible and coinsurance) as a combination of covered services and noncovered services paid under waiver and the exact dollar amount of waiver payment is not available without contacting the provider, report an approximation of the waiver payment. In calculating this approximation, apply to total charges the proportion of waiver days to total days represented in the claim and then subtract any applicable deductible or coinsurance for the waiver period.

3898.10 Quarterly Supplement to the Intermediary Workload Report - Pages 1, 2 3.--



QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
PAGE 1

INTERMEDIARY NUMBER ______

REPORT PERIOD ______

SECTION A: BILLS PROCESSED BY STATE OF PROVIDER	TOTAL 1	INP HOSP 2	OUTPATIENT 3	SNF 4	HHA 5	OTHER 6
STATE CODE						
1. TOTAL--ALL STATES						
A.						
B.						
C.						
D.						
E.						
F.						
G.						
H.						
I.						
J.						
K.						
L.						
M.						
N.						
O.						
P.						
Q.						
R.						

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
PAGE 2

INTERMEDIARY NUMBER ______ REPORT PERIOD ______

SECTION A: BILLS PROCESSED BY STATE OF PROVIDER	TOTAL 1	INP HOSP 2	OUTPATIENT 3	SNF 4	HHA 5	OTHER 6
S. ____________						
T. ____________						
U. ____________						
V. ____________						
W. ____________						
X. ____________						
Y. ____________						
Z. ____________						
AA. ____________						
BB. ____________						
CC. ____________						
DD. ____________						
EE. ____________						
FF. ____________						
GG. ____________						
HH. ____________						
II. ____________						
JJ. ____________						
KK. ____________						
LL. ____________						

QUARTERLY SUPPLEMENT TO INTERMEDIARY WORKLOAD REPORT
HCFA-1566A-PAGE 3

INTERMEDIARY NUMBER _______ REPORT PERIOD _______

	TOTAL 1	INP HOSP 2	OUTPATIENT 3	SNF 4	HHA BILLS 5	HHA VISITS 6	OTHER 7
SECTION B: VISIT DATA	*********	*********	***********	*********	*********	*********	*********
1. VISITS PROCESSED	*********	*********	***********	*********	*********		*********
SECTION C: DENIALS	*********	*********	***********	*********	*********	*********	*********
2. TOTAL							
2A. MEDICAL							
2B. NON-MEDICAL							
SECTION D: WAIVER OF	*********	*********	***********	*********	*********	*********	*********
LIABILITY DETERMINATIONS	*********	*********	***********	*********	*********	*********	*********
3. NUMBER							
3A. INITIAL							
4. AMOUNT REIMBURSED						*********	

SIGNATURE | PHONE NUMBER | DATE

Monthly Statistical Report on Medicare Secondary Payer Savings

3899. MONTHLY INTERMEDIARY REPORT ON MEDICARE SECONDARY PAYER SAVINGS (FORM HCFA-1563)

3899.1 General.—Each month electronicaly transmit to CO a Monthly Intermediary Report on Medicare Secondary Payer Savings (HCFA-1563) via the IBM PC. Continue to use existing dialup instructions and the RLINK software sent to you. (See §3899.9.) Hardcopy reports are not required. Transmit a separate report for each office assigned a separate intermediary number and also, for each State for which you have been designated the servicing intermediary for one or more providers. You are not required to complete an individual State report for those States in which you have had no MSP activity during the month (reports that would show zeros in every category, including pending).

3899.2 Purpose and Scope.—The Monthly Intermediary Report on Medicare Secondary Payer Savings supplies HCFA with current data on MSP savings and MSP pending workloads.

3899.3 Due Date.—Form HCFA-1563 is due in CO as soon as possible after the end of the month being reported, but not later than the 15th of the following month. Nonreceipt of the report by the 15th will result in a telephone contact with you to obtain required information.

3899.4 Form Heading.—Enter your name, assigned number and the State in which the provider is located. In the space labeled "Reporting Period" enter the numeric designation for month and year for which the report is being prepared, e.g., show 01/87 for January 1987.

3899.5 Savings Calculations.—

A. Reporting Dollar Values.—Round all values to the nearest whole dollar. This includes all amounts shown on lines 2, 4, 6, 8 and 10.

B. Checking Reports.—Before mailing the reports, check their completeness and arithmetical accuracy as follows:

- Lines 1 + 3 + 5 = line 7 for all columns.
- Lines 2 + 4 + 6 = line 8 for all columns.
- Line 10 should be equal to, or greater than, line 9 for all columns, unless line 9 is equal to "0" in any column; in that case, line 10 should also be equal to "0" for the same column.
- For each line of the report column "i" (TOTAL), must equal the sum of the items in columns "ii" + "iii" + "iv" + "v" + "vi."

3899.6 Recording Savings.--Control all claims from which you extract MSP savings and be able to verify all amounts recorded on the HCFA-1563.

A. MSP Savings File.--Retain claims specific key identifying information on each claim counted as savings on the HCFA-1563. At a minimum, record the beneficiary's name, HICN, type/dates of service, claim control number, billed charges and savings amounts reported.

B. Savings Data From Non-Medicare Sources.--If you record savings from data which you have obtained from your "private side" records or any other "outside" source, you must be able to extract the same claims specific information noted above, i.e., you must verify that Medicare covered services are involved and be able to calculate "what Medicare would have paid." In addition, you must compare this data with the data contained in your MSP savings file to ensure that savings have not previously been recorded for the same claims. If savings have not previously been taken for the claim, count them as savings on the HCFA-1563 and enter them into your MSP savings file.

3899.7 Source of Savings.--Report data by total and by source as shown below:

Column (i)	Total--All MSP savings regardless of source.
Column (ii)	Workers' Compensation, Black Lung, and VA.--Include data related to all MSP savings resulting from medical benefits provided by the WC Plans of the 50 States, the District of Columbia, Guam and Puerto Rico. Also include Federal WC provided under the Federal Employee's Compensation Act, the U. S. Longshoremens' and Harborworkers' Compensation Act and its extensions, the Federal Coal Mine Health and Safety Act of 1969 as amended (the Federal BL Program), and any fee-for-service medical care paid for by the VA. Keep separate records for each distinct category (WC, BL or VA) as this may become a reporting requirement in the future.
Column (iii)	Working Aged--Include data related to all MSP savings resulting from benefits payable under an EGHP for beneficiaries aged 65 and older who are covered by reason of their own employment or the employment of a spouse of any age. Section 3491 further defines the working aged provisions.
Column (iv)	ESRD--Include data related to all MSP savings resulting from benefits payable under an EGHP for individuals who are entitled to Medicare benefits solely on the basis of ESRD during a period of up to 12 months. The period during which Medicare pays secondary benefits is defined in §§3490.5 and 3490.6.

Column (v) Auto Medical, No Fault and Liability Insurance--Include data related to all MSP savings resulting from:

o Automobile Medical or No Fault Insurance--Insurance coverage (including a self-insured plan) that pays for all, or part, of the medical expenses for injuries sustained in the use of, or occupancy of, an automobile, regardless of who may have been responsible for the accident. (This insurance is sometimes called "personal injury protection," "medical payments coverage" or "medical expense coverage.")

o Liability Insurance--Insurance (including a self-insured plan) that provides payment based on legal liability for injury, illness or damage to property. It includes, but is not limited to, automobile liability insurance, uninsured motorist insurance, homeowners' liability insurance, malpractice insurance, product liability insurance, and general casualty insurance. It does not include situations where a beneficiary receives medical payment under his or her own homeowners' insurance.

Column (vi) Disabled--Include data related to all MSP savings resulting from situations where Medicare is the secondary payer for disabled beneficiaries under age 65 (except ESRD beneficiaries) who elect to be covered by a large group health plan (LGHP) as a current employee or family member of such employee. A LGHP is any health plan that covers employees of at least one employer who normally employs 100 or more employees. The disabled provisions apply to items and services furnished on or after January 1, 1987 and before January 1, 1992.

3899.8 Type of Savings.--Report data by type of savings as shown below.

Unpaid (Cost Avoided) MSP Claims

Unpaid (cost avoided) claims are those that you have returned without payment because you have strong evidence that another insurer is the primary payer and there is no indication that payment has been requested from that payer. The information indicating MSP involvement may be contained in your files, on the query reply, or on the claim itself. In addition, any information which you obtain from a non-Medicare source and use as the basis for claiming cost avoidance savings must meet the criteria in §3899.6B.

Information considered adequate for claiming cost avoidance savings includes statements on the claim noting "automobile accident," "collision", or the name of the automobile insurer. Another example would be previous information that you have obtained which shows that EGHP coverage exits. Do not count claims which you develop as "possible" MSP situations based on routine edits as cost avoidance savings unless you have previous information that another payer has primary responsibility. For example, "trauma code" edits are not, by themselves, considered strong evidence that Medicare is the secondary payer.

Line 1—Number.—Report the total number of cost avoided claims from which you are recording savings on the report.

Line 2—Dollar Value.—Report the total dollar value of the potential Medicare payments calculated for the claims on Line 1 that will be saved if the primary payer makes a payment which relieves Medicare of all payment liability.

Show as the amount cost avoided what Medicare would have paid. Do not count total charges as cost avoided savings. The cost avoided amount is the "Medicare payment rate" or the "current Medicare interim reimbursement amount" less any co-insurance amount applicable. Reduce Part B services subject to coinsurance for the coinsurance amount or you may use a "coinsurance reduction factor" of 19 percent to calculate coinsurance charges for all Part B services. You do not have to query for deductible status, but may assume that the deductible has been met.

Tracking/Adjusting Cost Avoidance Savings

Cost avoidance savings may not duplicate savings reported as full or partial recoveries and may not be shown where Medicare ultimately makes primary payment. To prevent duplicate counting, suspend all claims which you return unpaid. Set up a control on the claim when it is returned for development. Maintain this control for 75 days, unless you receive further information before that time which allows you to process the claim. If no further information on the claim is received, you may deny the claim after 75 days. You are not required to continue tracking the claim, but retain the key identifying information on the claim, as described in §3899.6A.

HCFA prefers you to show cost avoidance savings only after 75 days have elapsed. You do, however, have the option of counting the savings when the claim is initially suspended or at any time during the suspension period. If you choose the latter alternative, you must adjust your cost avoidance savings if the claim is resubmitted during the suspension period with information showing it is not a legitimate cost avoidance.

The following situations require special consideration if cost avoidance savings are counted before the 75 day suspense period has ended:

- A claim returned (and counted as cost avoided) is paid in part by another payer and the provider resubmits it for secondary payment.
- A claim returned (and counted as cost avoided) is denied by the other payer and the provider resubmits it for primary payment.
- A claim returned (and counted as cost avoided) is paid in full by the other payer and the provider submits a no-payment bill. Show "full recovery" savings and not cost avoidance.

In these situations, adjust your cost avoidance savings figures by deducting or "backing out" the applicable amounts. Make the adjustments in the reporting month in which a final determination is rendered. The following chart outlines the correct reporting of savings in each situation.

ADJUSTMENTS TO REPORTED MSP COST AVOIDANCE SAVINGS

CLAIMS PROCESSING ACTIONS	MSP SAVINGS REPORTED		
	Cost Avoidance	Partial Recoveries	Full Recoveries
I. Partial Recovery Adjustment			
o MSP situation indicated. Medicare payment calculated to be $1200 if Medicare was primary payer. Claim is returned to provider.	$ 1,200		
o Provider resubmits the claim showing $900 paid by the other insurer. Medicare secondary payment of $300 is made.	$ (1,200) *	$ 900	
II. "Other Payer Denial" Adjustment			
o MSP situation indicated - Medicare "primary" payment, $2,000. Claim is returned to provider.	$ 2,000		
o Other payer denies claim. Medicare found to be primary and Medicare payment of $2,000 is made.	$(2,000) *		
III. Full Recovery Adjustment			
o MSP situation indicated - Medicare "primary" payment, $900. Claim is returned to provider.	$ 900		
o Provider submits a "no-payment" bill showing full payment by the other payer.	$(900) *		$900

*Amounts "backed out" of cost avoidance savings figures.

Full Recoveries

Line 3--Number.--Report the number of full recoveries made during the month.

Line 4--Dollar Value.--Report the dollar value of full recoveries made during the month.

Full Recoveries are claims where the primary payer made a payment which relieved Medicare of all payment liability. Full recoveries can be either prepayment or postpayment. Count full recoveries in the month in which you recover the full payment or receive a no-payment bill for prepayment full recovery cases. Where the "full recovery" is paid in installments, count the claim as pending until all monies have been received. Instructions for processing full recovery claims are in §§3680, 3681, 3682, 3685B, and 3685C1.

A. Prepayment Full Recovery.--A prepayment full recovery occurs when a primary payer makes full payment on a charge before Medicare makes any payment.

EXAMPLE: A hospital identifies an EGHP as the primary payer, submits its charge to that insurer, and the EGHP pays the hospital's full cost. You subsequently receive a "no pay" bill in accordance with §3682. Determine what you would have paid if the EGHP had not made payment and record that total as a full recovery savings.

B. Postpayment Full Recovery.--A postpayment full recovery occurs when a primary payer makes full payment on a charge after Medicare has paid.

EXAMPLE: Medicare paid a hospital bill for charges incurred as a result of an automobile accident. Subsequently, an auto liability insurer reimburses the Medicare beneficiary for the full amount of the medical expenses and the beneficiary refunds that amount to the program. Count the amount of Medicare's initial payment as a postpayment full recovery.

Record as savings, that portion of a full recovery paid to an attorney or other agent as Medicare's share of the recovery cost. Consequently, there may be instances where you have made a full recovery but do not get back the full amount paid. When you refer a case to the RO for recovery action, however, do not record any savings at that point. Savings from a compromise or "subrogation" case may be recorded only after a final determination. Do not count these cases for CPEP credit prior to final settlement.

EXAMPLE: A beneficiary incurs a $1,000 physician's bill and a $5,000 hospital bill as a result of injuries sustained in an automobile accident. Assuming that all deductibles are satisfied, Part B pays $800 toward the physician's charges, and Part A covers the hospital bill in full. After litigation, a liability insurer agrees to pay $6,000 for the beneficiary's medical expenses from which the attorney takes a fee. (If the attorney's fee were 33 percent, the dollar recovery would be $4,000.) The Part B contractor can record $800 in

Full Recovery savings. You are also allowed to count your payment as a Full Recovery savings even though the amount recovered, due to attorney's fees, does not equal what was paid.

Partial Recoveries

Line 5--Number.--Report the number of partial recoveries made during the month.

Line 6--Dollar Value.--Report the dollar value of partial recoveries made during the month.

Partial recoveries are those savings realized when a primary payer makes a payment which covers only a part of the Medicare allowable charge, leaving Medicare with a balance to pay. Use the following formula in computing the savings from a partial recovery:

o The dollar amount of Medicare benefits available for the services or supplies (calculated as if Medicare were the primary payer) less the Medicare benefits paid for the services or supplies, equals the partial recovery savings. (Primary Payment -Actual Payment = Partial Recovery Savings)

Count partial recoveries in the month when you take final action on the claim (either making a payment supplemental to that of the primary payer or making a partial recovery from a payment by the primary payer). Instructions for processing partial recovery claims are in §§3679, 3680, 3681, 3682 and 3685.

Record as savings, that portion of a partial recovery paid to an attorney or other agent as Medicare's share of the recovery cost. When you refer a case to the RO for recovery action, however, do not record any savings at that point. Savings from a compromise or "subrogation" case may be recorded only after a final determination. These cases may not be counted for CPEP credit prior to final settlement.

Totals

In this part of the report (lines 7 and 8), report data on the totals of unpaid claims plus full and partial recoveries.

Line 7--Claims.--Report the total number of MSP claims handled during the month.

Line 8--Dollar Value.--Report the total dollar value associated with MSP claims during the month.

Pending Claims/Cases

Line 9--Number.--Report the number of pending claims/cases as of the close of the reporting month. Include claims/cases for which "Full Recovery" is expected but all money due has not been received.

Line 10—Estimated Value.—Report the gross charges for all claims/cases reported as pending on line 9. Where "Full Recovery or Partial Recovery" has been determined, but all monies have not been received, report the gross charges until you receive the full amount due or it is reasonable not to expect further payments.

A case is defined as one or more claims filed on behalf of an individual and related to one specific occurrence which necessitated medical care. When recording data for column 1 concerning WC and Auto Liability, and No Fault Insurance, count only cases. For Working Aged (column iii), ESRD (column iv), and Disabled (column vi), count each individual claim.

A case/claim is pending only after it has been developed to the point where it is determined to be an MSP claim and no final resolution has been made. A partial or interim payment is not sufficient to remove a case/claim from the pending rolls. Final resolution occurs when there is no longer a practical expectation of further reimbursement.

Remarks.—Enter any comments relevant to the interpretation and analysis of the report.

Signature.—The report is signed by the individual responsible for its compilation.

Date.—Enter the Date that the report is completed and signed.

3899.9 Electronic Submission.—

A. Keying HCFA-1563.—

- Use existing RLINK dialup instructions.
- Key letter "L" to bring up blank HCFA-1563.
- Enter valid 5 digit intermediary number. Use tab key to move from column to column.
- Enter reporting period using numeric designation month and year, e.g., 0187 for January 1987.
- Enter two-position alpha State code.
- Complete each column of data. Fields with zero do not have to be keyed. System will presume all blank fields to be zero.
- Do not key dollar signs or commas. Key only whole dollar amounts.
- After completing the form key F1. System will edit and print any error messages on the line above "contractor number." Tab to incorrect field and rekey correct entry. When form passes all edits, line will read "record has been written." Key F4 to return to menu.

- To abort at any time without writing a record, key F3 and refer to CICS instructions.

- To verify that a report has been written, return to the main menu (F4) and key "L" to bring up a blank form. Key in contractor number, reporting period and State code. Key F7. Completed report should appear on the screen.

B. Edits for HCFA-1563.—

- A valid 5-digit intermediary number is required.
- The default value for areas not keyed is zero.
- Appropriate reporting period (MMYY) is required.
- Enter the two-position alpha State code.
- Lines 1 + 3 + 5 must equal line 7 for all columns.
- Lines 2 + 4 + 6 must equal line 8 for all columns.
- Line 10 must be equal to or greater than line 9 for all columns unless line 9 is zero. In that case line 10 must also be zero.
- For each line of the report column i must equal the sum of columns ii + iii + iv + v + vi.

EXHIBIT

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MONTHLY INTERMEDIARY REPORT ON MEDICARE SECONDARY PAYER SAVINGS

INTERMEDIARY NAME	NUMBER	STATE	REPORTING PERIOD (MO & YR)

	TOTAL (i)	WORKER'S COMP BLACK LUNG & VA (ii)	WORKING AGED (iii)	ESRD (iv)	AUTO MED NO FAULT AND LIABILITY (v)	DISABLED (vi)
Unpaid (Cost Avoided) MSP Claims 1 Number						
2 Dollar Value						
Full Recoveries						
3 Number						
4 Dollar Value						
Partial Recoveries						
5 Number						
6 Dollar Value						
Totals 7 Claims (Lines 1 + 3 + 5)						
8 Dollars (Lines 2 + 4 + 6)						
Pending 9 Number						
10 Estimated Gross Value						

Remarks

Signature	Title	Date

Form HCFA-1563 (4-86)

CHAPTER X
MEDICAL REVIEW

Section Page

Medical Review of Skilled Nursing Facility Bills

- Medical Review (MR) for Coverage of Skilled Nursing Facility Services.. 3900 10-3
  - MR of Hospital-Based and Nonhospital Based SNF Claims.. 3900.1 10-3
  - SNF Quarterly Report of Medical Review Activity - Exhibit I.. 10-5

Medical Review of Hospice Bills

- Medical Review of Hospice Bills.............................. 3901 10-7
  - Review of Routine Home and Inpatient Respite Care Bills.. 3901.1 10-7
  - Continuous Home Care Bills.............................. 3901.2 10-7
  - Review of Hospital Bills for Hospital Admissions of Beneficiaries Who Have Elected Hospice Care... 3901.3 10-8
  - Review of Hospice Revocations.............................. 3901.4 10-9
  - Intermediary Home Visits Related to Hospice Services.. 3901.5 10-9
  - Hospice Report of Medical Review Activity........... 3901.6 10-13
- Exhibit of Hospice Home Visit Consent Form................ 10-16

Medical Review of Home Health Bills

- Medical Review of Home Health Services.................. 3902 10-17
  - HCFA-485 - Home Health Certification and Plan of Treatment Data Elements.............................. 3902.1 10-19
  - HCFA-486 - Medical Update and Patient Information... 3902.2 10-25
  - Treatment Codes for Home Health Services............ 3902.3 10-32
  - HCFA-487 - Addendum to the Plan of Treatment/Medical Update.. 3902.4 10-39
  - HCFA-488 - Intermediary Medical Information Request.. 3902.5 10-40
  - Postpayment Review.. 3902.6 10-42
  - Exhibit I.. 10-45
  - Exhibit II.. 10-46
  - Exhibit III.. 10-47
  - Exhibit IV.. 10-48
  - Exhibit V.. 10-48a
  - Exhibit VI.. 10-48c

Medical Review of Comprehensive Outpatient Rehabilitation Facility (CORF) Bills

- Medical Review of Comprehensive Outpatient Rehabilitation Facility (CORF) Claims.. 3903 10-49

CHAPTER X
MEDICAL REVIEW

Medical Review of Part B Intermediary Outpatient Specialized Rehabilitation Bills

	Section	Page
Medical Review (MR) of Part B Intermediary Outpatient Physical Therapy (OPT) Bills	3904	10-53
MR of Part B Intermediary Outpatient		
Speech-Language Pathology (SLP) Bills		
MR Considerations	3905	10-75
Speech Language Pathology Terms	3905.1	10-83
Acronyms and Abbreviations	3905.2	10-85
Speech-Language Pathology Tests	3905.3	10-88
MR of Part B Intermediary Outpatient Occupational	3905.4	10-88
Therapy (OT) Bills		
Other MR Considerations	3906	10-119
Occupational Therapy Availability	3906.1	10-128
	3906.2	10-130

Prepayment Medical Review of All Bills

	Section	Page
Prepayment Medical Review	3915	10-185

Coverage Compliance Review for HHA Claims

	Section	Page
Intermediary Coverage Compliance Reviews		
Selection of HHAs	3916	10-197
Coverage Compliance Review	3916.1	10-197
Completion of the Quarterly Report of Coverage Review	3916.2	10-197
Activity (Exhibit III)		
Exhibit I - Home Health Agency Checklist	3916.3	10-202
Exhibit II - Individual Case Worksheet		10-204
Exhibit III - Quarterly Report of Coverage Review		10-209
Activity		10-211

3900. MEDICAL REVIEW (MR) FOR COVERAGE OF SKILLED NURSING FACILITY SERVICES

A. General.—Review SNF claims with supporting medical record documentation to ensure that payment is made only for services that are medically reasonable and necessary, require a skilled level of care on a daily basis, and, as a practical matter, can only be provided on an inpatient basis in a SNF. Review each service for which payment is requested.

Identify admissions where it appears that the beneficiary has been prematurely discharged from an acute care hospital. Identify cases where other quality of care issues appear. Refer quality issues other than those in subsection B to the RO for referral to the State agency.

B. Premature Discharge From PPS Setting.—Refer to the RO any cases where you believe a patient was prematurely discharged from the PPS acute care setting, admitted to a swing bed or hospital-based SNF and the patient continued to require and receive acute care services.

Based upon your review of the medical record, determine whether:

- The patient received any SNF services during the stay;
- If so, at what point the patient began receiving them;
- The total number of SNF days, if any, where the patient received SNF services; and
- If applicable, the dates the SNF services were rendered.

Attach all information (e.g., medical record) you used in your determination.

The RO forwards the material to the PRO for its review of the alleged premature discharge and the acute care services. The PRO determines if, in fact, the patient was prematurely discharged and the number of acute care days that were billed as SNF days. It informs you of the number of days and dates of service to deny. The PRO issues a denial notice to the provider and informs the beneficiary of the number of days counted as hospital days for utilization purposes. Treat the SNF payment as an overpayment in accordance with §3710.1.

3900.1 MR of Hospital-Based and Nonhospital Based SNF Claims.—

A. Covered Services.—Claims submitted for payment of SNF services.

Identify a 30 percent sample of claims for review using three different terminal digits of the HICN chosen and rotated at least every quarter (e.g., 1, 3, 5, or 2, 4, 6). You may use an alternative plan (e.g., LOS screens, sampling technique), to identify the 30 percent as long as the process does not exclude the possibility of the URC or SNF continued stay denials from falling into the sample.

NOTE: If you use LOS screens or other parameters to identify bills, furnish a copy with your report of MR activity. Furnish a new copy whenever you make changes in your selection process.

- Request appropriate medical records (i.e., medical information forms or copies of medical records) covering the period or up to discharge, as appropriate, a copy of the beneficiary notice and the basis for the determination when a URC or SNF continued stay denial falls in the sample.

- Review and determine the medical necessity of the admission and appropriateness of the continued stay. If you reverse the URC or SNF noncoverage, send a notice to the beneficiary and to the provider. Request a bill for the period reversed or adjust the bill submitted. (See §3723.) If you affirm the URC or SNF noncoverage decision, send a denial notice with appropriate waiver and appeals language.

- Increase the review for the next quarter to 100 percent if you identify, in more than 10 percent of the bills, improper covered or noncovered decisions. See §3439.2 for the effect of improper noncovered decisions on presumptive waiver status.

- Train the SNF if inaccurate decisions are being made.

B. Demand Bills.—The patient or his/her representative requests a claim be submitted for a coverage determination. The demand bill is identified by condition code 20.

Demand bills are submitted in the next billing cycle after the beneficiary's request and are accompanied by the medical information you require.

- Identify and review a 30 percent sample of "demand bills," the medical information and reasons for noncoverage to assure that the provider is making correct determinations. Review the noncoverage letter for timeliness and content. (See §3439.2.)

- If you concur that the care is not covered, send the appropriate denial letter. Include the appeal rights statement. If you reverse the determination, in whole or in part, notify the beneficiary and the provider in writing. (See §3723.)

- Train the SNFs if inaccurate decisions are made. (See §3439.3 for effect of improper noncoverage decisions on presumption waiver status.)

- Increase the level of review to 100 percent of demand bills for a SNF which you identify as making inaccurate decisions on more than 10 percent of the demand bills. Retain the 100 percent review for one quarter or until such time as accurate decisions are being made.

NOTE: You must also generate a HCFA denial letter with appeal rights on all demand bills which are not medically reviewed.

C. Bills Submitted for Medicare Denial Notices.—Medicaid or another insurer requires a medical denial letter.

These bills are identified by condition code 21. The bill must be accompanied by a copy of the beneficiary notice of noncoverage which includes the specific reasons the services were determined to be noncovered. Determine the level of review required based upon the SNF's description of the reason for denial in notice, your knowledge of the SNFs performance in making appropriate coverage/noncoverage decisions and other pertinent factors.

- Request and review medical documentation where there is a question that the SNF has inappropriately denied Medicare covered services. Advise the beneficiary and SNF if the denial is reversed.

- Send a denial letter with appeal rights to the beneficiary and a copy to the SNF in every case where the denial is affirmed.

D. Report of SNF MR Activity.—Complete the report for each calendar quarter. Within 30 days of end of the reporting quarters submit it to:

Health Care Financing Administration
Division of Provider Procedures, BPO
1-H-3 Meadows East Bldg.
6325 Security Blvd.
Baltimore, MD 21207

SNF QUARTERLY REPORT OF MEDICAL REVIEW ACTIVITY - Exhibit 1

Intermediary Number . Quarter Ending - Date: (M-D-Y)

Intermediary Name

Medical Review of SNF Bills

Percent of claims reviewed (include covered and demand bills).

A. Covered Services.—

Describe method of sample selection (e.g., HICN, LOS) ________

Number of payment claims subjected to review. ________

Number of payment claims denied. ________

Number of URC or SNF continued stay denials reviewed. ________

Number of URC or SNF continued stay denials partially or fully reversed. ________

B. Demand Bills.—

Number of demand bills submitted. ________

Number of demand bills reviewed. ________

Number fully or partially reversed. ________

C. Provider Waiver Status.—

Number/percentage of SNFs off waiver for exceeding 5 percent denial rate.

- Number ________
- Percent ________

Number/percent of SNFs off waiver for exceeding 10 percent denial rate.

- Number ________
- Percent ________

D. RO Referrals.—

Number of claims referred for PRO review of quality issues. ________

Number of SNFs referred for failure to timely submit beneficiary demand bills. ________

E. Beneficiary Complaints.—

Number of complaints from beneficiaries (or representatives) on failure of SNF to submit demand bills, give timely notice of noncoverage, or related issues. ________

Describe actions taken which are not included in subsection D.

3902. MEDICAL REVIEW OF HOME HEALTH SERVICES

Standardized data collection forms have been developed to promote more consistent coverage decisions and minimize payment for noncovered services. The home health data elements are contained on the following HCFA forms:

- o HCFA-485 - Home Health Certification and Plan of Treatment - contains data necessary to meet regulatory and national survey requirements for the physician's plan of treatment and certification. This form is completed by the physician/HHA.

- o HCFA-486 - Medical Update and Patient Information - contains data you need to make coverage determinations. This form is completed by the HHA.

- o HCFA-487 - Addendum to Plan of Treatment/Medical Update - may be used by HHAs to provide additional documentation of any elements on the HCFA-485/486. This form is completed by the physician/HHA.

- o HCFA-488 - Intermediary Medical Information Request - contains supplemental data elements which may be required on a case by case basis where the HCFA-485, 486, and/or 487 do not provide sufficient information for a decision. You generate this form.

You may use only the HCFA-485/486/487/488 as medical information forms. They must be completed in their entirety. No item can be left blank. However, there are items where "Not Applicable" (N/A) is an acceptable entry. These items are specified in the instructions.

HCFA requires HHAs to submit the HCFA-485/486 with the initial claim and with the claim closest to the recertification date thereafter. Providers submitting claims via electronic media are required to maintain the hardcopy version of the HCFA-485/486 on file. Request the hardcopy as needed. Specifications for electronic transmission of HCFA-485/486/487 are in Addenda A and D.

At your discretion you may require routine submission of the HCFA-486 more frequently than every 60 days, i.e., when a modification occurs. However, ask the agency to complete only Items 1 through 3, 5 through 10, 12 through 16, and 22 of the HCFA-486 and submit it with the interim claim. Require routine submission of medical records only when necessary (e.g., the agency has been identified as a poor performer based upon denial statistics or postpayment audits).

Where the information on the HCFA-485/486/487 is not sufficient to make a coverage decision, use the HCFA-488 to request additional information and/or the medical record. Use the HCFA-488 to request medical information on interim claims requiring development prior to payment because the HCFA-485/486 was not required.

In reviewing claims for home health services, review the HCFA-485/486 for the claims that require an initial certification or recertification. Make a determination on the entire certification period. If you determine that medical records for the interim claim are required or that services are noncovered from SOC or at some point during the billing period, flag your system so that the interim claim(s) is suspended for appropriate action.Establish an audit trail on each HCFA-485/486 reviewed. Include patient identifier(s), start of care date, period of review (claims and forms period), reviewer's initials and date of review. The review must be done on a prepayment basis.

You may deny visits/services based upon information provided on the forms and need not request medical records first. However, do not deny claims because a field on the HCFA-485/486 has not been completed. If the missing information is needed to make a coverage determination, use a HCFA-488 to request the necessary information. If a coverage determination can be made despite the missing information, pay the claim if the services are clearly covered or, deny it if they are not. It is appropriate to deny the claim if the missing information needed for a coverage determination is not submitted within your published timeframes for requested documentation or if the agency indicates that the information is not available. Follow the procedures below for the items noted.

o Missing or Incomplete Physician's Orders - (HCFA-485, Item 21; HCFA-486, Item 16; HCFA-487, Addendum).

— Visits for a discipline are billed but there is no physician order or the physician order is present but there is no frequency.

+ Request a copy of the physician's order for the services. Accept a countersigned verbal order or a physician's statement that there was a verbal order before the services were rendered. Do not accept postdated orders which do not specifically indicate a prior verbal order. If the agency is furnishing services without a physician's order, deny the claim. Advise the HHA that your findings will be reported to the RO for possible referral to the State survey office.

Services documented on the HCFA-486 Item 13 will not be accepted in lieu of physician's orders in the appropriate fields on the HCFA 485/486/487.

A postdated order is defined as one that is signed or written by the physician after the services were rendered when there is no evidence of a preexisting verbal order.

— Physician order for discipline and frequency is present but there is no duration of visits.

+ Accept the duration (if present) in HCFA 486 Item 13 or elsewhere on the HCFA-485/486/487.

+ Assume the duration is the same as the certification period if there is only one frequency per discipline.

+ Request the duration from the agency if a discipline is visiting at different frequencies during the certification period.

+ Where the agency consistently omits duration, you may return the claim and HCFA 485/486 for proper completion.

o Agency provides fewer visits than the physician orders.

-- Do not deny claims because the agency provides fewer visits than ordered. The agency should be reporting the decrease in visits to the physician. Where an agency is consistently decreasing visits without reporting to the physician, notify the RO so that the State survey office can be advised.

3902.1 HCFA-485 - Home Health Certification and Plan of Treatment Data Elements.--Is designed to meet the regulatory requirements (State and Federal) for the physician's plan of treatment and certification and recertification requirements. The HHA is required to submit a completed HCFA-485 with each initial claim and each claim closest to the beneficiary's recertification date thereafter. For example, if a patient has a start of care of 06/15/87, the HHA must submit a completed HCFA-485 (and HCFA-486) with the first claim for the services rendered from 06/15 to 06/30/87. The HHA must submit a completed HCFA-485 (and HCFA-486) again with the claim for services rendered 08/01 to 08/31/87, if the patient was recertified for home health services provided on or after 08/15/87. The HCFA-485 submitted with the claim for services is the physician recertification.

The following items are contained on the HCFA-485:

1. Patient's HICN.--The HHA enters the HICN (numeric plus alpha indicator(s)) as shown on the patient's health insurance card, certificate award, utilization notice, temporary eligibility notice, or as reported by the SSO.

2. SOC Date.--The HHA enters the 6 digit month, day, year on which covered home health services began, i.e., MMDDYY (061587). The start of care date is the first Medicare billable visit. This date remains the same on subsequent plans of treatment until the patient is discharged. Home health may be suspended and later resumed under the same start of care in accordance with the HHA's internal procedures. See §3120.3 regarding period of suspension.

3. Certification Period.—The HHA enters the 6 digit month, day, year, i.e., MMDDYY (06/15/87-08/15/87), which identifies the period covered by the physician's plan of treatment. The "From" date for the initial certification must match the SOC date. The "To" date can be up to, but never exceed two calendar months and, mathematically, never exceed 62 days. The "To" date is repeated on a subsequent recertification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period.

EXAMPLE: Initial certification "From" date 061587
Initial certification "To" date 081587

Recertification "From" date 081587
Recertification "To" date 101587

4. Medical Record No.—This is the patient's medical record number that is assigned by the HHA and is an optional item. If not applicable, the agency should enter "N/A."

5. Provider No.—This is the 6 digit number issued by Medicare to the HHA. It contains 2 digits, a hyphen, and 4 digits (e.g., 00-7000).

6. Patient's Name and Address.—The HHA enters the patient's last name, first name, and middle initial as shown on the health insurance card and the street address, city, State, and ZIP code.

7. Provider's Name and Address.—The HHA enters its name and/or branch office (if appropriate), street address (or other legal address), city, State and ZIP code.

8. Date of Birth.—The patient's date of birth (6 digit month, day, year) in numerics, i.e., MMDDYY (040120) is entered.

9. Sex.—The patient's sex is checked in the appropriate box.

10. Medications: Dose/Frequency/Route.—The physician's orders for all medications including the dosage, frequency and route of administration for each drug must be listed.

- Drugs which cannot be listed on the plan of treatment due to lack of space are listed on the addendum.
- The letter "N" is used after the medication(s) which are "new" orders.
- The letter "C" is used after the medication(s) which are "change" orders either in dose, frequency or route of administration.

"New" orders refer to medications which the patient has not taken recently, i.e., within the last 30 days, or which the patient has never taken previously. "Change" orders for medications include dosage changes, frequency changes or route of administration changes within the last 60 days.

11. Principal Diagnosis, ICD-9-CM Code and Date of Onset/Exacerbation.--The principal diagnosis is entered on all HCFA-485 forms. The principal diagnosis is the diagnosis most related to the current plan of treatment. The diagnosis may or may not be related to the patient's most recent hospital stay, but must relate to the services rendered by the HHA. If more than one diagnosis is treated concurrently, the diagnosis that represents the most acute condition and requires the most intensive services should be entered.

The HHA enters the appropriate ICD-9-CM code for the principal diagnosis in the space provided. The code is the full ICD-9-CM diagnosis code including all digits. V codes are acceptable as primary and secondary diagnosis. In many instances, the V code more accurately reflects the care provided. However, the V code should not be used when the acute diagnosis code is more specific to the exact nature of the patient's condition. A list of V codes can be found in Exhibit VI.

EXAMPLE: Patient is surgically treated for a subtrochanteric fracture (code 820.22). Admission to home care is for rehabilitation services (V57.1). The HHA uses 820.22 as the primary diagnosis since V57.1 does not specify the type or location of the fracture.

Patient is surgically treated for a malignant neoplasm of the colon (code 153.2) with exteriorization of the colon. Admission to home care is for instruction in care of colostomy (V55.3). The HHA uses V55.3 as the primary diagnosis since it is more specific to the nature of the proposed services.

The principal diagnosis may change on subsequent forms only if the patient develops an acute condition or an exacerbation of a secondary diagnosis requiring intensive services different than those on the established plan.

The medical diagnostic term is listed next to the ICD-9-CM code. The date reflects either the date of onset, if it is a new diagnosis, or the date of the most recent exacerbation of a previous diagnosis. If the exact day is not known, the HHA uses 00 for the day.

12. Surgical Procedure, Date, ICD-9-CM Code.--The surgical procedure relevant to the care being rendered is entered. For example, if the diagnosis in Item 8 is "Fractured Left Hip," the ICD-9-CM Code, the surgical procedure and date are noted (e.g., 81.62, Insertion of Austin Moore Prosthesis, 060987). If a surgical procedure was not performed or is not relevant to the plan of care, N/A is inserted. The addendum (HCFA-487) is used for additional relevant surgical procedures. At a minimum, the month and year must be present for date of surgery.

13. Other Pertinent Diagnoses: Dates of Onset/Exacerbation, ICD-9-CM Code.—All pertinent diagnoses, both narrative and ICD-9-CM Codes, relevant to the care rendered are entered. Other pertinent diagnoses are all conditions that coexisted at the time the plan of treatment was established or developed subsequently. Diagnoses that relate to an earlier episode, which have no bearing on this plan of treatment, are excluded.

If there are more than the four pertinent diagnoses, the addendum (HCFA-487) is used to list the additional conditions. The agency enters N/A if there are no pertinent secondary diagnoses.

The date reflects the date of onset, if it is a new diagnosis, or the most recent exacerbation of a previous diagnosis. If the date is unknown, the agency notes the year and place 00s in the month or day not known.

14. DME and Supplies.—The HHA enters all nonroutine supplies that it is billing Medicare. For example, dressing changes may require use of 4 x 4s, telfa pads, kling and non allergic tape. Catheter changes may require a catheter kit and irrigation kit as well as irrigating solutions. Agencies do not need to list the exact amount of usage.

The items of DME ordered by the physician that are billed by the HHA to Medicare are listed. The agency enters N/A if no supplies or DME will be billed.

15. Safety Measures.—The physician's instructions for safety measures are listed in this item.

16. Nutritional Requirementss.—The HHA enters the physician's orders for the diet. This includes specific therapeutic diets and/or any specific dietary requirements. Fluid needs or restrictions are recorded. Total parenteral nutrition (TPN) can be listed under this item, under medications, or on the HCFA-487.

17. Allergies.—Medications to which the patient is allergic are listed. In addition, other allergies the patient experiences (e.g., foods, adhesive tape, iodine) are included.

18A. Functional Limitations.—All items which describe the patient's current limitations as assessed by the physician and the agency are indicated.

18B. Activities Permitted.—The activity(ies) which the physician allows and/or for which physician orders are present are indicated.

If "Other" is checked under Item 18A or 18B, a narrative explanation is provided in Item 17 of the HCFA-486.

19. Mental Status.—The block(s) most appropriate to describe the patient's mental status is checked. If "Other" is checked, patient's condition is specified here.

20. Prognosis.—A check is placed in the box which specifies the most appropriate prognosis for the patient; poor, guarded, fair, good or excellent.

NOTE: The number or letter adjacent to the blocks in Items 18 though 20 correspond to the codes for EMC transmission only.

21. Orders for Discipline and Treatments (Specify Amt/Freq/Dura).—The physician must specify the frequency and the expected duration of the visits for each discipline. The duties/treatments to be performed by each discipline are stated. A discipline may be one or more of the following: skilled nursing (SN), physical therapy (PT), speech therapy (ST), occupational therapy (OT), medical social service (MSS), home health aide (AIDE) or others (e.g., nutritionist, male orderly, respiratory therapist).

Orders must include all disciplines and treatments even if they are not billable to Medicare.

Frequency denotes the number of visits per discipline to be rendered, stated in days, weeks, or months. Duration identifies the length of time the services are to be rendered and may be expressed in days, weeks or months.

EXAMPLE: Certification period is from 06/15/87 - 08/15/87:

OT -	Eval., ADL training, fine motor coordination	3x/wk x 6wks
ST -	Eval., increase articulation of single syllable words, all motor exercises following 2-step verbal directions	3x/wk x 4wks
SN -	Skilled observation of C/P and neuro status; instruct meds and diet/hydration, instruct wound care-wash, betadine to affected area, cover w/DSD, Foley catheter care	QD x 5 days 3x/wk x 2wks 2x/wk x 2wks 1x/wk x 4wks
MSS -	Arrange for Medicaid to pay for drugs; assessment of emotional and social factors	1x/mo x 2mos
AIDE -	Assist with personal care: complete bed bath, shave, catheter care	3x/wk x 9wks

Specific services rendered by physical, speech and occupational therapists may involve different modalities. The "AMOUNT" is necessary when a discipline is providing a specific modality for therapy. Modalities usually mentioned are heat, sound, cold, and electronic stimulation.

EXAMPLE: PT - To apply hot packs to the C5-C6 x 10 minutes3x/wk x 2wks

PRN visits may be ordered on a plan of treatment only where they are qualified in a manner that is specific to the patient's potential needs. Both the nature of the services and the number of PRN visits to be permitted for each type of service is specified in the plan of treatment. Open-ended, unqualified PRN visits do not constitute physician orders for patient care since neither the nature nor the frequency of the service is specified.

EXAMPLE: Skilled nursing visits 1xm x 2m for Foley change and PRN x 2 for emergency Foley irrigation and/or changes.

Skilled nursing visits 1xm x 2m to draw blood sugar and PRN x 2 to draw emergency blood sugar if blood sugar level is above 400.

22. Goals/Rehabilitation Potential/Discharge Plans.--This information reflects the physician's description of the achievable goals and the patient's ability to meet them as well as plans for care after discharge.

Examples of realistic goals:

- Independence in transfers and ambulation with walker.
- Healing of leg ulcer(s).
- Maintain patency of Foley catheter. Decrease risk of urinary infection.
- Achieve optimal level of cardiovascular status. Medication and diet compliance.
- Ability to demonstrate correct insulin preparation/administration.

Rehabilitation potential addresses the patient's ability to attain the goals and an estimate of the time needed to achieve them. This information should be pertinent to nature of the patient's condition and ability to respond. The words "Fair," or "Poor" alone, are not acceptable. Instead descriptors must be added:

EXAMPLE: Rehabilitation potential is good for partial return to previous level of care, but patient will probably not be able to perform ADL independently.

Where daily care has been ordered, the agency must be specific as to the goals and when the need for daily care is expected to end. Discharge plans include a statement of where or how the patient will be cared for once home health services are no longer provided.

23. Verbal Start of Care, Nurse's Signature and Date.—This area verifies for surveyors, HCFAs representatives, and you that a nurse spoke to the attending physician and has received verbal authorization to visit the patient. This date may precede the SOC date in Item 2 and may precede the "From" date in Item 3.

This item is signed by the nurse receiving the verbal orders, by the nurse responsible for completion of the form, or by a nonclerical agency representative or supervisor responsible for review. The DATE is necessary.

If the nurse who received the orders does not prepare the HCFA-485, then the orders must be transcribed to a form signed and dated by her and retained in the agency files.

The agency is responsible for documenting the initial and ongoing communications with the physician.

This item is applicable only to certifications. The HHA enters N/A if recertification, or if not applicable to the certification.

24. Physician's Name and Address.—The agency prints the physician's name and address. The attending physician is the physician who establishes the plan of treatment and who certifies and recertifies the medical necessity of the home health visits and/or services. Supplemental physicians involved in a patient's care are mentioned on the HCFA-486 only.

25. Date HHA Received Signed POT.—The date the agency received the signed POT from the attending/referring physician is entered. It is required only if the physician does not date Item 27. The agency enters N/A if Item 27, DATE, is completed.

26. Physician Certification.—The attending physician or agency checks whether this is an initial certification or a recertification.

27. Attending Physician's Signature and Date.—The attending physician signs and dates the plan of treatment/certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for his patients in his absence.

The agency should not predate the orders for the physician, nor write the date in this field. If the physician left it blank, the agency should enter the date it received the signed POT under Item 25. An unsigned copy is submitted to you with the signed copy retained in the agency's files.

3902.2 HCFA-486 - Medical Update and Patient Information.—Contains data needed by you to make coverage determinations. The HHA submits a completed HCFA-486 with each beneficiary's initial claim and with each subsequent claim closest to the beneficiary's recertification date. For example, if a patient has a start of care date of 06/15/87, the HHA must submit a completed HCFA-486 (and HCFA-485) with the first claim for services rendered from 06/15 to 06/30/87. The HHA must submit a completed HCFA-486 (and HCFA-485) with the claim for services rendered 08/01 to 08/31/87 if the patient was recertified for home health services to be provided on or after 08/15/87.

You may require the HHA to submit an updated HCFA-486 with interim claims which require development prior to adjudication. These claims are those where the HHA is not required to submit the HCFA-485 and HCFA-486. For example, the patient's start of care and initial certification date is 06/15/87. The HHA is required to submit a completed HCFA-485 and HCFA-486 with the claim for services provided from 06/15 to 06/30/87. However, if the HHA continues services during July, the HHA is not required to submit them. This claim is an interim claim.

If you are utilizing the Wisconsin module to screen claims and data sets, advise the HHAs you service to submit an updated HCFA-486 in the following situations:

- o Physician orders an increase in the frequency or duration of visits of any type.
- o Physician orders an additional discipline.
- o To justify the need for daily skilled services beyond an initial 2-3 week period.
- o To generate a Medicare denial letter for the beneficiary and/or provider.

When the HCFA-486 is submitted to reflect an increase in visits and/or additional discipline(s) or a denial, certain items are completed differently. See subsection B for completion of these items. Otherwise, the HCFA-486 is completed as indicated in subsection A.

A. Data Elements Required on the HCFA-486 for Submission with the HCFA-485 on Certifications and Recertifications.—The HHA completes all items on the HCFA-486 as follows:

1. Patient's HICN.—See §3902.1, Item 1.
2. SOC Date.—See §3902.1, Item 2.
3. Certification Period.—See §3902.1, Item 3.
4. Medical Record Number.—See §3902.1, Item 4.
5. Provider Number.—See §3902.1, Item 5.
6. Patient's Name.—See §3902.1, Item 6.
7. Provider' Name.—See §3902.1, Item 7.

8. Medicare Covered.—This is the agency's opinion as to whether the patient's care is covered or not. The box is checked "noncovered" when the agency feels the care is noncovered but the information is submitted "at the patient's request" or to establish other third party liability.

9. Date Physician Last Saw Patient.--The agency enters the date the physician last saw the patient if this information can be obtained from the patient or the family during the home visit. If the provider is unable to determine this date, the appropriate response is "Unknown."

NOTE: It is not intended that the agency contact the physician's office to account for patient's visits. Physician visits of less than one every 60 days, however, raise a question as to whether the patient requires a level of care which qualifies for home benefits. Carefully evaluate the patient's entire medical condition. Do not deny visits solely on the basis that physician visits are less than every 60 days.

10. Date Last Contacted Physician.--The agency notes the date MMDDYY (e.g., 071587) of its most recent physician contact (verbal or written) regarding the status or problems encountered with the patient during the last 60 days. The purpose of the agency's contact is stated under Item 16 (Updated Information).

11. Is Patient Receiving Care in §1861(J)(1) SNF or Equivalent?.--The agency checks the appropriate block. Since a requirement for eligibility for the home health benefit is that services are provided at the patient's residence, if the patient is residing in a nursing home which meets at least the requirements of §1861(J)(1), that facility cannot be considered the patient's residence. (See §3120.5.)

If the address indicated that a patient is in an institution, consult the Directory of Medical Facilities to determine whether the institution is one that meets the basic definition of an 1861(J)(1) facility. If unable to make a determination, seek assistance from the RO.

12. Certification Recertification Modified.--The agency checks one of the blocks to identify this plan as an initial certification, recertification or modification. Modified refers to the HCFA-486 submitted with an interim claim to report changes in the disciplines or numbers ordered or to obtain a Medicare denial letter.

13. Specific Services and Treatments.--The physician's orders for all Medicare billable visits listed on the HCFA-485, Item 21, and the HCFA-486, Items 16 and 18, are entered.

Discipline - Refers to SN, PT, ST, OT, MSS or AIDE. The agency uses a separate line for each discipline and all data elements for a discipline on the same line.

Visits (this bill) Related to Prior Certification - Bills which span two certification periods require specific information as to the number of visits rendered in the prior certification period. You need to know how many visits to charge to the prior certification. This information can be inserted by the agency's billing department.

EXAMPLE:

Start of Care	06/15/87
Recertification From Date	08/15/87
Bill	08/01 - 08/31/87
Visits Rendered This Billing Period	08/01, 08/04, 08/06, 08/08 08/11, 08/13, 08/15, 08/18 08/20, 08/22, 08/25, 08/27 and 08/29

Based upon the above example, number 6 would be inserted. The agency performs this calculation for each discipline involved and inserts the number in line with the discipline as shown in the example below:

Discipline	Visits (this bill) Rel. to Prior Recert.	Frequency & Duration	Treatment Codes	Projected Visits
SN	6	3wk4; 2wk5	A1, A2, A3, A4	22
PT	6	3wk4; 2wk5	B1, B2, B3	22
AIDE	6	3wk4; 2wk5	F2, F6, F7, F10	22

Frequency and Duration - The HHA reports frequency and duration by discipline, not by treatments. Where frequency is noted in days, weeks or months, duration must also be shown as days, weeks or months. Ranges in frequency or duration are not acceptable. They are recorded in chronological order separated by a semicolon. One of these abbreviations is used: da = days, wk = weeks, mo = months, q = once every "x" number of days, or PRN when appropriate. No other response is valid.

EXAMPLE: If orders are SN daily x 1 week; 3xwk x 3 weeks; 2xwk x 3 weeks; 1xwk x 2 weeks, it enters under frequency and duration 1da7; 3wk3; 2wk3; 1wk2.

If orders are 1 x month x 2 and PRN x 2, it enters frequency and duration 1mo2; 2PRN. Total visits projected this certification are 4.

Treatment Codes - Include specific alpha designators for each discipline: A(SN), B(PT), C(ST), D(OT), E(MSS), and F(AIDE). Appropriate codes are used to identify corresponding services across the line. For example, physical therapy (B) codes are not listed on the same line as skilled nursing (A) codes. (See §3902.3 for list of treatment codes.)

Projected Visits - are the total visits for each discipline projected over the period represented on the plan of treatment. For example, nursing visits 3 x week x 2 weeks then 2 x week x 7 weeks, total 20 nursing visits. Each discipline has one total number for that service.

14. Dates of Last Inpatient Stay.—The agency enters the admission and discharge dates (month, day and year: e.g, 060287 - 061087) of the last inpatient stay relevant to the care currently provided. N/A is entered if not applicable.

15. Type of Facility.—The agency identifies the type of facility (e.g., acute, SNF, rehabilitation). The agency enters N/A if not applicable.

16. Updated Information: New Order/Treatments/Clinical Facts Summary From Each Discipline.—The HHA records any new orders, treatments or changes and associated date(s) from the time the HCFA-485 is completed to the time the HCFA-486 is completed.

On certifications, the HHA enters the clinical findings of the initial assessment visit for all disciplines involved in the care plan. It describes the clinical facts about the patient that required home health services. It includes specific dates in the documentation.

On recertifications, the HHA records significant clinical findings for each discipline incorporating all symptoms and changes in the patient's condition during the last 60 days of service. Specific dates are included. The HHA documents progress or nonprogress for each discipline.

The HHA includes any pertinent information on patient's inpatient stay and the purpose of any agency contact with the physician, if applicable.

17. Functional Limitations (Expand from 485 and ADL) Reason Homebound/Prior Functional Status.—The agency provides a narrative description of the patient's prior functional status and current functional limitations and activities permitted, elaborating on the information in the checklist (HCFA-485, items 18A and 18B) and provides any other relevant information needed to describe the patient. The description of the patient's activities clearly reflects the restrictions imposed by the physician. This includes a description of ADL limitations and indicates the type and scope of assistance needed. The agency includes a brief statement of why the patient is homebound and a description of the home environment, if it is relevant to the homebound determination, e.g., patient lives in a third floor walk-up apartment and is recovering from congestive heart failure.

18. Supplementary Plans of Treatment on File From Physician Other Than the Referring Physician. (If Yes, Please Specify Giving Goals/Rehabilitation Potential/Discharge Plan).—The agency provides this information if more than one plan of treatment is being used to provide services. It may document the specialty, the type of service, duties, goals, rehabilitation potential, discharge plans and the reasons necessitating a supplemental plan here or attach a copy of the plan to the HCFA-486.

19. Unusual Home/Social Environment (Optional).—The agency uses this block to include information which would enhance your concept of the home situation and help justify the need for services in the home (e.g., patient lives with retarded son who is unable to provide any assistance or to comprehend instructions). This information may explain the rationale for medical social services by documenting the problems which are or will be an impediment to the effective treatment of the patient's condition or rate of recovery.

20. Indicate Any Times When the HHA Made a Visit and Patient Was Not Home and Reason if Ascertainable.—The agency indicates when and why this occurred. For example: 07/31/87 - Patient was taken to the emergency room for evaluation and treatment after a fall in her home.

21. Specify Any Known Medical and/or Nonmedical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence.—The agency obtains information from the patient, family or caretaker for the patient's absences from the home and whether they were for medical or nonmedical reasons. For example, the patient goes to the barber shop 1 x a month and to the doctor's 2 x a month.

22. Signature of Nurse or Therapist Completing or Reviewing Form/Date.—The nurse or therapist responsible for the completion of the form or a nonclerical representative or supervisor responsible for the review signs and dates the form. Neither return nor deny the claim if this item is not completed.

B. Data Elements Required on HCFA-486 for Submission with an Interim Claim.—When an updated HCFA-486 is submitted with an interim claim to modify an existing HCFA-486, the HHA completes the following items:

1. HICN.—See §3902.1, Item 1.

2. SOC Date.—See §3902.1, Item 2.

3. Certification Period.—

o There has been an increase in frequency and/or duration of visits and/or addition of a new discipline since the certification/recertification, or

o There is an extension of daily visits beyond the initial 2-3 week period certified by the physician:

The HHA enters the date of increase or addition as the "From" date and the original certification/recertification "To" date.

o The HHA has determined that the patient no longer requires covered Medicare services:

It enters the date services became noncovered as the "From" and "To" dates.

5. Provider Number.—See §3902.1, Item 5.

6. Patient's Name.—See §3902.1, Item 6.

7. Provider' Name.—See §3902.1, Item 7.

8. Medicare Covered.—This is the agency's opinion as to whether the patient's care is covered or not. The box is checked "noncovered" when the agency feels the care is noncovered but the information is submitted "at the patient's request" or to establish other third party liability.

9. Date Physician Last Saw Patient.—The agency enters the date the physician last saw the patient if this information can be obtained from the patient or the family during the home visit. If the provider is unable to determine the last time the patient was seen by the physician, the response is "Unknown."

NOTE: It is not intended that the agency contact the physician's office to account for patient's visits. Physician visits of less than one every 60 days, however, raises a question as to whether the patient requires a level of care which qualifies for home benefits. Carefully evaluate the patient's entire medical condition. Do not deny visits solely on the basis that physician visits are less than every 60 days.

10. Date Last Contacted Physician.—The agency notes the date MMDDYY (e.g., 071587) of its most recent physician contact (verbal or written) regarding the status or problems encountered with the patient during the last 60 days. The purpose of the agency's contact is stated in Item 16 (Updated Information).

12. Certification Recertification Modified.—The HHA checks "Modified." May be left blank if Item 8 is checked "Noncovered."

13. Specific Services and Treatments.—This reflects the orders for additional visits and/or disciplines that is submitted with an interim claim. It is not completed if the purpose of the submittal is to document Medicare noncoverage.

Discipline - The HHA enters the approved abbreviation for the changed or added discipline(s).

Visit(s), (This Bill) Related to Prior Certification - This item is not applicable when the HCFA-486 is submitted with an interim claim to modify the existing POT.

Frequency and Duration - The HHA enters the proposed frequency and duration from the date of change to the certification/recertification "To" date.

Treatment Codes - The HHA enters the appropriate alpha and numeric code(s) for the period covered on the HCFA-486.

Total Visits Projected This Certification - The HHA enters the additional visits requested for the period covered on this HCFA-486.

EXAMPLE: Certification Period: 06/15/87 - 08/15/87
Physician's Orders: SN daily x 3 weeks, then
3 x w x 6 weeks for wound care
Orders Modified 07/06/87: Continue daily
SN x 3 weeks, then 3 w x 3 weeks

Originally, 39 visits were projected. The modified plan adds 12 visits, i.e., 4 visits per week x 3 weeks.

Discipline	Visits (this bill) Rel. to Prior Recert.	Frequency & Duration	Treatment Codes	Projected Visits
SN		1da21; 3w3	A4	12

EXAMPLE: Certification Period: 06/15/87 - 08/15/87
Physician's Order: SN 2 x w x 3 weeks, then
1 x w x 6 weeks and Aide 3 x w x 9 weeks
Order Modified 07/06/87 - PT 3 x w x 6 weeks;
SN and Aide unchanged

Discipline	Visits (this bill) Rel. to Prior Recert.	Frequency & Duration	Treatment Codes	Projected Visits
PT		3w6	B1, B2, B3, B5	18

14. Dates of Last Inpatient Stay.—See §3902.2A, Item 14.

15. Type of Facility.—See §3902.2A, Item 15.

16. Updated Information: New Orders/Treatments/Clinical Facts/ Summary from Each Discipline.—The HHA records any new orders, treatments or changes and associated dates and all significant clinical findings, including all symptoms and changes in the patient's condition since the certification/recertification was completed. Specific dates are included in the documentation. A summary from each discipline is not required.

22. Signature of Nurse or Therapist Completing or Reviewing Form/Date (MO, DAY, YR).—The nurse or therapist responsible for completion of the form or a nonclerical agency representative or supervisor responsible for the review signs and dates the form. Neither return nor deny the claim if this item is not completed.

3902.3 Treatment Codes for Home Health Services.—The agency enters the code which represents the service(s) to be rendered under the plan of treatment in Item 13 of the HCFA-486. The listing of a code for a particular service is not intended to imply coverage. The codes are to ease identification of services ordered by the physician whether or not these services are reimbursable individually by Medicare. These codes are used to identify the services in item 21 on the HCFA-485 (Physician's Orders for Services). Physician's orders reflect a narrative description of treatment and services to be rendered.

A. Skilled Nursing.—These codes represent the services to be performed by the nurse. Services performed by the patient or other person in the home without the teaching or supervision of the nurse are not coded. The following is a further explanation for each service:

o A1. Skilled Observation (Inc. V.S., Response to Med., etc.) - Includes all skilled observation of the patient where the physician determines that the patient's condition is such that a reasonable probability exists that significant changes may occur which require the skills of a licensed nurse to supplement the physician's personal contacts with the patient. (See §3117.4.A.)

o A2. Foley Insertion - Insertion and/or removal of the Foley catheter by nurse.

o A3. Bladder Instillation - Instilling medications into the bladder.

o A4. Wound Care/Dressing - Includes irrigation of open, postsurgical wounds, application of medication and/or dressing changes. Does not include decubitus care. Describe dimension of wound (size and amount and type of drainage) in Item 16 on the HCFA-486. See A28 for observation uncomplicated surgical incision.

o A5. Decubitus Care - Includes irrigation, application of medication and/or dressing changes to decubitus. The agency describes size (depth and width) and appearance in Item 16 of the HCFA-486. (See A29 for teaching and care, first or second stage.

NOTE: Decubitus, stage 3 - the skin is necrotic with exposure of fat
Decubitus, stage 4 - necrosis extends through the skin and fat to muscle
Decubitus, stage 5 - extended fat and muscle necrosis.

o A6. Venipuncture - The HHA specifies the test and frequency to be performed under physician's orders.

o A7. Restorative Nursing - Includes exercises, transfer training, carrying out of restorative program ordered by the physician. This may or may not be established by a physical therapist. This code is not used to describe nonskilled services (e.g, routine range of motion exercises).

o A8. Post Cataract Care - Includes observation, dressings, teaching, etc., of the immediate postoperative cataract patient. (See §3117.4.A.)

o A9. Bowel/Bladder Training - Includes training of patients who have neurological or muscular problems or other conditions where the need for bowel or bladder training is clearly identified. (See §3114.4.E.1.)

o A10. Chest Physio (Inc. postural drainage) - Includes breathing exercises, postural drainage, chest percussion, conservation techniques, etc.

o All. Adm. of Vitamin B/12 - Administration of vitamin B-12 preparation by injection for conditions identified in Medicare guidelines. (See §3117.4.)

o A12. Prep/Adm. Insulin - Preparation of insulin syringes for administration by the patient or other person, or the administration by the nurse.

o A13. Adm. Other IM/Subq. - Administration of any injection other than vitamin B/12 or insulin ordered by the physician.

o A14. Adm. IV's/Clysis - Administration of intravenous fluids or clysis or intravenous medications.

o A15. Teach. Ostomy or Ileo Conduit Care - Teaching the patient or other person to care for a colostomy, ileostomy or ileoconduit or nephrostomy.

- A16. Teach. Nasogastric Feeding - Teaching the patient or other person to administer nasogastric feedings. Includes teaching care of equipment and preparation of feedings.

- A17. Reinsertion Nasogastric Feeding Tube - Includes changing the tube by the nurse.

- A18. Teach. Gastrostomy Feeding - Teaching the patient or other person to care for gastrostomy and administer feedings. Includes teaching care of equipment and preparation of feedings.

- A19. Teach. Parenteral Nutrition - Teaching the patient and/or family to administer parenteral nutrition. Includes teaching aseptic technique for dressing changes to catheter site. Agency documentation must specify that this service is necessary and does not duplicate other teaching.

- A20. Teach. Care of Trach. - Teaching the patient or other person to care for a tracheostomy. This includes care of equipment.

- A21. Adm. Care of Trach. - Administration of tracheostomy care by the nurse, including changing the tracheostomy tube and care of the equipment.

- A22. Teach. Inhalation Rx - Teaching patient or other person to administer therapy and care for equipment.

- A23. Adm. Inhalation Rx - Administration of inhalation treatment and care of equipment by the nurse.

- A24. Teach. Adm. of Injection - Teaching patient or other person to administer an injection. Does not include the administration of the injection by the nurse (see A11, A13) or the teaching/administration of insulin. (See A12, A25.)

- A25.Teach. Diabetic Care - Includes all teaching of the diabetic patient (i.e., diet, skin care, administration of insulin, urine testing).

- A26. Disimpaction/Follow-up Enema - Includes nursing services associated with removal of an impaction. Enema administration in the absence of an impaction only if a complex condition exists - e.g., immediate postoperative rectal surgery.

- A27. Other (Spec. Under Orders) - Includes any SN or teaching ordered by the physician and not identified above. The agency specifies what is being taught in Item 21 (HCFA-485).

- A28. Wound Care/Dressing - Skilled observation and care of surgical incision/suture line including application of DSD. (See A4.)

- A29. Decubitus Care - Includes irrigation, application of medication and/or dressing changes to decubitus/other skin ulcer or lesion, first or second stage. The HHA describes size (depth and width) and appearance in Item 16 of the HCFA-486. (See A5.)

- A30. Teaching Care of Any Indwelling Catheter - Teaching patient or other person to care for indwelling catheter.

NOTE: Decubitus, stage 1 - skin redness that disappears on pressure.
Decubitus, stage 2 - redness, edema, and induration with epidermal blistering and desquamation.

B. Physical Therapy (PT).—These codes represent all services to be performed by the physical therapist. If services are provided by a nurse they are included under A7. The following is a further explanation of each service:

- B1. Evaluation - Visit(s) made to determine patient's condition, physical therapy plans and rehabilitation potential; to evaluate home environment to eliminate structural barriers and improve safety to increase functional independence (ramps, adaptive wheelchair, bathroom aides).

- B2. Therapeutic Exercise - Exercises designed to restore function. Specific exercise techniques (e.g., Proprioceptive Neuromuscular Facilitation (PNF), Rood, Brunstrom, Codman's, William's) are specified in the plan of treatment. The exercise treatment is listed in the medical record specific to the patient's condition, manual therapy techniques which include soft tissue and joint mobilization to reduce joint deformity and increase functional range of motion.

- B3. Transfer Training - Evaluate and instruct safe transfers (bed, bath, toilet, sofa, chair, commode) using appropriate body mechanics, and equipment (sliding board, Hoyer lift, trapeze, bath bench, wheelchair). Instruct patient, family and caregivers in appropriate transfer techniques.

- B4. Establish or Upgrade Home Program - To improve the patient's functional level by instruction to patient and other responsible individuals in exercise which may be used in adjunct to PT programs.

- B5. Gait Training - Includes gait evaluation and ambulation training of patient whose ability to walk has been impaired. Gait training is the selection and instruction in use of various assistive devices (orthotic appliances, crutches, walker, cane, etc.).

- B6. Cardiopulmonary Physical Therapy - Includes breathing exercises, cardiopulmonary conditioning, postural drainage, etc., designed for patients with acute or severe cardiopulmonary dysfunction.

- B7. Ultra Sound - Mechanism to produce heat or micro-massage in deep tissues for conditions in which relief of pain, increase in circulation and increase in local metabolic activity are desirable.

- B8. Electro Therapy - Includes treatment for neuromuscular dysfunction and pain through use of electrotherapeutic devices (electromuscular stimulation, TENS, Functional Electrical Stimulation (FES), biofeedback, high voltage galvanic stimulation (HVGS), etc.).

- B9. Prosthetic Training - Includes stump conditioning, (shrinking, shaping, etc.), range of motion, muscle strengthening and gait training with or without the prosthesis and appropriate assistive devices.

- B15. Other (Spec. Under Orders) - Includes all PT services not identified above. Specific therapy services are identified under physician's orders (HCFA-485 Item 21).

- B10 through B14 - Reserved.

C. Speech Therapy (ST).—These codes represent the services to be performed by the speech therapist. Following is a further explanation of each.

- C1. Evaluation - Visit made to determine the type, severity and prognosis of a communication disorder, whether speech therapy is reasonable and necessary and to establish the goals, treatment plan, and estimated frequency and duration of treatment.

- C2. Voice Disorders Treatments - Procedures and treatment for patients with an absence or impairment of voice caused by neurologic impairment, structural abnormality, or surgical procedures affecting the muscles of voice production.

- C3. Speech Articulation Disorders Treatments - Procedures and treatment for patients with impaired intelligibility (clarity) of speech - usually referred to as anarthria or dysarthria and/or impaired ability to initiate, inhibit, and/or sequence speech sound muscle movements - usually referred to as apraxia/dyspraxia.

- C4. Dysphagia Treatments - Includes procedures designed to facilitate and restore a functional swallow when associated with a communication disorder.

- C5. Language Disorders Treatments - Includes procedures and treatment for patients with receptive and/or expressive aphasia/dysphasia, impaired reading comprehension, written language expression, and/or arithmetical processes.

- C6. Aural Rehabilitation - Procedures and treatments designed for patients with communication problems related to impaired hearing acuity.

- C7. Reserved

- C8. Nonoral Communications - Includes any procedures designed to establish a non-oral or augmentive communication system.

- C9. Other (Spec. Under Orders) - Speech therapy services not included above. Specify service to be rendered under physician's orders (HCFA-485 Item 21).

D. Occupational Therapy.—These codes represent the services to be rendered by the occupational therapist. Following is a further explanation:

- D1. Evaluation - Visit made to determine occupational therapy needs of the patient at the home. Includes physical and psychosocial testings, establishment of plan of treatment, rehabilitation goals, and evaluating the home environment for accessibility and safety and recommending modifications.

- D2. Independent Living/Daily Living Skills (ADL training) - Refers to the skills and performance of physical and psychological/emotional self care, work, and play/leisure activities to a level of independence appropriate to age, life-space, and disability.

- D3. Muscle Re-education - Includes therapy designed to restore function lost due to disease or surgical intervention.

- D4. Reserved

- D5. Perceptual Motor Training - Refers to enhancing skills necessary to interpret sensory information so that the individual can interact normally with the environment. Training designed to enhance perceptual motor function usually involves activities which stimulate visual and kinesthetic channels to increase awareness of the body and its movement.

- D6. Fine Motor Coordination - Refers to the skills and the performance in fine motor and dexterity activities.

- D7. Neurodevelopmental Treatment - Refers to enhancing the skills and the performance of movement through eliciting and/or inhibiting stereotyped, patterned, and/or involuntary responses which are coordinated at subcortical and cortical levels.

- D8. Sensory Treatment - Refers to enhancing the skills and performance in perceiving and differentiating external and internal stimuli such as tactile awareness, stereognosis, kinesthesia, proprioceptive awareness, ocular control, vestibular awareness, auditory awareness, gustatory awareness, and olfactory awareness necessary to increase function.

- D9. Orthotics/Splinting - Refers to the provision of dynamic and static splints, braces, and slings for relieving pain, maintaining joint alignment, protecting joint integrity, improving function, and/or decreasing deformity.

- D10. Adaptive Equipment (fabrication and training) - Refers to the provision of special devices that increase independent functions.

- D11. Other - Occupational therapy services not quantified above.

E. Medical Social Services (MSS).--These codes represent the services to be rendered by the medical social service worker. Following is a further explanation:

- E1. Assessment of Social and Emotional Factors - Skilled assessment of social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care; followed by care plan development.

- E2. Counseling for Long-Range Planning and Decisionmaking - Assessment of patient's needs for long term care including: evaluation of home and family situation; enabling patient/family to develop an inhome care system; exploring alternatives to inhome care; arrangement for placement.

- E3. Community Resource Planning - The promotion of community centered services(s) including education, advocacy, referral and linkage.

- E4. Short Term Therapy - Goal oriented intervention directed toward management of terminal illness; reaction/adjustment to illness; strengthening family/support system; conflict resolution related to chronicity of illness.

- E5. Reserved

- E6. Other (Specify Under Orders) - Includes other medical social services related to the patient's illness and need for care. Problem resolution associated with high risk indicators endangering patient's mental and physical health including: abuse/neglect, inadequate food/medical supplies; high suicide potential. The service to be performed must be written under doctor's orders (HCFA-485 Item 21).

F. Home Health Aide - These codes represent the services to be rendered by the home health aide. Specific personal care services to be provided by the home health aide must be determined by a registered professional nurse. Services are given under the supervision of the nurse, and if appropriate, a physical, speech or occupational therapist. Following is a further explanation:

- F1. Tub/Shower Bath - Assistance with tub or shower bathing.

- F2. Partial/Complete Bed Bath - Bathing or assisting the patient with bed bath.

- F3. Reserved

- F4. Personal Care - Includes shaving of patient or shampooing the hair.

- F5. Reserved

- F6. Catheter Care - Care of catheter site and/or irrigations under nursing supervision.

- F7. Reserved

- F8. Assist with Ambulation - Assisting the patient with ambulation as determined necessary by the nurse care plan.

- F9. Reserved

- F10. Exercises - Assisting the patient with exercises in accordance with the plan of treatment.

- F11. Prepare Meal - May be furnished by the aide during a visit for personal care.

- F12. Grocery Shop - May be furnished as an adjunct to a visit for personal care to meet the patient's nutritional needs in order to prevent or postpone the patient's institutionalization.

- F13. Wash Clothes - This service may be provided as it relates to the comfort and cleanliness of the patient and the immediate environment.

- F14. Housekeeping - Household services incidental to care and which do not substantially increase the time spent by the home health aide.

- F15. Other (Specify Under Orders) - Includes other home health aide services in accordance with determination made by a registered professional nurse. Specified in Item 21 HCFA-485.

3902.4 HCFA-487 - Addendum to the Plan of Treatment/Medical Update.—The HCFA-487 is used only as an addendum to the HCFA-485/486 when additional space is needed to complete fields. The data for each field is initiated on the HCFA-485 or 486. A separate addendum is used for the plan of treatment and the medical update. If the addendum is used to continue items on the plan of treatment, then the HCFA-487 is forwarded to the physician with the HCFA-485 for his signature.

To provide additional documentation of items on the plan of treatment or medical information form, the agency checks the appropriate block. It identifies the item being addressed under Item 8. For example, if the plan of treatment block is checked and Item 11 (medications) requires additional space, the HHA specifies Item (11) on the left margin of column 8. Upon completion of Item 11, it notes the next item number, e.g., Item 14, (DME) then completes that item.

1. HICN.—See §3902.1, Item 1.

2. SOC Date.—See §3902.1, Item 2.

3. Certification Period.—See §3902.1, Item 3.

4. Medical Record Number.—See §3902.1, Item 4.

5. Provider Number.—See §3902.1, Item 5.

6. Patient's Name.—See §3902.1, Item 6.

7. Provider Name.—See §3902.1, Item 7.

8. Item Number.—The HHA indicates the item number for which it is providing additional information.

9. Signature of Physician.—If the Certification/Plan of Treatment block is checked, the physician's signature or an annotation is required on the HCFA-485 which indicates that the physician is aware that he is signing for information contained on additional pages (e.g., page 1 of 2). The HHA retains the signed copy in its files.

10. Date.—The physician enters the date he signed the addendum.

11. Optional Name/Signature of Nurse/Therapist.—If the Medical Update/Patient Information block is checked, the Nurse/Therapist filling the form signs.

12. Date.—The date the Nurse/Therapist prepared the addendum appears in this space.

3902.5 HCFA-488 - Intermediary Medical Information Request.—Use only the HCFA-488 when necessary to obtain additional medical information. All requests for subsequent medical information are limited to the items listed below. Complete Items 1 through 9 for each request and check the item(s) you are requesting the agency to complete. The agency should provide the requested information as timely as possible. It may use the HCFA-488 to respond to items as space allows. It returns the HCFA-488 as a cover sheet for identification of requested information.

1. Initial Request Date.—Enter the date on which the request was initiated.

2. Final Request Date.—Enter the date that a second and final request was sent because a response was not received. This date should not exceed 30 days after the date in item 1.

3. Provider Number.—Enter the six digit provider number.

4. Document Control Number.—Enter the number used to identify individual claims. This number is an internal processing number determined by you.

5. Patient Name.—Enter the last name, first name, middle initial.

6. HICN.—Enter the patient's Medicare number including alpha designator.

7. Medical Record Number.—Enter the medical record number assigned by the provider and located in Item 4 on the HCFA-485.

8. Period of Claim.—Enter the 6 digit month, day, year from Item 22 on the HCFA-1450 claim. Include "From" and "To" dates.

9. SOC Date.—Enter the 6 digit month, day, year on which covered home health services began. This date remains the same on subsequent plans until the patient is discharged by the agency.

When pertinent to a coverage decision, request one or more of the following:

10. HCFA-485/486 - Period Covered.—Use to request a copy of the applicable POT/MIF forms (HCFA-485/486) on interim claims where the agency was not required to submit these forms with the claim. Enter the month, day, year (i.e., 60 day period) that incorporates the date of the claim. The agency forwards the applicable HCFA-485 and an updated HCFA-486 with Items 1-3, 5-10, 12-16, and 22 completed.

11. HCFA-486 - Period Covered.—Check this item to request only an updated HCFA-486 by entering the dates of the claim; month, day and year. The agency need complete only Items 1-3, 5-10, 12-16 and 22.

12. Frequency of Doctor's Visits.—Check this item if information is needed regarding the frequency that the patient is seen by the physician.

13. Status of Chronic Condition.—Check this item if a narrative statement is needed to explain the status of a chronic condition that is not adequately addressed on the HCFA-485/486.

14. List Primary Need for: SN, PT, ST, OT, MSS, HHA, Other Visits.—If one or more of the above services is in question as to their need, check the appropriate box(es). The HHA submits a narrative statement listing the reason(s) the patient requires the service.

15. List Dates of Visits for: SN, PT, ST, OT, MSS, AIDE, Other Visits.—If one or more of the above services is in question as to the dates that the services were provided, check the appropriate box(es). The agency submits a list of all dates on which the services were provided by that discipline for the period covered.

16. Laboratory Tests (frequency, types, results).—Check this box and circle one or more items as needed.

17. Other Tests (frequency, types, results).—Check this box and write in the name of the tests you are requesting.

18. Diet.—Check this item and the box(es) that represents the requested information.

19. Date(s) on Which Frequency of SN or AIDE Increased or Decreased.—Check this box and write in the service and the frequency in question.

20. Specific Progress Notes for: SN, PT, ST, OT, MSS, HHA, Other Visits.—Check this item and the box(es) specifying the type of progress notes being requested.

21. Reason for Continued Medicare Coverage.—Check this item if the HCFA-485/486 information raised a question for continued coverage of services.

22. Doctor's Orders, Signed by the Physician.—Check this item where a copy of the physician's orders or specific change of orders is requested.

23. Supplemental Plans of Treatment, if Applicable.—Use this item to request supplemental plans of treatment when necessary to make a coverage decision. It corresponds to Item 18 on the HCFA-486.

24. Signature of FI Representative.—The nurse reviewer requesting the information or the supervisor signs in this space.

3902.6 Postpayment Audit.—Perform a postpayment audit of the medical record to ascertain that the information on the HCFA-485/486 matches that in the medical record a minimum of once per year for every provider served. If a coverage compliance review is performed, do not perform a postpayment audit in that year.

Include in the audit:

[o Inhouse or onsite audit of medical records for 15 beneficiaries per provider. Count noncovered services identified during the audit in that quarter's denial statistics. Select the sample from claims processed on the basis of information on the HCFA-485/486.

o Establish an audit trail which identifies the claims selected, sample size, the beneficiaries audited, the period of audit (claims and forms periods), the records audited, and the findings of the audit.

o Review the entire medical record relevant to the HCFA-485/486 period.

o Compare information on the HCFA-485/486 with that in the medical record to:

— Determine the accuracy of the information;

— Identify any discrepancies and the reasons they occurred, e.g., if all items on the forms were completed, what reasons did the agency give for failing to include pertinent information;

— Determine whether the payment decision was appropriate; if not, identify inappropriate payments (services/visits and reasons noncovered); and

— Evaluate the form content to determine whether some type of information which led to a change in payment decision, either is not currently captured on the HCFA-485/486 and requires rewording or whether provider education in completing the forms would suffice.

o Identify and recoup inappropriate payments.

o Send the appropriate denial notices to the beneficiary and the HHA.

o Advise the HHA of the results of the audit in a letter within 6 weeks of the audit.

partment of Health and Human Services
Health Care Financing Administration

EXHIBIT I

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF TREATMENT

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address

7. Provider's Name and Address

8. Date of Birth:

9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD-9-CM Principal Diagnosis Date

12. ICD-9-CM Surgical Procedure Date

13. ICD-9-CM Other Pertinent Diagnoses Date

14. DME and Supplies

15. Safety Measures:

16. Nutritional Req.

17. Allergies:

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinence)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status: 1 ☐ Oriented 2 ☐ Comatose 3 ☐ Forgetful 4 ☐ Depressed 5 ☐ Disoriented 6 ☐ Lethargic 7 ☐ Agitated 8 ☐ Other

20. Prognosis: 1 ☐ Poor 2 ☐ Guarded 3 ☐ Fair 4 ☐ Good 5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Verbal Start of Care and Nurse's Signature and Date Where Applicable:

24. Physician's Name and Address

25. Date HHA Received Signed POT

26. I ☐ certify ☐ recertify that the above home health services are required and are authorized by me with a written plan for treatment which will be periodically reviewed by me. This patient is under my care, is confined to his home, and is in need of intermittent skilled nursing care and/or physical or speech therapy or has been furnished home health services based on such a need and no longer has a need for such care or therapy, but continues to need occupational therapy.

27. Attending Physician's Signature (Required on 485 Kept on File in Medical Records of HHA)

Date Signed

Form HCFA-485 (C4) (4-87)
Rev. 1364

Department of Health and Human Services
Health Care Financing Administration

EXHIBIT II

Form Approved
OMB No 0938-0357

MEDICAL UPDATE AND PATIENT INFORMATION

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name

7. Provider's Name

8. Medicare Covered: ☐ Y ☐ N

9. Date Physician Last Saw Patient:

10. Date Last Contacted Physician:

11. Is the Patient Receiving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent? ☐ Y ☐ N ☐ Do Not Know

12. ☐ Certification ☐ Recertification ☐ Modified

13. Specific Services and Treatments

Discipline	Visits (This Bill) Rel. to Prior Cert.	Frequency and Duration	Treatment Codes	Total Visits Projected This Cert.

14. Dates of Last Inpatient Stay: Admission Discharge

15. Type of Facility:

16. Updated Information: New Orders/Treatments/Clinical Facts/Summary from Each Discipline

17. Functional Limitations (Expand From 485 and Level of ADL) Reason Homebound/Prior Functional Status

18. Supplementary Plan of Treatment on File from Physician Other than Referring Physician: ☐ Y ☐ N
(If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)

19. Unusual Home/Social Environment

20. Indicate Any Time When the Home Health Agency Made a Visit and Patient was Not Home and Reason Why if Ascertainable

21. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence

22. Nurse or Therapist Completing or Reviewing Form

Date (Mo., Day, Yr.)

Form HCFA-486 (C3) (4-87)

Department of Health and Human Services
Health Care Financing Administration

EXHIBIT III

Form Approved
OMB No. 0938-0357

ADDENDUM TO: ☐ PLAN OF TREATMENT ☐ MEDICAL UPDATE

1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name	7. Provider Name

8. Item No.

9. Signature of Physician	10. Date
11. Optional Name/Signature of Nurse/Therapist	12. Date

Form HCFA-487 (C4) (4-87)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

EXHIBIT IV

FORM APPROVED
OMB NO. 0938-0357

HOME HEALTH AGENCY
INTERMEDIARY MEDICAL INFORMATION REQUEST

1. Initial Request Date:	2. Final Request Date:
3. Provider Number:	4. Document Control Number:
5. Patient Name:	6. HI Claim Number
7. Medical Record Number:	8. Period of Claim: From: To: / 9. SOC Date
☐ 10. HCFA-485/486: Period Covered:	☐ 11. HCFA-486: Period Covered:

☐ 12. Frequency of doctors visits:

☐ 13. Status of chronic condition:

☐ 14. List primary need for:
☐ SN ☐ PT ☐ ST ☐ OT ☐ MSS ☐ HHA ☐ Other Visits

☐ 15. List dates of visits for:
☐ SN ☐ PT ☐ ST ☐ OT ☐ MSS ☐ HHA ☐ Other Visits

☐ 16. Laboratory tests (frequency, types, results):

☐ 17. Other tests (frequency, types, results):

☐ 18. Diet ☐ Type ☐ Compliance ☐ Teaching Duration ☐ Length of time on the diet

☐ 19. Date(s) on which frequency of SN or HHA increased or decreased:

☐ 20. Specific progress notes for:
☐ SN ☐ PT ☐ ST ☐ OT ☐ MSS ☐ HHA ☐ Other Visits

☐ 21. Reason for continued Medicare coverage:

☐ 22. Doctor's orders, signed by physician

☐ 23. Supplemental Plans of Treatment, if applicable:	24. Signature of F.I. Representative

Form HCFA-488 (C4) (4-87)

EXHIBIT V

TREATMENT CODES FOR PROFESSIONAL SERVICES REQUIRED

Skilled Nursing

A1	Skilled Observation (Inc. V.S., Response to Med., etc.)
A2	Foley Insertion
A3	Bladder Instillation
A4	Open Wound Care/Dressing
A5	Decubitus Care - Stage 3, 4, 5
A6	Venipuncture
A7	Restorative Nursing
A8	Post Cataract Care
A9	Bowel/Bladder Training
A10	Chest Physio (Inc. Postural drainage)
A11	Adm. of Vitamin B/12
A12	Adm. Insulin
A13	Adm. Other IM/Subq.
A14	Adm. IV's/Clysis
A15	Teach Ostomy or Ileo conduit care
A16	Teach Nasogastric Feeding
A17	Reinsertion Nasogastric Feeding Tube
A18	Teach Gastrostomy Feeding
A19	Teach Parenteral Nutrition
A20	Teach Care of Trach
A21	Adm. Care of Trach
A22	Teach Inhalation Rx
A23	Adm. Inhalation Rx
A24	Teach Adm. of Injection
A25	Teach Diabetic Care
A26	Disimpaction/F.U. Enema
A27	Other (Spec. under Orders)
A28	Wound Care/Dressing - Closed Incision/Suture Line
A29	Decubitus Care - Stage 1, 2
A30	Teaching Care of Any Indwelling Catheter

Physical Therapy

B1	Evaluation
B2	Therapeutic Exercise
B3	Transfer Training
B4	Home Program
B5	Gait Training
B6	Chest Physiotherapy
B7	UltraSound
B8	ElectroTherapy
B9	Prosthetic Training
B10-B14	Reserved
B15	Other (Specify under Orders)

Speech Therapy

C1	Evaluation
C2	Voice Disorders Treatments
C3	Speech Articulation Disorders Treatments
C4	Dysphagia Treatments
C5	Language Disorders Treatments
C6	Aural Rehabilitation
C7	Reserved
C8	Non-oral Communication
C9	Other (Specify under Orders)

Occupational Therapy

D1	Evaluation
D2	Independent Living/Daily Living Skills (ADL Training)
D3	Muscle Re-education
D4	Reserved
D5	Perceptual Motor Training
D6	Fine Motor Coordination
D7	Neuro-developmental Treatment
D8	Sensory Treatment
D9	Orthotics/Splinting
D10	Adaptive Equipment (fabrication and training)
D11	Other (Specify Under Orders)

Medical Social Services

E1	Assessment of Social and Emotional Factors
E2	Counseling for Long Range Planning and Decision Making
E3	Community Resource Planning
E4	Short Term Therapy
E5	Reserved
E6	Other (Specify Under Orders)

Home Health Aide

F1	Tub/Shower Bath
F2	Partial/Complete Bed Bath
F3	Reserved
F4	Personal Care
F5	Reserved
F6	Catheter Care
F7	Reserved
F8	Assist with Ambulation
F9	Reserved
F10	Exercises
F11	Prepare Meal
F12	Grocery Shop
F13	Wash Clothes
F14	Housekeeping
F15	Other (Spec. under Orders)

EXHIBIT VI

ACCEPTABLE V CODES

V46.0	Dependence on Aspirator
V46.1	Dependence on Respirator
V53.5	Fitting and Adjustment of Ileostomy or Other Intestinal Appliance
V53.6	Fitting and Adjustment of Urinary Devices
V55.0	Attention to Tracheostomy
V55.1	Attention to Gastrostomy
V55.2	Attention to Ileostomy
V55.3	Attention to Colostomy
V55.4	Attention to Other Artificial Opening of Urinary Tract

3903. MEDICAL REVIEW OF COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF) CLAIMS

A. General.—CORF services are an expansion of the scope of benefits under Medicare Part B which enable beneficiaries to receive coordinated comprehensive outpatient rehabilitation services at one fixed location (rather than at different sources).

The purpose of your MR is to assure that reimbursement is made only for covered care as described in §§3180ff. and that it neither exceeds the medical needs of the patient nor represents a noncovered level of care (e.g., maintenance therapy).

B. Review of CORF Claims.—

1. New CORFs.—Review 100 percent of the claims submitted by newly certified CORFs for two quarters. Use this information to perform the applicable level of MR indicted below.

2. CORFs With a Denial Rate in Excess of 5 Percent.—Review 100 percent of claims.

When the denial rate decreases to 5 percent or less for two consecutive quarters, you may reduce the level of review as indicated below.

3. CORFs With a Denial Rate of Less Than 5 Percent.—Use your internal screens to identify questionable claims for review.

- o Review 30 percent of the claims submitted per quarter. If a CORFs claim volume is less than 100 per quarter, review a minimum of 30 claims.
- o Review all claims if their are fewer than 30 in the quarter.

Increase the level of review if you find an increase in the incidence of noncovered services.

C. Calculation of Denial Rates.—Calculate the denial rate as follows:

$$\frac{\text{Total Services Denied}}{\text{Total Services Reviewed}}$$

Calculate the denial rate to determine the level of MR to perform. The rate indicates the CORF's understanding of Medicare covered services. You need not report the denial rate to the CORF. However, inform it of the Medicare coverage guidelines in areas where they are billing for noncovered services.

D. Purpose of the MR.—Generally, services provided by the CORF must be furnished onsite under a written plan of treatment, except for one nonmandatory home evaluation visit. Effective December 22, 1987, physical therapy, occupational therapy, and speech pathology services may be furnished off-site. (See §3182.) Such services may be covered if furnished pursuant to the plan of treatment, and if they do not duplicate services for which payment has otherwise been made under Medicare. Assure that the CORF services provided were:

o Covered services as described in §§3181 and 3183.

o Furnished to a patient who is under the care of a physician and was referred by the physician certifying that the individual needs skilled rehabilitation services.

o Stipulated in a written plan of treatment which:

— Was established and signed by a physician; and

— Prescribes the type, amount, frequency, and duration of the services to be furnished and indicates the diagnosis and anticipated specific rehabilitation goals.

o Reasonable and necessary in relation to the patient's rehabilitation potential and progress.

NOTE: Where a signed copy of the plan of treatment is not being required for review and/or the certification/recertification statement and physician signature is not on the same document as the plan of treatment, this information must be retained in the CORF files and be available upon request.

E. Documentation Requirements.—Request as a minimum, the documentation outlined below for MR of CORF claims. You may request that the information be entered on a medical information form designed to elicit this information or that copies of information be supplied from the medical record.

1. With the Initial Bill and Every 60 Days Thereafter.—A written plan of treatment signed by the physician which includes the information specified in subsection D., or information from the plan of treatment provided transcribed on a medical information form;

2. With the Initital Bill.—The pertinent medical history including the date of onset or exacerbation of the condition for which the services are being rendered, and the results of prior rehabilitation services (if any) for the same condition.

o A description of functional limitations and rehabilitation potential; and

o The results of the initial evaluation by the CORF.

3. With Subsequent Claims.—(i.e., monthly claims that fall within the 60-day certification period) the progress report and reevaluation findings must reflect:

o A description of the treatment rendered;

o A description of the progress the patient is making toward attaining the rehabilitation goals, and the results of both subjective and objective tests and measures as compared to the initial or prior evaluation results; and o A statement by the physician of why treatment should be continued if progress is not being made.

NOTE: Daily notes are not required. A summary of progress or nonprogress must be documented with each billing.

F. Reasons for Denial of Claims.—Deny a claim when the:

o Description of the treatment is limited or absent.

o Documentation is not sufficient to adequately describe the treatment rendered, thus, it cannot be determined if the services delivered were skilled.

o Treatment delivered was not skilled physical therapy services, as defined by Medicare regulations. That is, documentation reflects evidence that the services rendered do not require the skills of a registered physical therapist (e.g., the application of hot packs to a patient without a circulatory disorder). (See §3101.8.C.)

o Patient appears to have reached a plateau in functional status. There is no evidence of the continued need for a skilled restorative program as defined by Medicare. (See §§3101.8ff.)

o Patient appears to be on a maintenance program for an extended period of time. Documentation shows the maintenance program has been established and learned, but continues to be carried on.

o Documentation indicates that the services rendered to the patient are skilled, but the patient is not making significant progress within a predictable period of time. Carefully examine persistent delivery of treatment less than once a week to determine if this pattern will produce improvement within a predictable period of time.

G. Psychiatric Services Limitation.—Section 1833(c) of the statute imposes a limitation on reimbursement for outpatient psychiatric treatment. This provision limits the amount of a beneficiary's incurred expenses that will be recognized, in any calendar year, to $312.50 or 62-1/2 percent of incurred expenses, whichever is less.

In determining when the limitation applies, separate the charges for the psychotherapeutic aspects of the treatment from the nonpsychiatric aspects. When the psychiatric and nonpsychiatric components are not readily distinguishable, allocate the charges as follows:

o Psychological services, whether furnished by psychologists or other personnel, are always subject to limitation regardless of the patient's diagnosis.

o Physical therapy, respiratory therapy, speech therapy and services furnished in connection with prosthetic and orthotic devices and the use of equipment and appliances related to these services are not subject to the limitation.

- For services not specified above, such as occupational therapy, determine the primary reason for the patient being referred to the CORF.

If the referral is primarily on the basis of a psychiatric condition, all services are subject to the limitation except as specific in §3903.C.

If the referral is primarily on the basis of a diagnosis of Alzheimer's Disease (coded 331.0 in the International Classification of Diseases, 9th Revision) or Alzheimer's or other disorders coded 290.XX in the American Psychiatric Association's Diagnosis and Statistical Manual - Mental Disorders, such services typically represent management of the patient's condition (rather than psychotherapy) and are not subjected to the benefit limitation. Where a particular service provided a patient with such a diagnosis is primarily for psychological services as specified in §3903.C., it is subject to the limitation.

If the referral is primarily on the basis of a physical condition, the services are not subject to this limitation. If the primary reason for referral is not clear, 50 percent of the customary charges is subject to limitation.

Identify and review every claim involving services provided by a CORF to beneficiaries being treated for a mental psychoneurotic or personality disorder. Request appropriate medical records, (see §3600.1), for all identified claims.

Review each claim to assure that:

- When the CORF services furnished were for the treatment of a psychiatric disorder, that the services were provided as stipulated in the plan of treatment; and
- When payment is made for such services, the expenses incurred in connection with the treatment of a mental psychoneurotic or personality disorder are limited, as specified in §§3185ff.
- If the CORF services rendered were for both a psychiatric condition and one or more nonpsychiatric conditions:
  - Determine the medical necessity and appropriateness of the services provided; and
  - Apply the limitations specified in §3903.C.

H. CORF Report of Medical Review Activity.—Complete and submit within 30 calendar days of the close of the calendar quarter the following report to:

Health Care Financing Administration
Office of Program Operations Procedures, BPO
1-H-3 Meadows East Bldg.
6325 Security Blvd.
Baltimore, MD 21207

In addition, submit a copy of the report to the RO.

Page 1 of 1 Page

CORF REPORT OF MEDICAL REVIEW ACTIVITY

Quarter Reporting (M - D - Y)

Intermediary Number

Intermediary Name

Reporting Section and Item	(Data Entry Identifier) (for HCFA use)	Number Reported
Section 3903 Medical Review of CORF Claims		
Total number of claims subjected to medical review.	(CMRO10)	
Percent of CORFs on 100 percent medical review.	(CMRO20)	
Percent of CORFs whose denial rate exceeds 5 percent (i.e., 5 percent of services medically reviewed.	(CMRO30)	
Total number of services medically reviewed	(CMR040)	
Total number of psychiatric-related services medically reviewed.	(CMRO50)	
Total number of psychiatric-related services denied.	(CMRO51)	
Total number of nonpsychiatric-related CORF services denied.	(CMRO60)	
Number of physical therapy services denied.	(CMRO61)	
Number of occupational therapy services denied.	(CMRO62)	
Number of speech pathology services denied.	(CMRO63)	
Number of social services denied.	(CMRO64)	
Number of other services denied.	(CMRO65)	

Medical Review of Part B Intermediary Outpatient Physical Therapy Bills

3904. MEDICAL REVIEW (MR) OF PART B INTERMEDIARY OPT BILLS

A. General.--The following criteria identify OPT services that your MR staff must review. You may select these cases manually or by computer. You must either select OPT claims for medical review by using the diagnostic edits identified in these instructions or review OPT claims at a 100 percent level. However, if you choose to use any of the diagnostic edits listed in Exhibit I, the visits and/or duration parameters may not be changed without approval from CO. You may review claims in addition to those identified here. If you choose to select claims for review in addition to those identified in Exhibit I, or if you elect to review OPT claims at a 100 percent level, secure approval from your RO and for the criteria you use to select the additional claims. However, you must conform to the MR requirements for all outpatient claims identified in these instructions from rehabilitation agencies, SNFs, hospitals, and HHAs that provide OPT in addition to home health services (bill types, hospital-13, SNF-23, HHA-34, rehabilitation agency, public health agency or clinic-74). These criteria do not apply to inpatient PT services or to PT services provided under a home health plan of treatment or to PT services furnished by CORFs.

The criteria for MR case selection are based on ICD-9-CM diagnoses, elapsed time from start of care (at the billing provider) and number of visits. See Exhibit I for these criteria. Denial of a bill solely on the basis that it exceeds the criteria in these edits is prohibited. The edits are only for selecting bills to review or for paying bills that meet Level I criteria without MR. Also, do not provide automatic coverage, up to these criteria. They neither guarantee minimum coverage nor set maximum coverage limits.

B. Level I Review Process.--PT edits have been developed for a number of diagnoses. The diagnoses were selected on the basis that, when linked with a recent date of onset, there is a high probability that Medicare patients with those diagnoses will require skilled OPT. The edits do not specify every diagnosis which may require PT, and therefore, the fact that a given diagnosis does not appear in the edits does not create a presumption that OPT services are not necessary or are inappropriate for that diagnosis. Claims may not be approved or denied at Level I for reasons of medical necessity. Claims that pass the edits in Exhibit I and any additional edits approved by your RO may be paid without being subjected to Level II MR.

Evaluate bills at Level I based upon each of the following:

o Facility and Patient Identification - (facility name, patient name, provider number, HICN, age).

o Diagnosis - The primary diagnosis for which OPT services were rendered must be listed by ICD-9-CM code first; other Dx(s) applicable to the patient or that influence care must be listed next.

o Duration - The total length of time OPT services have been rendered (in days) from the date treatment was initiated for the diagnosis being treated at the billing provider (including the last day in the current billing period).

o Number of Visits - The total number of patient visits completed since OPT services were initiated for the diagnosis being treated by the billing provider. The total visits to date (including the last visit in the billing period) must be given rather than for each separate billing (value code 50).

o Date of Onset (Occurrence Code 11) - The date of onset of the primary physical therapy diagnosis for which OPT services were being rendered by the billing provider.

o Date Treatment Started (Occurrence Code 35) - The date OPT services were initiated by the billing provider for the primary physical therapy Dx being treated.

o Billing Period - When OPT services began and ended in the billing period (from through dates).

C. Level II Review Process.—If a bill exceeds the limit set in the edits or represents a diagnosis other than one on the edits, refer it to the Level II health professional MR staff. If possible, have physical therapists review OPT bills.

Once the bill is selected for MR, review it in conjunction with medical information submitted by the provider.

1. Reimbursable PT Services.—Reimburse OPT services only if they meet all requirements established by the Medicare guidelines and regulations. Each bill for OPT services that is subjected to Level II or III MR must be supported with adequate medical documentation for you to make a determination. The documentation must show that the requirements of §§3101.8, 3118.1 and 3148 and in these instructions are met.

2. MR and Documentation.—When a claim is subsequently referred to Level II MR, use the following pertinent data elements in addition to those used for Level I review:

o Medical History - Obtain only the medical history which is pertinent to, or influences the OPT treatment rendered, including a brief description of the functional status of the patient prior to the onset of the condition requiring OPT, and any pertinent prior PT treatment.

o Physician Referral and Date -

o PT Initial Evaluation and Date -

o Plan of Treatment and Date Established -

o Date of Last Certification - Obtain the date on which the plan of treatment was last certified by the physician.

o Progress Notes - Obtain updated patient status reports concerning the patient's current functional abilities/limitations.

Use the above information along with that in subsection B, to assess the appropriateness of the OPT plan of treatment and the patient's progress relative to diagnosis, date of onset, etc. The medical information supporting a bill must be specific. Documentation written in general terms, e.g, "strength appears to have increased" or "can now reach higher overhead" or "medical history-chronic arthritis" is insufficient. To make an informed MR decision request documentation from the provider when incomplete or inadequate documentation is present. The physician's pertinent evaluations, progress notes and opinions about the patient's need for rehabilitation services, should also be used (when these are available). Obtain this information from the provider regardless of the document type the provider keeps (i.e., it does not matter whether the baseline evaluation is part of the treatment plan, the progress notes or the medical history, obtain and use this information).

3. Medical History.—If a history of previous PT treatment is not available, the provider may provide a general summary regarding the patient's past relevent medical history recorded during the initial evaluation with the patient/family (if reliable) or through contact with the referring physician. Information regarding prior history and treatment by the referring physician must be provided when available.

The patient's medical history, as it relates to the OPT, must include the date of onset and/or exacerbation of the illness or injury. If the patient has had prior OPT for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is also necessary for patients who have transferred to a new provider for additional treatment. For example, if surgery has been performed, be aware of the type and date of surgery. The date of onset and type of surgical procedure should be specific for diagnoses such as fractured hip. For other diagnoses, such as arthritis, the date of onset may be general and can be established from the date the patient first required medical treatment. For other types of chronic diagnoses, the history must give the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled OPT. For example, a patient that had an amputation several years ago might recently have been fitted with a new prosthesis.

4. Evaluation.—A PT initial evaluation, (excluding routine screening) should be approved when it is reasonable and necessary for the therapist to determine if there is an expectation that either restorative or maintenance services will be appropriate for the patient's condition. Reevaluations should be approved when the patient exhibits a demonstrable change in physical functional ability in order to reestablish appropriate treatment goals, or when required for ongoing assessment of the patient's rehabilitation needs. Initial evaluations or reevaluations that are determined reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the evaluation determines that skilled rehabilitation is not needed.

The PT evaluation establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The evaluation of the patient's condition must form the basis for the physical therapy treatment goals.

The evaluation must (when possible) include objective tests and measurements which normally will include functional, strength, and range of motion (ROM) assessments. However, for patients with certain neurological conditions (such as upper motor neuron conditions) assessment of strength may not be valid. Where the above tests are not applicable, the physical therapist should document the patient's functional loss and the need for skilled OPT intervention resulting from conditions such as:

o Self-Care Dependence - The individual is dependent upon skilled assistance or supervision from another person in self-care activities. These activities include, but are not limited to, signficant functional loss or loss of previous functional gains in the ability to:

- Drink;
- Feed;
- Dress; or
- Maintain personal hygiene.

Additionally, this could include care of braces or other adaptive devices.

o Mobility Dependence - The individual is dependent upon another person for skilled OPT assistance or supervision in such areas as transfer, gait training, stair climbing, and wheelchair maneuvering activities due to, but not limited to:

- Decreased strength;
- Marked muscle spasticity;
- Moderate to severe pain;
- Contractures;
- Incoordination;
- Perceptual motor loss;
- Orthotic need; or
- Need for ambulatory or mobility device.

This could involve patients with or without impairment of the lower leg who are partially independent with wheelchair and/or who have significant architectural or environmental barriers.

o Safety Dependence/Secondary Complications - A safety problem exists when a patient without skilled assistance cannot handle him/herself in a manner that is physically safe. This may extend to the performance of activities of daily living or to acquired secondary complications which could potentially intensify medical sequelae such as fracture nonunion, or decubiti. Some examples of safety dependence may be demonstrated by high probability of falling, swallowing difficulties, severe pain, loss of skin sensation, progressive joint contracture, and infection requiring skilled PT intervention to protect the patient from further complication.

Each patient's condition calls for assessments which are unique to specific impairments. For example, documentation in the treatment of open wounds or ulcerations require other objective and subjective documentation, such as size and depth of the wound, amount and frequency of drainage, signs of granulation, or evidence of infection, etc.

If the goal for any patient is to increase functional abilities, range of motion, or strength, the initial evaluation must measure (if possible) the patient's starting functional abilities, range of motion and strength. If the assessment indicates that joint range of motion or strength is normal, there should be evidence of this assessment in the initial evaluation or progress notes, e.g., "within normal limits." If objective documentation cannot be accomplished for any reason, this should be noted in the inital evaluation or progress notes along with the reason(s).

5. Plan of Treatment.--The PT plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." The plan of treatment must include modalities/procedures, frequency, and duration of treatment. The modalities/procedures must be specific. Changes in the plan of treatment should be submitted with the progress notes.

The plan of treatment must contain the following information concerning the PT treatment:

o Type of Modalities/Procedures - Should describe he specific nature of the therapy to be provided. Some examples of PT modalities/procedures are deep heat (e.g., diathermy, ultrasound), superficial heat (e.g., hot packs, whirlpool), and therapeutic exercises and gait training.

o Frequency of Visits - An estimate of the frequency of treatment to be rendered (e.g., 3x week).

o Estimated Duration - Identifies the length of time over which the services are to be rendered and may be expressed in days, weeks, or months.

o Diagnoses - Should include the PT diagnosis if different from the medical diagnosis. For example, the medical diagnosis might be "rheumatoid arthritis." However, the shoulder might be the only area being treated, so the PT diagnosis might be "adhesive capsulitis." In order to establish the PT diagnosis, diagnostic tests must be used whenever possible.

o Functional Goals - Should reflect the physical therapist's and/or physician's description of what the patient is expected to achieve as a result of therapy.

o Rehabilitation Potential - The therapist's and/or physician's expectation concerning the patient's ability to meet the goals at initiation of treatment.

6. Progress Reports (Status Summary(s) Related to the Billing Period).--The physical therapist must provide treatment information regarding the current status of the patient during the course of the billing period. The PT progress notes and any needed reevaluation(s) must update the baseline information provided at the initial evaluation. If there is a change in the plan of treatment, it must be documented in accordance with §3148.3. Additionally, when a patient is continued from one billing period to another, the progress report(s) must reflect comparison between the patient's current functional status and that obtained during the previous billing and/or at the initial evaluation.

Where a valid expectation of improvement exists at the time OPT services are initiated, or thereafter, reasonable and necessary services would be covered even though the expectation may not be realized. However, in such instances, the OPT services are covered only up to the point in time that no further significant functional improvement can be reasonably expected. Progress reports or status summaries by the physician and/or physical therapist must document a continued expectation that the patient's condition will continue to improve significantly in a reasonable and generally predictable period of time. "Significant," in this context, means a generally measurable and substantial increase in the patient's present level of physical functional abilities compared to their level at the time treatment was initiated.

Do not interpret the term "significant" so stringently that you deny a claim simply because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. The medical reviewer should approve the claim if the services are considered reasonable and necessary and if there is still a reasonable expectation that significant improvement in the patient's overall safety or functional ability will occur. However, the physical therapist and/or physician should document such lack of progress and briefly explain the need for continued skilled PT intervention.

Medical review of rehabilitation claims must be conducted with an understanding that skilled intervention may be needed, and improvement in a patient's condition may occur, even where a patient's full or partial recovery is not possible. For example, a terminally ill patient may begin to exhibit self care, mobility and/or safety dependence requiring PT services. The fact that full or partial recovery is not possible or rehabilitation potential is not present, must not affect MR coverage decisions. The deciding factor is always based on whether the services are considered reasonable, effective, treatment for the patient's condition and they require the skills of a physical therapist, or whether they can be safely and effectively carried out by nonskilled personnel, without physical therapy supervision. The reasons for physical therapy intervention must be clear to you, as well as their goals, prior to a coverage determination. These claims often require review at Level III.

It is essential that the physical therapist document the updated status in a clear, concise, and objective manner. Objective tests and measurements are stressed when these are practical. The physical therapist selects the appropriate method to demonstrate current patient status. However, the method chosen, as well as the measures used, should be consistent during the treatment duration. If the method used to demonstrate progress is changed or comparable measures are used; the reasons for the change should be documented, including how the new method relates to the old. You must have an overview of the purpose of treatment goals in order to compare the patient's current functional status to that in previous reporting periods.

While objective documentation often necessitates range of motion, strength, and other objective measurements; documentation of the patient's current functional status compared to previous reporting period(s) is of paramount importance. The deficits in functional ability should be clear.

Physical therapists must document functional improvements (or lack thereof) as a result of their treatments. Documentation of functional progress must be stated whenever possible in objective, measurable terms. The following illustrates these principles:

o Pain - Documentation describing the presence or absence of pain and its effect on the patient's functional abilities must be considered in MR decisions. A description of its intensity, type, changing pattern, and location at specific joint ranges of motion will materially aid correct MR decisions. Documentation should describe the limitations placed upon the patient's self care, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

Transcutaneous electrical nerve stimulation (TENS) uses surface electrodes and electrical current to interrupt pain pathways and sensation of pain through peripheral nerves. Generally, it is covered on a trial basis for up to 1 month. Any trial period extending beyond 1 month must be documented as to reason and medical necessity. Approve such claims only when the documentation supports the need to assess the patient's suitability for continued treatment with TENS. When it is determined that TENS should be continued as therapy and the patient has been trained to use the stimulator, it is expected that the stimulator will be employed by the patient at home. Payment may be made under the prosthetic devices benefit for the TENS stimulator. Payment may not be approved for continued OPT treatments with TENS. (See Coverage Issues Manual 35-46 and 65-8.)

o Therapeutic Exercise - The objective documentation should support the skilled nature of the exercise program, and/or the need for design and establishment of a maintenance exercise program. The goals should be to increase functional abilities in self care, mobility or patient safety. Documentation should indicate the goals and type of exercise provided and the major muscle groups treated.

Approve claims when the therapeutic exercise, because of documented medical complications, the condition of the patient, or complexity of the exercise employed, must be rendered by, or under, the supervision of a physical therapist. For example, while passive and active assistive exercise may often be performed safely and effectively by nonskilled personnel, the presence of fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled PT intervention to render the service and/or to establish a safe maintenance program. In these cases, the complications and the skilled services they require, must be documented by physician orders and/or physical therapy notes. To make correct MR decisions, the patient's losses and/or dependencies in self care, mobility and safety must also be documented. The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support why skilled PT is needed for the patient's medical condition and/or safety.

Approve establishment and design of a maintenance exercise program to fit the patient's level of ADL, function, and any instructions supportive personnel and/or family members need to safely and effectively carry out the program. Reevaluation may be approved when reasonable and necessary to readjust the maintenance program to meet the changing needs of the patient. There must be adequate justification for readjusting a maintenance program, e.g., loss of previous functional gain.

o Cardiac Rehabilitation Exercise - Physical therapy is not covered when furnished in connection with cardiac rehabilitation exercise program services (see Coverage Issues Manual 35-25) unless there also is a diagnosed noncardiac condition requiring it e.g., where a patient who is recuperating from an acute phase of heart disease may have had a stroke which requires PT. (While the cardiac rehabilitation exercise program may be considered by some a form of PT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are performed under the direct supervision of a physician.) Restrictions on coverage of PT do not affect rules regarding coverage or noncoverage of such services when furnished in a hospital inpatient or outpatient setting.

o Gait Training - The documentation must support that the skilled gait training is designed to restore functional abilities (or to design and establish a safe maintenance program) which can reasonably be expected to improve the patient's ability to walk or walk more safely. Documentation should clarify the patient's gait deviation, current functional abilities and limitations, and/or safety dependence during gait. Documentation should identify the gait problem being treated, e.g., to correct a balance/incoordination and safety problem or a specific gait deviation, such as a Trendelenberg gait. The type of gait deviation requiring skilled intervention, the functional limitations in mobility, the patient's understanding or lack of understanding of the gait training, and the amount of assistance needed during training is needed to make correct review decisions. The documentation must differentiate skilled gait training rendered from assistive walking, when the patient is walking repetitiously and merely improving distance or endurance (assistive or nonassistive).

o Transfer Training - The documentation should describe the patient's functional limitations in transfer ability that warrant skilled PT intervention. Documentation should include, the special transfer training needed and rendered, and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Transfer training should be approved when the documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the task.

Documentation that supports only repetitious carrying out of the transfer method, once established, and monitored for safety and completion of the task is noncovered care.

o Electrical Nerve Stimulation - Approve reasonable and necessary electrical stimulation to delay or prevent disuse atrophy, but only where the documentation indicates that the nerve supply (including brain, spinal cord and peripheral nerves) to the muscle is intact, and other nonneurological reasons for disuse are causing atrophy. (See Coverage Issues Manual §35-77.)

Electrotherapy for the treatment of facial nerve paralysis, e.g., Bell's palsy is not a covered service. (See Coverage Issues Manual §35-72.)

Approve functional electrical stimulation (FES) used to test the suitability for improving the patient's functional ability when documented in the PT notes as lost. For example, to stimulate the dorsiflexors of the ankle, thereby, reducing toe drag during the swing-through phase of gait.

o Biofeedback Therapy - Approve claims when the documentation indicates that it is reasonable and necessary for the patient for muscle reeducation of specific muscle groups, or for treating pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness.

Deny claims where the documentation supports treatment for ordinary muscle tension states or for psychosomatic conditions. (See Coverage Issues Manual 35-27.)

o Fabrication of Temporary Prostheses, Braces, and Splints - Approve reasonable and necessary fabrication of temporary prostheses, braces and splints, and any reasonable and necessary skilled training needed in their safe and effective use. The documentation must indicate the need for the device and training.

D. Certification and Recertification.—To meet Medicare guidelines, PT services must be certified and recertified by a physician. They must be furnished while the patient is under the care of a physician. The OPT services may be furnished under a written plan of treatment established by the physician or a qualified physical therapist providing them; however, if the plan is established by a physicial therapist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or the provider when it makes a written record of the oral orders) before treatment is begun. When OPT services are continued under the same plan of treatment for a period of time, the physician must certify at least every 30 days that there is a continuing need for them. Obtain the recertification at the time the plan of treatment is reviewed since the same 30 day interval is required for the plan's review. Any changes to the treatment plan established by a physicial therapist must be in writing and signed by the physicial therapist or by the attending physician. Recertifications must be signed by the physician who reviewed the plan of treatment. The physician may change a plan of treatment established by the physical therapist, the physical therapist may not alter a plan of treatment established by a physician.

E. Physical Therapy Forms.—Documentation may be submitted on a specific form or may be copies of the provider's record. You may require a specific form if you find it more efficient than using provider records; however, it must capture the MR information required by these instructions. If you choose to require one, show the OMB clearance number. The information must be complete. If it is not, request the missing information and return the bill for the additional information. The information you require to review the bill is that required by a physical therapist to properly treat a patient.

F. Post-Pay Sample.—Review a random sample (percent determined by HCFA) of the bills that pass all edits (i.e., are paid without MR), using either a random number generator or terminal HICN. Each quarter, assign a new random number generator/HICN. This is unnecessary if you medically review all OPT claims.

Conduct a post-pay MR on each claim selected in accordance with subsection C. Determine a provider's denial rate by combining the prepay and postpay denials for the same quarter. Calculate the rate by dividing the provider's total charges that you have determined noncovered by the total charges submitted by the provider in that quarter. Place providers having a 5 percent or higher denial rate in any quarter on 100 percent

best copy available

prepay MR in the subsequent quarter. Providers with a denial rate of less than 5 percent for two (2) consecutive quarters may be removed from 100 percent MR. Handle new providers according to your existing procedures.

Consider investigating abnormal trends uncovered during the post-pay sample review by conducting special Level I edit studies. Alert your RO to your findings, along with recommendations, prior to taking any corrective action or procedural changes.

G. Completion of the MR Report.--

1. Report of OPT MR Activities.--Complete and submit within 15 calendar days of the close of the calendar quarter, the following report (Exhibit II).

Submit reports to:

Health Care Financing Administration
Office of Program Operations Procedures, BPO
1-H-3 Meadows East Bldg.
6325 Security Blvd.
Baltimore, MD 21207

Send a copy to the regional administrator.

2. Completing the OPT Edits Report (Exhibit II).--

NOTE: If you perform 100 percent MR, see subpart 3 below.

Item 1 - Intermediary Number - Enter your assigned identification number.

Item 2 - Intermediary Name - Enter your corporate name.

Item 3 - Intermediary Contact - Enter the name of the individual responsible for completing the report.

Item 4 - Telephone Number - Enter the phone number of the individual named in Item 3.

Item 5 - Reporting Quarter - Enter the last month of the reporting quarter and the year (i.e., December, March, June, or September).

Item 6 - Date of Completion - Enter the date the report is forwarded to HCFA.

Item 7 - Total Bills to Pass Edits - Enter the total number of OPT bills (revenue code 42x) that were paid or identified for payment without MR. (Bills passing edits.)

Item 8 - Charges for Bills Passing Edits - Enter the dollar amount (charges) for OPT bills passing edits.

Item 9 - Total Number of Bills Suspended - Enter the number of bills suspended for MR as a result of your edits.

Item 10 - Charges for Bills Suspended - Enter the dollar amount (charges) for bills suspended for MR.

Item 11 - Total Number Bills Paid - Enter the number of bills paid as billed after MR.

Item 12 - Total Number of Bills Denied - Enter the number of bills denied (including partial denials) after MR.

Item 13 - Charges Denied - Enter the dollar amount (charges) denied after MR.

Item 14 - Review - Based upon HCFA's, RO's, or your edits, or 100 percent review. Enter the applicable category.

3. Completing the OPT Edits Report (Exhibit II) With 100 Percent Medical Review.—

Item 1 through Item 6 - See subpart 2.

Item 7 - Total Number Bills to Pass Edits - Enter 0.

Item 8 - Charges for Bills Passing Edits - Enter 0.

Item 9 - Total Number Bills Suspended - Enter the number of OPT bills reviewed.

Item 10 - Charges for Bills Suspended - Enter the sum of all OPT charges for all bills reviewed.

Item 11 - Total Number Bills Paid - Enter all OPT bills which were subjected to MR and subsequently paid.

Item 12 - Total Number of Bills Denied - Enter the number of OPT bills denied (including partial denials) after MR.

Item 13 - Charges Denied - Enter the dollar amount (charges) denied after MR.

Item 14 - Review - Based upon HCFA's, RO's, or your edits, or 100 percent review. Enter the applicable category.

NOTE: If you peform 100 percent review, skip the following items.

4. Completing of Items 15-18 of the OPT Screens Report (Exhibit II).—

Item 15 - Number Sample Bills Reviewed - Enter the number of OPT bills selected for sample review from the bills passing the edits.

Item 16 - Charges for Sample Bills Reviewed - Enter the dollar amount (sum of the charges) on the OPT bills selected.

Item 17 - Number Sample Bills Denied - Enter the number of OPT bills denied after MR.

Item 18 - Charges for Sample Bills Denied - Enter the dollar amount (sum of the charges) denied following MR.

EXHIBIT I
OUTPATIENT PHYSICAL THERAPY EDITS

The following edits are not based on normative treatment. It is prohibited to deny a bill solely on the basis that it exceeds the edits. The edits are for selecting bills for Level II MR.

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
1.	CA (category A)	162.0-163.9	7	1
	CA (category B)	165.0-165.9	24	2
		170.0-172.9		
		174.0-174.9		
		191.0-192.9		
		195.3-195.8		
		201.0-201.9		
		225.0-225.9		
		238.0-238.1		
		239.6		
2.	Parkinson's Disease	332.0-332.1	13	1
3.	Meningitis/Encephalitis	320.0-323.9	16	2
	Intracranial and intraspinal abcess	324.0-324.9		
	Huntington's Chorea and other choreas	333.4-333.7		
	Spinocerebellar disease	334.0-334.9		
	ALS and other motor neuron diseases	335.2-335.9		
	Other diseases of the spinal cord	336.0-336.9		
	Multiple Sclerosis	340		
	Demyelinating Diseases of CNS	341.8-341.9		
	Hemiplegia (old)	342.0-342.9		
	Paralytic syndrome	344.0-344.9		
	Late effects of CVA	438		
4.	Cerebral hemorrhage, occlusion, stenosis	430-434.9	32	3
	CVA, acute	436		
	Concussion, Loss of consciousness without return to previous level	850.4		
	Intracranial injury including those with skull Fx	800.7-800.8		
		801.7-801.8		
		803.2-803.3		
		803.7-803.8		
		804.7-804.8		

Exhibit 1 (Cont.)

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
5.	T.I.A.	435.0	7	1
	Other ill defined cerebrovascular diseases	437.0-437.9		
	Late effects of viral encephalitis	139.0		
6.	Other paralytic syndromes, paraplegia quadriplegia	344.0-344.9	39	3
	FX of vertebral column with spinal cord injury	806.0-806.5 806.8-806.9		
	Spinal cord injury	952.0-952.9		
7.	Post-herpetic polyneuropathy	053.13	19	2
	Neurosyphilis	094.0-094.9		
	Late effects polio	138		
	Diabetes with neurological manifest	250.6		
	Bell's palsy	351.0		
	Disorders of peripheral nerves	353.0-359.9		
	Other peripheral nerve injuries	953.0-957.9		
8.	Diabetes with peripheral circulatory disorders	250.7	13	1
	Diseases of circulatory system	402.0-429.9		
	Raynaud's/Buerger's/PVD	443.0-443.9		
	Thrombophlebitis lower extremity	451.0-451.2		
	Lymphedema	457.0-457.9		
9.	Hansen's Disease	030.0-030.9	29	2
	Gas gangrene	040.0		
	Diabetes with ulcer manifestation	250.8		
	Varicose vein with ulcer	454.0-454.2		
	Cellulitis	681.0-682.9		

Exhibit 1 (Cont.)

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
	Other local infection of skin	686.0-686.9		
	Chronic ulcer of skin	707.0-707.9		
	Gangrene	785.4		
	Open wounds	875.0-884.2		
		890.0-894.2		
	Burns (second degree)	941.2		
		942.2		
		943.2		
		944.2		
		945.2		
		946.2		
		949.2		
	Post traumatic wound infection	958.3		
	Infection of stump	997.62		
10.	Tuberculosis respiratory	010.0-012.8	7	1
	Acute Bronchitis	466.0-466.1		
	Bronchopneumonia	480.0-486		
	Bronchitis, emphysema	491.0-492.8		
	Asthma, unspecified	493.9		
	Bronchiectasis	494		
	Chronic airway obstruction	496		
11.	Diffuse disease of connective tissue	710.0-710.9	18	2
	Arthropathy associated with infection	711.0-711.9		
	Arthropathy associated with other disorders	713.0-713.8		
	Rheumatoid arthritis and inflamatory polyarthropathies	714.0-714.9		
	Gouty arthopathy	274.0		
12.	Osteoarthrosis and allied disorders	715.0-716.9	13	1
13.	T.M.J. disorders	524.6	13	1
	Internal derangement of joint, other derangement of joint and other unspecified disorders of joint	717.0-719.9		

Exhibit 1 (Cont.)

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
14.	Dorsopathies	720.0-724.9	13	1
	Osteoporosis	733.0		
	Pathological Fx	733.1		
	Aquired spondylolisthesis	738.4-738.5		
	Anomalies of spine	756.10-756.12		
15.	Peripheral enthesopathies and allied syndromes disorders of muscles, tendons and their attachments and other soft tissues	725-729.9 (excluding 727.1 and 727.4)	13	1
16.	Gait disturbances due to weakness, incoordination debility and/or after surgery or Fx	780.7 739.6 781.2 799.3 V66.4	13	1
17.	Fx of vertebral column without cord injury	805.0-805.9	14	1
	Late effects of Fx spine	905.1		
18.	Fx of pelvis	808.0-808.9	18	2
	Fx of femur	820.0-821.39		
19.	Fx of patella	822.0-822.1	18	2
	Fx of tibia and fibula	823.0-823.9		
	Fx of ankle, tarsals, metatarsals	824.0-825.39 827.0-827.1		
20.	Fx of humerus	811.0-819.1	18	2
	Fx of radius and ulna			
	Fx of carpals			
	Fx of metacarpals and phalanges			
	Fx of radius and ulna			

Exhibit 1 (Cont.)

Edit Identification Number	Diagnosis	ICD-9-CM	Number of Visits	Duration (MO.)
21.	Dislocations	830.0-839.9	18	2
	Crushing injury	927.0-929.9		
22.	Sprains and strains	840.0-848.9	13	1
	Late effects of strains, sprains, dislocations	905.6-905.7		
	Contusions	922.0-924.9		
	Injury, other unspecified	959.1-959.9		
23.	Amputation	885.0-887.7 896.0-897.7	32	3
24.	Burns (3rd and 4th degree)	941.3-941.5 942.3-942.5 943.3-943.5 944.3-944.5 945.3-945.5 946.3-946.5 949.3-949.5	32	3
25.	Joint replacement	V43.6	19	2
26.	Fitting and adjustment of prosthetic care	V52.0-52.1	13	1
	Removal internal fixation device	V54.0		
	Orthopedic aftercare	V54.8-V54.9		
	Late effects FX	905.1-905.5		
	Late effects tendon injury	905.8		
	Late effects amputation	905.9		

Exhibit IV

Report of Outpatient Physical Therapy Bills

FI # (1) ______ FI Contact (3) ______ Reporting Qtr (5) ______

FI name (2) ______ Telephone No (4) ______ Date of Completion (6) ______

For all bills processed, fill in Items 7-13.

7 Total # Bills to Pass Screens	8 Charges for Bills Passing Screens	9 Total # Bills Suspended	10 Charges for Bills Suspended	11 Total # Bills Paid	12 Total # Bills Denied	13 Charges Denied

14. Review based on: ______________________________

For sample (of bills passing screens) review, fill in Items 15-18.

15 #Sample Bills Reviewed	16 Charges for Sample Bills Reviewed	17 #Sample Bills Denied	18 Charges for Sample Bills Denied

3905. MEDICAL REVIEW (MR) OF PART B INTERMEDIARY OUTPATIENT SPEECH-LANGUAGE PATHOLOGY (SLP) BILLS

A. Claims Documentation.—Medically review each claim referred to Level II or III for outpatient speech-language (SLP) services, regardless of setting. All information must be readable. If possible, use speech-language pathologists to review SLP claims. Obtain the following required information from the provider:

o Facility and Patient Identification - (Facility name, provider number, patient name, HICN, age.)

o Physician Referral and Date.

o Date of Last Certification - Obtain the date on which the plan of treatment for SLP was last certified by the physician.

o Diagnosis - The primary medical diagnosis for which services are rendered must be listed first; other diagnoses applicable to the patient or that influence care follow.

o Communication Disorder Diagnosis.

o Duration - The total length of time services have been rendered (in days) from the date they were initiated for the diagnosis being treated at the billing provider (including the last day in the current billing period).

o Number of Visits - The total number of patient visits completed since services were initiated for the communication disorder diagnosis being treated by the billing provider. The total visits to date (including the last visit in the billing period) must be given rather than for each separate billing.

o Date of Onset - (Occurrence Code 11) - The date of onset or exacerbation of the communication disorder diagnosis for which services were rendered by the billing provider.

o Date Treatment Started - (Occurrence Code 35) - The date services were initiated by the billing provider for the communication disorder diagnosis.

o Billing Period - When services began and ended in the billing period (from-through dates).

o Medical History - Obtain only the medical history which is pertinent to, or influences, the treatments or tests rendered. Include a brief description of the functional status of the patient prior to the onset of the condition requiring services and any pertinent prior treatment.

o Initial Assessment and Date - (At the billing period.)

- Plan of Treatment and Date Established.

- Progress Notes - Obtain updated patient status reports concerning the patient's current functional communication abilities/limitations.

1. Medical History.—If a history of previous SLP treatment is not available, the provider may provide a general summary regarding the patient's past relevent medical history recorded during the initial assessment with the patient/family (if reliable) or through contact with the referring physician. Information regarding prior treatment for the current condition, progress made, and treatment by the referring physician must be provided when available. The level of function prior to the current exacerbation or onset should be described.

The patient's medical history includes the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is necessary for patients who have transferred to a new provider for additional treatment. For chronic conditions, the history gives the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled care.

2. Assessment.—Approve initial assessment when it is reasonable and necessary for the speech-language pathologist to determine if there is an expectation that either restorative services or establishment of a maintenance program will be appropriate for the patient's condition.

Reassessments are covered if the patient exhibits a demonstrable change in motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicted SLP services. Periodic routine reevaluations (e.g., monthly, bimonthly) for a patient undergoing a SLP program are part of the treatment session and are not covered as separate evaluations. An initial assessment or reassessment that is determined reasonable and necessary based on the patient's condition, may be approved even though the expectations are not realized, or when the assessment determines that skilled services are not needed.

The assessment establishes the baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring communication status at periodic intervals.

The initial assessment must include objective baseline diagnostic testing (standardized or nonstandardized), interpretation of test results, and clinical findings. If baseline testing cannot be accomplished for any reason, this should be noted in the initial assessment or progress notes along with the reason(s). The assessment must include a statement of the patient's expected rehabilitation potential.

3. Plan of Treatment.--The plan of treatment must contain the following:

- Type and nature of care to be provided;
- Functional goals and estimated rehabilitation potential;
- Treatment objectives;
- Frequency of visits; and
- Estimated duration of treatment.

a. Functional Goals.—Must be written by the speech-language pathologist to reflect the level of communicative independence the patient is expected to achieve outside of the therapeutic environment. The functional goals reflect the final level the patient is expected to achieve, are realistic, and have a positive effect on the quality of the patient's everyday functions.

Assume that certain factors may change or influence the final level of achievement. If this occurs, the speech-language pathologist explains the factors which led to the change of the functional goal. Examples of functional communication goals in achieving optimum communication independence are the ability to:

- Communicate basic physical needs and emotional status.

- Communicate personal self-care needs.

- Engage in social communicative interaction with immediate family or friends.

- Carry out communicative interactions in the community.

NOTE: The term "communication" includes speech, language, as well as voice skills.

A functional goal may reflect a small, but meaningful change which enables the patient to function more independently in a reasonable amount of time. For some patients it may be the ability to give a consistent, functional "yes" and "no" response; for others it may be the ability to demonstrate a competency in naming objects using auditory/verbal cues. Others may receptively and expressively use a basic spoken vocabulary and/or short phases; and still others may regain conversational language skills.

b. Treatment Objectives--Specific steps designed to reach a functional goal. When the patient achieves these objectives, the functional goal is met.

c. Frequency of Visits—An estimate of the frequency of treatment to be rendered (e.g., 3x week).

Length of visits are typically 30, 45, or 60 minutes. Sometimes patients are seen for shorter periods several times a day (for example, three 10 minute sessions or a total of 30 minutes.) Rarely, except during an assessment, are session lengths longer than 60 minutes. If longer times are used, the provider must justify them, by noting that e.g., the patient is exceptionally alert, the number of appropriate activities needing skilled intervention is greater than average, special staff/family training is required. Intensive treatment is sometimes required post-operatively (e.g., tracheoesophageal puncture) or post-onset of disorder (due to intensive family involvement).

d. Estimated Duration of Treatment—Identifies the total estimated time over which the services are to be rendered and may be expressed in days, weeks, or months.

4. Progress Reports (Treatment Summary for Billing Period).--Obtain the following:

- The initial functional communication status of the patient at this provider setting;
- The present functional status of the patient and progress (or lack of progress) specific for this reporting period;
- The patient's expected rehabilitation potential; and
- Changes in the plan of treatment.

Where a valid expectation of improvement existed at the time services were initiated, or thereafter, the services are covered even though the expectation may not be realized. However, in such instances, approve the services only to the time that no further significant practical improvement can be expected. Progress reports must document a continued expectation that the patient's condition will improve significantly in a reasonable and generally predictable period of time.

"Significant," means a generally measurable and substantial increase in the patient's present level of communication, independence, and competence compared to their levels when treatment was initiated. Do not interpret the term "significant" so stringently that you may deny a claim because of a temporary setback in the patient's progress. For example, a patient may experience a new intervening medical complication or a brief period when lack of progress occurs. The medical reviewer may approve the claim if there is still a reasonable expectation that significant improvement in the patient's overall functional ability will occur. However, the speech-language pathologist and/or physician should document such lack of progress and explain the need for continued intervention.

Documentation includes a short narrative progress report and objective information in a clear, concise manner. This provides you the progress in meeting the plan of treatment, along with any changes in the goals or the treatment plan. Request new plans attached to the original so that you can review the entire plan. However, you must have access to an overall treatment plan with final goals and enough objective information with each claim to determine progress toward meeting the goals.

Consistent reporting is important. For example, if the provider reports that the patient can produce an "m" 25 percent of the time, then reports 40, 60, 90 percent success, you may believe that treatment might be ending. However, if you have the final goal and the objectives, you can see the progress toward that goal and the steps needed to reach it. The speech-language pathologist might state that the final goal is "the ability to converse in a limited environment." One underlying SLP goal might be to "reduce the apraxia sufficiently so the patient can initiate short intelligible phrases with a minimum of errors." Short-term goals may include the patient's ability to initiate easier phonemes before other, more difficult, phonemes. Therefore, the speech-language pathologist has a linguistically and neurologically sound basis for working on one phoneme production before initiating another.

The speech-language pathologist might work on a group of phonemes having a "feature" in common before working on another group. For example, working on all bilabials (since the patient can easily see the movement), might be desirable prior to sounds that are produced more intraorally.

The speech-language pathologist may choose how to demonstrate progress. However, the method chosen, as well as the measures used, generally remain the same for the duration of treatment. The provider must interpret reports of test scores, or comparable measures and their relationship to functional goals, in progress notes or reports. Diagnostic testing should be appropriate to the communication disorder.

While a patient is receiving SLP treatment, the speech-language pathologist reassesses the patient's condition and adjusts the treatment. However, if the method used to document progress is changed, the reasons must be documented, including how the new method relates to the previous method. If the speech-language pathologist reports a subtest score for one month, then a score of a different subtest the next month without demonstrating the subtest's interrelationship, you are not able to judge the progress. Return these claims for an explanation/interpretation. Refer to Level III MR if needed.

5. Level of Complexity of Treatment.--Base decisions on the level of complexity of the services rendered by the speech-language pathologist, not what the patient is asked to do. For example, the patient may be asked to repeat a word and the speech-language pathologist analyzes the response and gives the patient feedback that the patient uses to modify the response. The speech-language pathologist may ask staff or family to repeat the activity as a reinforcement. It is the speech-language pathologist's analysis that makes the activity skilled.

6. Reporting on New Episode or Condition.--Occasionally, a patient who is receiving or who has previously received SLP services, experiences a secondary or complicating new illness. The provider documents the signficance of any change to the communication capabilities. This may be by pre and post episodic objective documentation, through nursing notes or by physician reports. If the patient is receiving treatment, it might have to be lengthened because of his change in condition. If the patient has completed treatment, a significant change in the communication status must be documented to warrant a new treatment plan.

7. Qualified Speech-Language Pathologist.—

- A person who is licensed, if applicable, by the State in which he/she is practicing, and

- Is eligible for a certificate of clinical competence in SLP granted by the American Speech·Language·Hearing Association, or:

  — Meets the educational requirements for certification, and is in the process of accumulating the supervised experience required for certification.

- The speech-language pathologist normally indicates certification status by utilizing CCC-SLP or CFY-SLP:

  — CCC-SLP - Certificate of Clinical Competence in SLP; or
  — CFY-SLP - Clinical Fellowship Year in Speech-Language Pathology.

8. Certification and Recertification.—SLP services must be certified and recertified by a physician and furnished while under the care of a physician. They must be furnished under a written plan of treatment established by the physician or a qualified speech-language pathologist providing such services. If the plan is established by a speech-language pathologist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or the provider when it makes a written record of the oral orders) before treatment is begun. When outpatient SLP services are continued under the same plan of treatment for a period of time, the physician must certify at intervals of at least every 30 days that there is a continuing need for them. Obtain the recertification when reviewing the plan of treatment since the same interval of at least 30 days is required for the review of the plans. Recertification must be signed by the physician who reviewed the plan of treatment. Any changes established by the speech-language pathologist must be in writing and signed by the speech-language pathologist or by the attending physician. The physician may change a plan of treatment established by the speech-language pathologist. The speech-language pathologist may not alter a plan of treatment established by a physician.

B. Examples of Skilled and Unskilled Procedures.—

1. Skilled Procedures.—

- Diagnostic and assessment services to ascertain the type, causal factor(s) and severity of speech and language disorders. Reassessment if the patient exhibits a change in functional speech or motivation, clearing of confusion, or remission of some other medical condition which previously contraindicated SLP or audiology services.

o Design of a treatment program relevant to the patient's disorder(s). Continued assessment of progress during the implementation of the treatment program, including documentation and professional analysis of the patient's status at regular intervals.

o Establishment of compensatory skills (e.g., air-injection techniques, word finding strategies).

o Establishment of a hierarchy of speech-language tasks and cueing that directs a patient toward communication goals.

o Analysis related to actual progress toward goals.

o Patient and family training to augment restorative treatment or to establish a maintenance program.

2. Unskilled Procedures.—

o Nondiagnostic/nontherapeutic routine, repetitive and reinforced procedures (e.g., the practicing of word drills without skilled feedback).

o Procedures which are repetitive and/or that reinforce previously learned material which the patient or family is instructed to repeat.

o Procedures which may be effectively carried out with the patient by any nonprofessional (e.g., family member, restorative nursing aide) after instruction and training is completed.

o Provision of practice for use of augmentative or alternative assessment communication systems.

NOTE: It is only after the patient has established a high level of consistency of performance in a task with the speech-language pathologist, that unskilled techniques can be implemented.

C. Examples of Statements Supporting and Not Supporting Coverage.—

1. Statements Supporting Coverage.—Typically, these statements have an objective component which is compared to previous reports, and which demonstrate progress toward a stated functional goal.

EXAMPLES: "Mr. Smith achieved 75 on the Word Subtest on the Johnson Test of Aphasia compared with last month's score of 50 on the same Subtest."

"Mr. Jones achieved a combined score of 352 on the A, B, C, D, and E, subtests this month compared with an overall score of 250 for these same subtests last month."

"Mrs. Jones achieved the next steps in the treatment plan outlined last month (see attached sheet). If she continues at this rate she should complete treatment within the next 2 months."

"Mrs. Jones achieved 75% (7.5 out of 10 or 75 out of 100) on word naming which compares to last month's score of 50% (5.0 out of 10 or 50 out of 100)."

NOTE: Percent should be based on real number count. Interpretation of scores must be presented in progress notes or summary information. The narrative should also contain reference to objective scoring, comparison of previous scores, or treatment plan with present status compared to previous status. This information may be embedded in narrative or attached, however, the reviewer should have access to this information and stated functional goals.

2. Statements Not Supporting Coverage.—Typically, these statements are subjective, and do not demonstrate progress toward a stated functional goal, or a comparison to previous test scores.

EXAMPLE: "Ms. Jones is very concerned about going home. She has begun smoking again which is causing family as well as physical problems."

"Speech somewhat slurred today."

"Mr. Smith more consistent in responses."

"Mr. Jones has shown significant improvement in his ability to make himself understood."

"Patient is now able to inject air 80% of the time." (No comparison to previous report.)

"Mrs. Smith achieved 75% accuracy on word naming task. (No comparison to previous report)."

"Auditory comprehension improved from moderately impaired to mildly impaired," (by itself, the statement does not offer sufficient objective information.)

D. Resumption of Treatment.—There are conditions and circumstances that justify resuming treatment after it has been delayed. Obtain verification (when needed for coverage decisions). Examples include:

- Patient becomes more alert, attentive, cooperative;
- Patient shows rehabilitation potential;
- Medical complications cleared;
- Environmental change improves motivation or communicative capabilities;
- Progressive nature of disorder warrants further treatment; and
- Drug or other medical treatment is reduced or ended.

3905.1 MR Considerations.--

A. Disorders Typically Not Covered for the Geriatric Patient.--

- Stuttering (except neurogenic stuttering caused by brain damage)

  Fluency Disorder
  Cluttering
  Disprosody
  Disfluency

- Myofunctional Disorders

  Tongue Thrust

- Behavioral/Psychological Speech Delay

B. Maintenance.--Approve claims only when the specialized knowledge and judgment of a qualified speech-language pathologist is required to design and establish a maintenance program. By the time the patient's restorative program has been completed, the maintenance program has already been designed, with instructions to patient, supportive personnel, or family. Do not approve a separate charge for establishing the maintenance program immediately after the restorative program has been completed.

Obtain documentation that justifies a provider reestablishing a maintenance program, e.g., loss in previous functional abilities occurs, intervening medical conditions develop, difficulty in communicating with caregivers arises.

The initial assessment should be documented with standardized testing (if possible) to establish base-line data. This is critical if a claim is submitted for care at a future date. Documentation should show that the maintenance program is designed by the speech-language pathologist appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician.

The maintenance program is established when documentation indicates it has been designed for the patient's level of function and instructions to the patient and supportive personnel have been completed for them to safely and effectively carry them out. The documentation must give reasonable assurances that this has occurred. After that point, the services are not reasonable and necessary.

C. Group Treatment.--Generally, group therapy treatment and attendance at social or support groups, such as stroke clubs or lost cord clubs, are not reimbursable. Ensure that the "reasonable and necessary" requirements are met.

D. Total Laryngectomy.--A total laryngectomy is the surgical removal of the larynx. Documentation may involve pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about alternative communication methods, and to provide an immediate means of communication. Documentation includes assessment and any treatment necessary to establish a means of communication using esophageal speech, an artifical larynx (electronic or pneumatic device), a trecheoesophageal puncture prosthesis, and/or other alternate communication methods.

E. Partial Laryngectomy.--A partial laryngectomy is the surgical removal of part of the larynx. Documentation includes the voice problems that require assessment and treatment. Documentation may involve pre-op/post-op sessions as part of the assessment, and to inform the patient, the family, and staff about voice problems. Documentation for rehabilitation also includes the assessment, type of treatment required for the voice disorders, and includes base-line objective data and progress notes.

F. Total Glossectomy.--Total glossectomy is the surgical removal of the tongue. Total glossectomy results in articulation problems that require assessment and may require treatment. Documentation may include pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication and/or to establish an effective maintenance program. Documentation includes assessment and type of treatment for the articulation disorders. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

G. Partial Glossectomy.--Partial glossectomy is the surgical removal of part of the tongue. Documentation should indicate the articulation problems that require assessment and treatment. Documentation may include pre-op/post-op sessions as part of the assessment, to inform the patient, the family, and staff about articulation disorders, and to provide an immediate means of communication following surgery. Documentation includes the assessment and type of treatment for the articulation disorders including base-line objective data and progress notes. Documentation for articulation treatment involves instruction of compensatory techniques and alternate communication methods if needed.

H. Congenital Disorders.--Documentation must always substantiate need, e.g., no previous treatment; the patient's communicative capabilities have recently deteriorated; new, special techniques or instruments have become available; or intervening medical complications have affected SLP communication. Approve claims for maintenance or short-term treatment only if objective documentation supports that need.

I. Alzheimer's Disease.--(Chronic brain syndrome, organic brain syndrome). Objective documentation must indicate the patients' condition, alertness and mental awareness. Documentation must justify that services are needed to establish a reasonable and necessary maintenance program. Review these claims carefully for medical necessity.

J. Chronic Conditions.--Claims for patients with chronic conditions such as MS, ALS, Parkinson's Disease or Myasthenia Gravis can be approved if they document a need for reasonable and necessary short-term care or a need to establish a maintenance program. However, clear documentation must be submitted concerning any prior care or maintenance program designed for the same condition. Approve claims for reasonable and necessary short-term intervention to improve oral and laryngeal strength, speech intelligibility, or vocal intensity, but only when the documentation supports the need to increase function, or to establish a maintenance program.

3905.2 Speech-Language Pathology Terms.--

Agnosia - Inability to attach meaning to sensory information although the physiologic receptor mechanism is intact.

Agrammatism - Impairment of the ability to produce words in their correct sequence; difficulty with grammar and syntax.

Agraphia - Disorder of writing. It may result from a central nervous system lesion or from lack of muscular coordination.

Anomia - Loss of the ability to identify or to recall and recognize names of persons, places or things.

Aphasia - Communication disorder caused by brain damage and characterized by complete or partial impairment of language comprehension, formulation, and use. It excludes disorders associated with primary sensory deficits, general mental deterioration, or psychiatric disorders. Partial impairment is often referred to as dysphasia.

Aphonia - Loss of voice.

Apraxia - (1) Disruption in the ability to transmit a motor response along a specific modality; involves disruption of voluntary or purposeful programming of muscular movememts while involuntary movements remain intact; characterized by difficulty in articulation of speech, formulation of letters in writing, or in movements of gesture and pantomime. (2) In speech, a nonlinguistic sensorimotor disorder of articulation characterized by impaired capacity to program the position of speech musculature and the sequencing of muscle movements (respiratory, laryngeal, and oral) for the volitional production of phonemes.

Dysarthria - Term for a collection of motor speech disorders due to impairment originating in the central or peripheral nervous system. Respiration, articulation, phonation, resonation, and/or prosody may be affected; volitional and automatic actions, such as chewing and swallowing, and movements of the jaw and tongue may also be deviant. It excludes apraxia and functional or central language disorders.

Dysphagia - Difficulty in swallowing. It may include inflammation, compression, paralysis, weakness, or hypertonicity of the esophagus.

Generalization - (1) In conditioning, the eliciting of a conditioned response by stimuli similar to a particular conditioned stimulus. (2) Transfer of learning from one environment to a similar environment; the more similar the environments or situations, the more transfer takes place.

Hard Glottal Attack - Forceful approximation of the vocal folds during the initiation of phonation.

Intonation - Linguistic system within a language which is concerned with pitch, stress, and juncture of the spoken language; a unit with specific communicative import, such as interrogation, exclamation, and assertion.

Lexicon - Total accumulation of linguistic signs, words or morphemes, or both, in a given language; the list of all the words in a language.

Morphology - Component of grammar concerned with the formation of words, the smallest meaningful unit in a language, as a bridge between phonology and syntax.

Obturator - (1) Any structure which occludes an opening. (2) Prosthetic appliance, similar to a dental plate, that forms an artificial palate to cover a cleft palate, designed so that the musculature of the palate and pharynx are able to contract around it.

Paraphasia - Any error of commission modifying a specific word (sound and morpheme substitution) or of word substitution in the spoken or written production of a speaker or writer.

Perseveration - Tendency to continue an activity, motor or mental, once started, and to be unable to modify or stop even though it is acknowledged to have become inappropriate.

Phoneme - Shortest arbitrary unit of sound in a given language that can be recognized as being distinct from other sounds in the language.

Phonological - Component of grammar determining the meaningful combination of sounds.

Pitch - Acuteness or gravity of a tone, dependent upon the frequency of the vibrations producing it and their intensity and overtone structure. The greater the number of vibrations per unit of time, the higher the pitch and the more acute the tone.

Pragmatics - Functional use of language in context. It includes such factors as intention in communication; sensorimotor actions preceding, accompanying, and following the utterance; knowledge shared in the communicative dyad; and the elements in the environment surrounding the message.

Prosody - (1) Physical attributes of speech that signal linguistic qualities such as stress and intonation. It includes the fundamental frequency intensity of the voice, and the duration of the individual speech sounds. (2) Melody of speech determined primarily by modifications of pitch, quality, strength, and duration; perceived primarily as stress and intonational patterns.

Psychoacoustics - Combined disciplines of psychology and acoustics concerned with the study of man's response to sound.

Semantic - Component of grammar concerned with word meanings and meaningful sentences.

Syntactic - Component of grammar concerned with grammatically well formed structures.

3905.3 Acronyms and Abbreviations.—

ADL - Activities of Daily Living.

ALPS - Aphasia Language Performance Scales.

ASHA - American-Speech-Language-Hearing Association.

ASL - American Sign Language.

CVC - Consonant-vowel-consonant.

CPS - Cycles per second. Former unit of measurement for the number of successive compressions and rarefactions of a sound wave within one second of time, now replaced with Hertz (Hz).

Dx - Diagnostic therapy.

MLU - Mean Length of Utterance - Average length of oral expressions as measured by a representative sampling of oral language. It is usually obtained by counting the number of morphemes per utterance and dividing by the number of utterances.

VOT - Voice Onset Time - (1) Time between the release of the stop consonant and the beginning of voicing in the vowel. (2) Time required to initiate sound at the vocal folds.

3905.4 Speech-Language Pathology Tests.—Include but are not limited to:

A. Widely Used Adult Language Tests.—

Ammons Full Range Picture Vocabulary Test
Aphasia Clinical Battery I
Aphasia Language Performance Scales (ALPS)
Appraisal of Language Disturbances (ALD)
Boston Diagnostic Aphasia Examination (BDAE)
Communicative Abilities in Daily Living (CADL)
Examining for Aphasia
Functional Communication Profile
International Test for Aphasia
Language Modalities Test for Aphasia
Language Proficiency Test (LPT)

Minnesota Test for Differential Diagnosis of Aphasia
Porch Index of Communicative Abilities (PICA)
Revised Token Test
Sklar Aphasia Scale
Token Test for Receptive Disturbances in Aphasia
Hodson Phonological Process Analysis
Clinical Evaluation of Language Functions (CELF)
Western Aphasia Battery

B. Widely Used Adult Articulation Tests.—

Apraxia Battery for Adults (ABA)
Assessment of Intelligibility of Dysarthric Speech
Compton-Hutton Phonological Assessment
Frenchay Dysarthria Test
The Fisher-Logemann Test of Articulation Competence
Iowa Pressure Articulation Test
Templin Darley Test of Articulation

C. Speech and Language Diagnostic Tests.--It is required that an initial assessment (including diagnostic testing, if clinically possible) be performed prior to the commencement of treatment. If you need assistance in understanding tests used, consult your speech-language pathologist consultant or the American·Speech·Language·Association.

3906. MEDICAL REVIEW (MR) OF PART B INTERMEDIARY OUTPATIENT OCCUPATIONAL THERAPY (OT) BILLS

These guidelines assist the reviewer in understanding the field of OT as well as facilitate the MR process. They are flexible and neither guarantee a minimum amount of coverage nor establish a maximum coverage amount. They do not cover all situations. They are intended to use in conjunction with §3100 and the knowledge of medical and occupational therapy consultants. If possible, have occupational therapists review OT bills.

Medically review all outpatient OT claims referred to Level II or III, regardless of the setting.

Claims Documentation - medically review each claim referred to Level II or III for outpatient OT services to make a coverage determination. The following provider documentation is required:

o Facility and Patient Identification - (Facility name, patient's name, provider number, HICN, age).

o Physician Referral and Date.

o Date of Last Certification - The date on which the plan of treatment was last certified by the physician.

o Diagnosis - The primary diagnosis for which OT services were rendered is listed first; other diagnoses applicable to the patient or that influence care follow.

o Duration - The length of time OT services have been rendered (in days) from the date services were initiated for the diagnosis at the billing provider (including the last day in the current billing period).

o Number of Visits - The number of patient visits completed since OT services were initiated by the billing provider for the diagnosis being treated. The total visits to date (including the last visit in the billing period) is given rather than for each separate billing.

o Date of Onset (Occurrence Code 11) - The date of onset of the primary OT diagnosis for which OT services were rendered by the billing provider.

o Date Treatment Started (Occurrence Code 35) - The date OT services were initiated by the billing provider for the primary OT diagnosis being treated.

- Billing Period - When OT services began and ended in the billing period (from-through dates).

- Medical History - The provider submits the medical history pertinent to, or which influences, the OT treatment, including a brief description of the functional status of the patient prior to the onset of the condition requiring OT and pertinent prior OT treatment.

- OT Initial Evaluation and Date. (At the billing provider.)

- Plan of Treatment and Date Established.

- OT Progress Notes - The provider supplies updated status reports concerning the patient's current functional abilities/limitations.

1. Medical History.--If a history of previous OT treatment is not available, the provider provides a general summary regarding the patient's past relevent medical history recorded during the initial evaluation with the patient/family or through contact with the referring physician. Information regarding prior OT treatment for the current condition, progress made, and treatment by the referring physician is provided when available. The level of function prior to the current exacerbation or onset is described.

The patient's medical history, as it relates to OT, includes the date of onset and/or exacerbation of the illness or injury. If the patient has had prior therapy for the same condition, use that history in conjunction with the patient's current assessment to establish whether additional treatment is reasonable.

The history of treatments from a previous provider is necessary for patients who have transferred to a new provider. For example, if surgery has been performed, obtain the type and date. The date of onset and type of surgical procedure should be specific for diagnoses such as fractures. For other diagnoses, such as arthritis, the date of onset may be general. Establish it from the date the patient first required medical treatment. For other types of chronic diagnoses, the history gives the date of the change or deterioration in the patient's condition and a description of the changes that necessitate skilled OT.

2. Evaluation.--Approve an OT initial evaluation, (excluding routine screening) when it is reasonable and necessary for the therapist to determine if there is an expectation that either restorative or maintenance services are appropriate. Approve reevaluations when the patient exhibits a demonstrable change in physical functional ability, to reestablish appropriate treatment goals, or when required for ongoing assessment of the patient's rehabilitation needs. Approve initial evaluations or reevaluations that are reasonable and necessary based on the patient's condition, even though the expectations are not realized, or when the evaluation determines that skilled rehabilitation is not needed.

The OT evaluation establishes the physical and cognitive baseline data necessary for assessing expected rehabilitation potential, setting realistic goals, and measuring progress. The evaluation of the patient's functional deficits and level of assistance needed forms the basis for the OT treatment goals. Objective tests and measurements are used (when possible) to establish base-line data.

The provider documents the patient's functional loss and the level of assistance requiring skilled OT intervention resulting from conditions such as:

o Activities of Daily Living (ADL) Dependence - The individual is dependent upon skilled intervention for performance of activities of daily living. These include, but are not limited to, signficant physical and/or cognitive functional loss, or loss of previous functional gains in the ability to:

- Feed, eat, drink;
- Bathe;
- Dress;
- Perform personal hygiene;
- Groom; or
- Perform toileting.

This could include management and care of orthoses and/or other adaptive equipment, or other customized therapeutic adaptations.

o Functional Limitation - The individual is dependent upon skilled OT intervention in functional training, observation, assessment, and environmental adaptation due to, but not limited to:

- Lack of awareness of sensory cues, or safety hazards;
- Impaired attention span;
- Impaired strength;
- Incoordination;
- Abnormal muscle tone;
- Range of motion limitations;
- Impaired body scheme;
- Perceptual deficits;
- Impaired balance/head control; and
- Environmental barriers.

o Safety Dependence/Secondary Complications - A safety problem exists when a patient, without skilled OT intervention, cannot handle him/herself in a manner that is physically and/or cognitively safe. This may extend to daily living or to acquired secondary complications which could potentially intensify medical sequelae such as fracture nonunion, or skin breakdown. Safety dependence may be demonstrated by high probability of falling, lack of environmental safety awareness, swallowing difficulties, abnormal agressive/destructive behavior, severe pain, loss of skin sensation, progressive joint contracture, and joint protection/preservation requiring skilled OT intervention to protect the patient from further medical complication.

If the goal for the patient is to increase functional abilities and decrease the level of assistance needed, the initial evaluation must measure the patient's starting functional abilities and level of assistance required.

3. Plan of Treatment.--The OT plan of treatment must include specific functional goals and a reasonable estimate of when they will be reached (e.g., 6 weeks). It is not adequate to estimate "1 to 2 months on an ongoing basis." The plan must include specific OT procedures, frequency, and duration of treatment. The provider submits changes in the plan with the progress notes.

The plan of treatment contains:

o Type of OT Procedures - Describes the specific nature of the therapy to be provided.

o Frequency of Visits - An estimate of the frequency of treatment to be rendered (e.g., 3x week).

The provider's medical documentation should justify the intensity of services rendered. This is crucial when the treatments are given more frequently than 3 times a week.

o Estimated Duration - Identifies the length of time over which the services are to be rendered. It may be expressed in days, weeks, or months.

o Diagnoses - Includes the OT diagnosis if different from the medical diagnosis. The OT diagnosis should be based on objective tests, whenever possible.

o Functional OT Goals (short or long-term) - Reflects the occupational therapist's and/or physician's description of what functional physical/cognitive abilities the patient is expected to achieve.

Assume that certain factors may change or influence the level of achievement. If this occurs, the occupational therapist explains the factors which led to the change in functional goal(s).

o Rehabilitation Potential - The occupational therapist's and/or physician's expectation concerning the patient's ability to meet the established goals.

4. Progress Reports (Treatment Summary for Billing Period).—The provider documents and reports:

o The initial functional status of the patient;

o The patient's functional status and progress (or lack of progress) specific for this reporting period; including clinical findings (amount of physical and/or cognitive assistance needed, range of motion, muscle strength, unaffected limb measurements, etc.); and

o The patient's expected rehabilitation potential.

Where a valid expectation of improvement exists at the time OT services are initiated, or thereafter, the services are covered even though the expectation may not be realized. However, in such instances, the OT services are covered only to the time that no further significant practical improvement can be expected. Progress reports or status summaries must document a continued expectation that the patient's condition will continue to improve significantly in a reasonable and generally predictable period of time.

"Significant," means a generally measurable and substantial increase in the patient's present level of functional independence and competence, compared to that when treatment was initiated. Do not interpret the term "significant" so stringently that you deny a claim simply because of a temporary setback in the patient's progress. For example, a patient may experience an intervening medical complication or a brief period when lack of progress occurs. The medical reviewer may approve the claim if there is still a reasonable expectation that significant improvement in the patient's overall safety or functional ability will occur. However, the provider should document such lack of progress and briefly explain the need for continued skilled OT intervention.

The provider must provide treatment information regarding the status of the patient during the billing period. The provider's progress notes and any needed reevaluation(s) must update the baseline information provided at the initial evaluation. If there is a change in the plan of treatment, it must be documented. Additionally, when a patient is continued from one billing period to another, the progress report(s) must reflect the comparisons between the patient's current functional status and that during the previous billing and/or initial evaluation.

Conduct MR of claims with an understanding that skilled intervention may be needed, and improvement in a patient's condition may occur, even where a patient's full or partial recovery is not possible. For example, a terminally ill patient may begin to exhibit ADL, mobility and/or safety dependence requiring OT services. The fact that full or partial recovery is not possible or rehabilitation potential is not present, does not affect MR coverage decisions. The deciding factor is whether the services are considered reasonable, effective, treatment for the patient's condition and they require the skills of an occupational therapist, or whether they can be safely and effectively carried out by nonskilled personnel, without the occupational therapist's supervision. The reasons for OT must be clear to you, as well as their goals, prior to a favorable coverage determination. They often require review at Level III.

It is essential that the provider documents the updated status in a clear, concise, and objective manner. Objective tests and measurements are stressed when these are practical. The occupational therapist selects the appropriate method to demonstrate current patient status. However, the method chosen, as well as the measures used, should be consistent during the treatment duration. If the method used to demonstrate progress is changed, the reasons for the change should be documented, including how the new method relates to the old. You must have an overview of the purpose of treatment goals in order to compare the patient's current functional status to that in previous reporting periods.

Documentation of the patient's current functional status and level of assistance required compared to previous reporting period(s) is of paramount importance. The deficits in functional ability should be clear. Occupational therapists must document functional improvements (or lack thereof) as a result of their treatments. Documentation of functional progress must be stated whenever possible in objective, measurable terms. The following illustrates these principles and demonstrates that significant changes may occur in one or more of these assistance levels:

a. Change in Level of Assistance.--Occupational therapist's document assistance levels by describing the relationship between functional activities and the need for assistance. Within the assistance levels of minimum, moderate, and maximum, there are intermediate gradations of improvement based on changes in behavior and response to assistance. Improvements at each level must be documented. Documentation should compare the current cognitive and physicial level achieved to that achieved previously. While the need for cognitive assistance often is the more severe and persistent disability, the requirement of physical assistance often is the major obstacle to successful outcomes and subsequent discharge. Interpret the levels as follows:

o Total Assistance is the need for 100 percent assistance by one or more persons to perform all physical activities and/or cognitive assistance to elicit a functional response to an external stimulation.

A patient requires total assistance if the documentation indicates the patient is only able to initiate minimal voluntary motor actions and requires the skill of an occupational therapist to develop a therapeutic program or implement a maintenance program to prevent or minimize deterioration.

A cognitively impaired patient requires total assistance when documentation shows external stimuli are required to elicit automatic actions such as swallowing or responding to auditory stimuli. Skills of an occupational therapist are needed to identify and apply strategies for eliciting appropriate, consistent automatic responses to external stimuli.

o Maximum Assistance is the need for 75 percent assistance by one person to physicially perform any part of a functional activity and/or cognitive assistance to perform gross motor actions in response to direction.

A patient requires maximum assistance if maximum OT physical support and proprioceptive stimulation is needed for performance of each step of a functional activity, every time it is performed.

A cognitively impaired patient, at this level, may need proprioceptive stimulation and/or one-to-one demonstration by the occupational therapist due to the patient's lack of cognitive awareness of other people or objects in the environment.

o Moderate Assistance is the need for 50 percent assistance by one person to perform physical activities or constant cognitive assistance to sustain/complete simple, repetitive activities safely.

A physically impaired patient requires moderate assistance if documentation indicates that moderate OT physical support and proprioceptive stimulation is needed for the patient to perform a functional activity, every time it is performed.

The records submitted should state how a cognitively impaired patient, at this level, requires intermittent one-to-one demonstration or intermittent cueing (physical or verbal) throughout performance of the activity. Moderate assistance is needed when the occupational therapist/caregiver needs to be in the immediate environment to progress the patient through a sequence to complete a functional activity. This level of assistance is required to halt continued repetition of a task and to prevent unsafe, erratic or unpredictable actions that interfere with appropriate sequencing.

o Minimum Assistance is the need for 25 percent assistance by one person for physical activities and/or periodic, cognitive assistance to perform functional activities safely.

A physically impaired patient requires minimum assistance if documentation indicates that activities can only be performed after physical set-up by the occupational therapist or caregiver, and if physical help is needed to initiate, or sustain an activity. A review of alternate procedures, sequences and methods may be required.

A cognitively impaired patient requires minimal assistance if documentation indicates help is needed in performing known activities to correct repeated mistakes, to check for compliance with established safety procedures, or to solve problems posed by unexpected hazards.

o Standby Assistance is the need for supervision by one person for the patient to perform new activity procedures which were adapted by the therapist for safe and effective performance.

A patient requires standby assistance when errors and the need for safety precautions are not always anticipated by the patient.

o Independent Status means that no physical or cognitive assistance is required to perform functional activities.

Patients at this level are able to implement the selected courses of action, consider potential errors and anticipate safety hazards in familiar and new situations.

b. Change in Response to Treatment Within Each Level of Assistance.--Significant improvement must be indicated by documenting a change in one or more of the following categories of patient responses within any level of assistance:

o Decreased Refusals. The patient may respond by refusing to attempt performance of an activity because of fear or pain. The documentation should indicate what activity and performance is refused, the reasons, and how the OT plan addresses them.

These responses are often secondary to a change in medical status or medications. If the refusals continue over several days, the therapy program should be put on "hold" until the documentation indicates the refusal response has changed and the patient is willing to attempt performance of functional activities.

For the cognitively impaired patient, refusal to perform can escalate into agressive, destructive or verbally abusive behavior if pressed by the therapist or caregiver to perform. In these cases, a reduction in these behaviors is significant and must be clearly documented, including the skilled OT provided to reduce the abnormal behavior.

For the psychiatrically impaired patient, refusals to participate in an activity frequently are symptoms of the diagnosis. This patient should not be put on a "hold" status due to refusals. If the documentation indicates the patient is receiving OT, contacted regularly, and actively encouraged to participate, medically review the claim to determine if reasonable and necessary skilled care has been rendered.

o Increased Consistency. The patient may respond by inconsistently performing functional tasks from day-to-day or within a treatment session.

Approve the claim when the documentation indicates a significant progression in consistency of performance of functional tasks within the same level of assistance.

o Increased Generalization. The patient may respond by applying previously learned concepts and performance of one activity to another, similar activity. The records submitted should document a significant increase in scope of activities that the patient can perform, the type of activities, and the skilled OT services rendered.

c. A New Skilled Functional Activity is Initiated.--Two examples of skilled care are:

o Adding teaching of lower body dressing to a current program of upper body dressing;

o Increasing the ability to perform personal hygiene activities for health and social acceptance.

d. A New Skilled Compensatory Technique is Added.--(With or without adapted equipment.) Two examples are:

o Teaching a patient techniques such as one-handed shoe tying;

o Teaching the use of a button hook for buttoning shirt buttons.

e. Length of Time in Treatment.--The acceptable length of time in treatment for various disorders is determined by the patient's functional abilities and progress as reflected in the documentation.

5. Level of Complexity of Treatment.--Base decisions on the level of complexity of the services rendered by the occupational therapist and not what the patient is asked to do. Examples of complexity of treatment are:

a. Skilled OT.--The documentation must indicate that the severity of the physical/emotional/perceptual/cognitive disability requires complex and sophisticated knowledge to identify current and potential capabilities. In addition, consider instructions required by the patient and/or the patient's caregivers. Instructions may be required for activities that most healthy people take for granted. The special knowledge of an occupational therapist is required to decrease or eliminate limitations in functional activity performance imposed by illness or disability. Occupational therapists must often address underlying factors which interfere with the performance of specific activities. Some of these factors could be cognitive, sensory, or perceptual deficits.

The occupational therapist modifies the specific activity by using adapted equipment, making changes in the environment and surrounding objects, altering procedures for accomplishing the task, and providing specialized assistance to meet the patient's current and potential abilities. Skilled services include, but are not limited to reasonable and necessary:

- Evaluations of the patient;
- Determinations of effective goals and services with the patient and patient's caregivers and other medical professsionals;
- Analyzing and modifying functional tasks;
- Determinating that the modified task obtains optimum performance through tests and measurements;
- Providing instructions of the task(s) to the patient/family/caregivers; and
- Periodically reevaluating the patient's status with corresponding readjustment of the OT program.

A period of practice may be approved for the patient and/or patient's caregivers to learn the steps of the task, to verify the task's effectivnesss in improving function, and to check for safe and consistent activity performance.

b. Nonskilled OT.--When the documentation indicates a patient has attained the therapy goals or has reached the point where no further significant improvement can be expected, the skills of an occupational therapist are not required to maintain function at the level to which it has been restored. Examples of maintenance procedures are:

- Daily feeding programs after the adapted procedures are in place;
- Routine exercise and strengthing programs;
- The practice of coordination and self-care skills on a daily basis; and
- Presenting information on energy conservation or pacing, but not having the patient perform the activity.

You may approve a claim because the patient requires the judgment and skills of the occupational therapist to design a safe and effective maintenance program and make periodic checks of its effectiveness. The services of an occupational therapist in carrying out the established maintenance program are not considered reasonable and necessary for the treatment of illness or injury and may not be approved.

6. Reporting on New Episode or Condition.--Occasionally, a patient who is receiving or who has received OT services, experiences a new illness. The provider must document the significance of any change to the patient's functional capabilities. This may be by pre and post episodic through nursing notes or physician reports. If the patient is receiving treatment, it might be lengthened. If the patient has completed treatment for the functional deficit; a significant change in the patient's functional status must be documented which warrants a new treatment plan.

3906.1 Other MR Considerations.—

A. Pain.—Documentation describing the presence or absence of pain and its effect on the patient's functional abilities must be considered in MR decisions. A description of its intensity, type, changing pattern, and location at specific joint ranges of motion materially aids correct MR decisions. Documentation should describe the limitations placed upon the patient's ADL, mobility and/or safety, as well as the subjective progress made in the reduction of pain through treatment.

B. Therapeutic Programs.--The objective documentation should support the skilled nature of the program, and/or the need for the design and establishment of a maintenance OT program. The goals should generally be to increase functional abilities in ADL, mobility or patient safety. Documentation should indicate the goals and type of program provided.

Approve claims when the therapeutic program, because of documented medical complications, the condition of the patient, or complexity of the OT employed, must be rendered by, or under, the supervision of an occupational therapist. For example, while functional ADL may often be performed safely and effectively by nonskilled personnel, the presence of fracture nonunion, severe joint pain, or other medical or safety complications may warrant skilled occupational therapist intervention to render the service and/or to establish a safe maintenance program. In these cases, the complications and the skilled services, they require, must be documented by physician orders and/or occupational therapist notes. To make correct MR decisions, the patient's losses and/or dependencies in ADL, mobility and safety must be documented. The possibility of adverse effects from the improper performance of an otherwise unskilled service does not make it a skilled service unless there is documentation to support why skilled OT is needed for the patient's medical condition and/or safety.

Approve establishment and design of a maintenance exercise program to fit the patient's level of ADL, function, and any instructions supportive personnel and/or family members need to safely and effectively carry it out. Reevaluation may be approved when reasonable and necessary to readjust the maintenance program to meet the changing needs of the patient. There must be adequate justification for readjusting a maintenance program, e.g., loss of previous functional gains.

C. Cardiac Rehabilitation Exercise.--Occupational therapy is not covered when furnished in connection with cardiac rehabilitation exercise program services (see Coverage Issues Manual 35-25) unless there is also a diagnosed noncardiac condition requiring it e.g., where a patient who is recuperating from an acute phase of heart disease may have had a stroke which requires OT. (While the cardiac rehabilitation exercise program may be considered by some a form of OT, it is a specialized program conducted and/or supervised by specially trained personnel whose services are performed under the direct supervision of a physician.)

D. Transfer Training.--The documentation should describe the patient's functional limitations in transfer ability that warrant skilled OT intervention. Documentation should include the special transfer training needed to perform functional daily living skills and any training needed by supportive personnel and/or family members to safely and effectively carry it out. Approve transfer training when the documentation supports a skilled need for evaluation, design and effective monitoring and instruction of the special transfer technique for safety and completion of the functional activities of daily living or mobility task.

Documentation that supports only repetitious carrying out of the transfer method, once established, and monitored for safety and completion is noncovered care.

E. Fabrication of and Training in Use of Orthoses Prostheses and Adaptive Equipment.--Approve reasonable and necessary fabrication of orthoses, prostheses, adaptive equipment, and any reasonable and necessary skilled training needed in their safe and effective use. The documentation must indicate the need for the device and training required.

F. OT Forms.--Documentation may be submitted on a specific form or may be copies of the provider's record. You may require a specific form if you find it more efficient than using provider records; however, it must capture the needed MR information. If you choose to require a particular form, show the OMB clearance number. The information must be complete. If it is not, return the bill for the additional information and request the missing information. The information you require to review the bill is that required by an occupational therapist to properly treat a patient.

G. Certification and Recertification.--OT services must be certified and recertified by a physician. They must be furnished while the patient is under the care of a physician. They must be furnished under a written plan of treatment established by the physician or a qualified occupational therapist providing such services. If the plan is established by a occupational therapist, it must be reviewed periodically by the physician. The plan of care must be established (reduced to writing by either professional or the provider when it makes a written record of the oral orders) before treatment is begun. When outpatient OT services are continued under the same plan of treatment for a period of time, the physician must certify at intervals of at least every 30 days that there is a continuing need for such services. Obtain the recertification when reviewing the plan of treatment since the same interval of at least 30 days is required for the review of the plans. Recertification must be signed by the physician who reviewed the plan of treatment. Any changes to the treatment plan established by the occupational therapist must be in writing and signed by the occupational therapist or by the attending physician. The physician may change a plan of treatment established by the occupational therapist, the occupational therapist may not alter a plan of treatment established by a physician.

3906.2 Occupational Therapy Availability.—There may be instances where two or more disciplines are providing therapy services to the same patient. There may also be occasions where these services are duplicative. In many instances, however, the description of the services appears duplicative, but the documentation proves that they are not. Some examples where there is not a duplication:

- Transfers - Physical therapy instructs the patient in transfers to ascertain the level of safety with the techniques. Occupational therapy instructs and utilizes transfers as they relate to the performance of daily living skills, i.e., transfer from wheelchair to bathtub to bathe.

- Pulmonary - Physical therapy teaches the patient an adapted breathing program. Occupational therapy carries the breathing retraining program into activities of daily living training.

- Hip Fractures/Arthroplasties - Physical therapy instructs the patient in hip precautions and gait training. Occupational therapy carries out and reinforces the precautions when training the patient in activities of daily living, e.g., lower extremity dressing, toileting, and bathing.

- CVA - Physical therapy utilizes upper extremity neurodevelopmental (NDT) techniques to assist the patient in positioning the upper extremities on a walker and in gait training. Occupational therapy utilizes upper extremity neurodevelopmental (NDT) techniques to increase the functional use of the upper extremity for dressing, bathing, grooming, etc.

Prepayment Medical Review of All Bills

3915. PREPAYMENT MEDICAL REVIEW

Conduct a MR of all Medicare claims (except outpatient hospital) on a prepayment basis. You have the option to perform pre-or postpayment review on hospital outpatient claims:

If you perform MR of outpatient hospital claims on a postpayment basis, complete the review, notify the provider of denials, and initiate recovery of the overpayment if applicable, within:

o Thirty days of the date the claim was processed if medical evidence was submitted with the bill or was not required; or

o Sixty days of the date the claim is processed if medical evidence had to be obtained from the provider.

Initiation of overpayment recovery means, at the minimum, withholding or offsetting provider payments, or taking refund action against the provider.

You may request the RO to approve short-term relief from prepayment review requirements if backlogs occur because of staffing or systems problems. If approved, the postpayment review requirements listed above apply.

Continue postpayment audits, do not confuse with MR of Medicare claims during the claims processing cycle, as appropriate.

3916. COVERAGE COMPLIANCE REVIEW FOR HHA CLAIMS

Each year perform coverage compliance reviews by reviewing medical records onsite for a prescribed number of HHAs. The purpose of the review is to assure that HHAs are providing services in accordance with Medicare program requirements.

3916.1 Selection of HHAs.—Conduct coverage compliance reviews on a 20 percent sample of HHAs using the following priorities:

o Review newly participating HHAs which reach their anniversary date during the review year. (An agency that has changed intermediary is not a "newly participating HHA.")

o With RO approval exclude agencies with low utilization of processed visits (less than 100 visits in a 6 month period).

o Prepare a listing by State, using the waiver of liability denial data or other equivalent denial data for medical necessity.

o Array the providers from highest to lowest denial rates. Select from each State HHAs with the highest denial rate averaged over the year. Select 2 percent of HHAs with the lowest denial rates. Exclude any agency with fewer than two quarters of statistics.

o If you have fewer than 20 HHAs, coverage compliance audits are not required unless the RO deems a review necessary.

o Complete reviews by the end of each FY (i.e., 9/30). Ranking may be done at anytime that permits timely completion of your reviews.

o The RO may approve selections for review on a basis other than denial rates, e.g., profiling, aberrant patterns.

NOTE: If your 20 percent is not reached, add HHAs which have been identified during postpayment audit or MR as having potential problems.

3916.2 Coverage Compliance Review.—

A. Sample Selection.—Select for review at least 20 beneficiaries currently or recently served by the agency. Select from patient history paid claims files or any appropriate in-house source (e.g., check registers, remittance advice).

After selecting the beneficiaries files, gather 3 months of bills processed within 6 months of the scheduled review for each. Document that 3 months sequential billings were selected.

Review, for the sample beneficiaries, at least 100 visits. If the total visits are fewer than 100, add as many beneficiaries as necessary to assure review of at least 100 visits.

B. File Compilation.—After gathering the history files and paid claims for the sample beneficiaries, collect all information available in-house with respect to the services rendered.

C. Notification of Selection for a Coverage Compliance Review.—Advise the HHA by telephone of your visit 24 hours in advance, followed by a written confirmation. Do not provide the HHA with advance knowledge of which records will be reviewed. Do not reschedule the visit unless unavoidable.

D. Onsite Review.—

1. Staff.—To perform the review, use staff who have authority to deny claims. This process intends that denials be made during the onsite review. Only where a question arises which requires physician consultation should the pertinent records be photocopied for the physician's review. In these cases, the final decision to deny the claim is made by the physician reviewer, based upon information gathered in the onsite review.

2. Points to Address.—Include the following in your review:

- Is patient homebound? (See §3120.4.);
- Is patient's residence an 1861(j)(l) facility? (See §3120.5.);
- Were services furnished under a plan of treatment? (See §3120.3.);
- Was the plan put into writing timely? (See §3120.3.);
- Is the plan complete? (See §3120.3, par. 1 & 2.);
- Were changes or extensions made in accord with policy? (See §3120.3,.);
- Did the HHA count the visits accurately? (See §3124.);
- Were length and frequency of aide visits accurate? (See §3124.2.);
- Were evaluation visits billed only when appropriate? (See §3124.3.);
- Were excluded services supplied? If yes, enumerate. (See §§3125, 3150.);

- Was the physician certification requirement met? (See §§3128, 3326-3329.);

- Were the services rendered medically necessary? (See §§3117-3119.);

- Were the visits billed consistent with Medicare coverage requirements? (See §§3116-3119.);

- Were medical appliances and/or medical supplies appropriately ordered and/or supplied? (See §3119.3.); and

- Do the records support the evidence submitted originally? (See §3902.)

3. Record Review.--Compare prepayment information to the medical record to determine the accuracy of the information. Evaluate what information, or lack thereof, influenced the prepayment coverage decision.

Review all claims from the earliest date through the date of the onsite review. Although the provider has the option to bill some of the unbilled services as noncovered, you may have to make a coverage decision on services rendered through the date of the onsite review.

Do not review services prior to the period of the selected claims unless the issue is homebound status. Where that question is raised, review all previous records to determine when the patient ceased to meet that criterion.

NOTE: Where the medical records do not contain documentation that a service was rendered, deny the service and identify an overpayment. There is no provision for a provider to submit late documentation of such visits.

4. Copying Records.--Where you deny services, photocopy the pertinent medical records. Obtain copies of records where physician consultation is needed before a decision is made, or where records may have been altered. Do not routinely photocopy medical records for review following the onsite visit.

5. Entrance and Exit Interviews.--Hold both entrance and exit interviews. Explain in the entrance interview its scope and purpose. Answer staff questions. Exhibit I is a sample checklist which could facilitate the entrance and exit interviews.

During the exit interview, discuss the tentative findings. Detail what services were denied and why. The discussion should be sufficient to enable the agency to provide comments on the cases involved.

Where physician review is required after the exit interview, complete it within 7 days of the date of the interview. Notify the agency in writing of any additional services which you determine are noncovered.

Within 2 weeks of the exit conference, or receipt of the letter regarding the physician's findings, whichever is later, the agency may submit written comments on the denied services. Consider any comments received onsite or in writing.

Finalize your findings within 6 weeks after the exit conference. Do not alert the agency to any indications of fraud or abuse which you may have found. Refer instances of possible fraud or abuse to the OIG.

E. Completion of the Individual Case Worksheet.--For each case reviewed, complete an individual worksheet. A sample is in Exhibit II. The worksheet may take any form you choose, as long as the following information is contained:

o Provider name;
o Provider number;
o Beneficiary's last name, first name, middle initial;
o Beneficiary's HICN;
o Name of the physician on the plan of treatment;
o Start of care date;
o Billing periods;
o Total visits;
o Total charges;
o Date of first visit reviewed;
*o Date of last visit reviewed;
o Type and number of visits denied on prepay review;
o Principal and other diagnoses;
o Date of the onset of illness;
o Specific issues to review according to SS3116-3128, and 3326-3329. Item 15 (homebound) includes why the patient is, or is not, considered homebound;
*o Number of visits ordered according to the plan of treatment by type, for the period of review;
o Number of visits billed as covered during the period of review, by type;
*o Number of visits rendered by type, for the period of review regardless of payer;

- *o Month and day of visits not documented in the medical record, by type;
- o Number of visits covered on prepayment review, by type;
- o Number and type of visits noncovered on prepayment review; and
- *o Number and type of visits noncovered on the onsite review.

*Includes all visits from the earliest date of the selected claims through the date of the onsite review. (See Subsection 2A.)

Include a discussion of each noncovered service.

F. Impact of Adverse Review Findings.--

1. Impact Upon Payment.--Where care is found to have been custodial or not medically necessary, deny the claim. Apply the waiver of liability provision. (See §3432.) Consider these denials in your calculation of the denial rate in determining whether the provider qualifies for a favorable waiver presumption. Do not count visits not yet billed. (See §§3707-3712 where the provider is determined to be liable.)

Where care is not covered for a reason for which waiver of liability provisions do not apply (e.g., lack of physician certification) deny the claim. In these cases, determine the amount of overpayment and recover it. (See §§3707-3712.) There may be cases where services which were previously denied are covered. Pay for them and credit the denial rate for these visits.

2. Impact on Prepayment Review.--Put on 100 percent MR, beginning with the date of final notification, HHAs in which noncovered visits exceed more than 5 percent of the visits processed. Retain the HHA on 100 percent MR for at least one calendar quarter.

3. Other Impact.--Target intensive provider education on areas identified as problems. Conduct educational activities with individual HHAs where indicated.

Refer suspected cases of fraud or abuse to the OIG.

G. Distribution of Findings.--Send a letter to the HHA with your findings. Include:

- o Specifics of denied care; and
- o Impact on prepayment review or documentation requirements.

Release the letter within 6 weeks after the exit conference.

For denied services, send the beneficiary a notice if one would have been sent in the course of prepayment review.

Advise the certifying physician in writing of the denials resulting from the onsite reviews. State:

- Period reviewed;
- Number and type of services denied;
- Reason(s) the services were denied; and
- Your personnel for the physician to contact.

3916.3 Completion of the Quarterly Report of Coverage Review Activity (Exhibit III).—Complete the Quarterly Report of Coverage Review Activity by the end of the month following the close of the calendar quarter. Send it to:

Health Care Financing Administraton
Office of Program Operations Procedures, BPO
1-H-3 Meadows East Bldg.
6325 Security Blvd.
Baltimore, MD 21207

Send a copy to the RO.

A. Instructions for Completion.—

1. Item 1.—Enter your number.

2. Item 2.—Enter the month and year of the last month of the calendar quarter in which the final result was released.

3. Item 3.—Enter the number of your RO (i.e., I-X).

4. Item 4.—Enter the provider's name.

5. Item 5.—Enter the provider's number.

6. Item 6.—Enter all code(s) appropriate to the reason(s) for the onsite review.

   - Enter "1" if the agency was reviewed because of a high denial rate;
   - Enter "2" if the agency was reviewed because it is a newly certified provider;
   - Enter "3" if the agency with a low denial rate was reviewed; and
   - Enter "4" if the agency was reviewed for other reasons, e.g., because of prior year's review findings, profiling or aberrant patterns of care.

7. Item 7.—Enter the total number of visits billed as covered during the 3 months for the sample beneficiaries.

8. Item 8.—Enter the total number of visits which were denied in prepayment bill review during the 3 months for the sample beneficiaries.

9. Item 9.—Enter the total visits reviewed onsite.

10. Item 10.—Enter total visits denied because of onsite review. Include any visits denied on prepayment review (Item 8) which continue to be denied.

11. Item 11.—Enter the number and type of visits found to be noncovered and denied because of onsite review (Item 10).

12. Item 12.—Enter the total charges for the noncovered services in Item 11 by type of visit.

13. Item 13.—Enter the number of visits paid under waiver because of onsite review by type of visit (Item 11).

14. Item 14.—Enter the total amount paid under waiver for visits (Item 13) by type of visit.

15. Item 15.—Enter the pertinent costs for performing the onsite review. Include salary, per diem, travel, clerical time, computer time prior to and after review, pulling cases, etc.

16. Item 16.—Enter the number of visits denied for services which did not meet the intermittent requirements. Include the number of visits denied where the patient was determined not to be homebound.

17. Item 17.—Enter the total charges for services denied in Item 16, i.e., not intermittent or homebound.

Exhibit I

SAMPLE OF
HOME HEALTH AGENCY COMPLIANCE REVIEW CHECKLIST

AGENCY NAME____________________ DATE OF AUDIT__________
PROVIDER NUMBER____________________ AUDITOR__________
CONTACT PERSON____________________

1. BASELINE DATA:

a) Reason for audit____________________

b) Services offered____________________

c) Average total visits per month____________________

d) Hospital based/Freestanding____________________

e) Waiver of Liability denial record____________________

f) Medicare claims requests for medical information:

Frequency____________________
Types of cases____________________

g) Date of last State agency survey____________________

h) Geographic area served____________________

2. MEDICAL RECORDS:

a) Construction of sample record____________________

b) Method of recording visits____________________

c) Note unusual inclusions, i.e.. Pharmacy Evaluation__________

d) Adequacy____________________

EXHIBIT I (Cont.)

3. PHYSICIAN INVOLVEMENT:

a) Quality of relationship with agency staff__________________

b) Timeliness of Certification__________________

Procedure for securing certification__________________

Success of procedure__________________

Suggestions__________________

4. ADMISSION PROTOCOL:

a) Mechanism for referral of patients__________________

b) Physician's order for services secured__________________

c) Source of Patients:

Hospital, SNF__________________
Physician's office__________________
Other__________________

d) Information available prior to evaluation__________________

e) Plan of Treatment:

Who prepared__________________
Timeliness__________________
Physician involvement__________________

f) Frequency of Visits:

Who decided__________________
How determined__________________
Leeway__________________
Procedures to change frequency__________________

EXHIBI. I (Cont.)

5. INTERIM PROCEDURES:

a) Procedure for addition of a service modality________________
____

b) Procedure for interim physician orders________________
____

c) Visits by physician to the patient:

Frequency________________________________
Telephone contact with agency/patient________________

d) Frequency of changes in Plan of treatment, e.g., every 60 days
____
____

e) Timeliness of physician signature on interim changes
____
____

6. PATIENT ASSESSMENTS:

a) Diagnoses clearly listed________________________

b) Pertinent Diagnosis first________________________

c) Onset of conditions noted on record________________
____

d) Services and documentation fit diagnoses________________
____

e) Baseline patient data complete:

Social history________________________________
____

Medical history________________________________
____

"Normal activity"________________________________
____

Functional assessment________________________
____

Homebound status________________________________
____

EXHIBIT I (Cont.)

Frequency of reassessment of homebound status____________

Frequency of absences from home described____________

Care giver(s) described____________

Who assists in ADL's e.g., weekdays, weekends____________

f) Justification given for aide visits when adequate care giver available

g) Daily visits justified by documentation____________

h) Care of the dying patient:

Skilled services documented____________

"Hospice" type care documented____________

Hospice Interface____________

7. COMMUNITY SERVICES:

a) Brief summary of what is available____________

b) Meals on Wheels, Private help____________

8. BILLING PROCEDURES:

a) How are visits, supplies transcribed from record to claim

EXHIBIT I

b) Who is responsible for billing______________________
____

c) Questions on billing procedures______________________
____

d) Confirm procedure for obtaining information about other Third Party coverage
____

9. DISCHARGE PROCEDURE:

a) Written order by physician______________________
____

b) Check Notice of Noncoverage to beneficiary______________________
____

c) Check discharge procedure______________________
____

Exhibit II

INDIVIDUAL CASE WORKSHEET

1. HHA Name: ____________________ 2. HHA No.: ________

3. Beneficiary Name: ______________ 4. HICN: ___________

5. Physician Name: ________________ 6. SOC: ___________

7. Billing Periods: ________________________

8. Total Visits: ___________ 9. Total Charges: ________

10. First Visit Reviewed: _____ 11. Last Visit Reviewed: ____

12. Visits Non Covered on Prepay Review: ____________________

13. Primary Diagnosis: ____________________ 14. Date of Onset: ____
Secondary Diagnosis: ____________________ ____
____________________ ____
____________________ ____

15. Homebound ___ yes ___ no (attach a narrative)

16. 1861(j)(i) facility ___ yes ___ no

17. Plan of Treatment ___ yes ___ no

18. Timeliness of Plan ___ yes ___ no

19. Completeness of Plan ___ yes ___ no

20. Changes or Extensions ___ yes ___ no

21. Pertinence of services ___ yes ___ no

22. Visits accurate ___ yes ___ no

23. Evaluation visit ___ yes ___ no

24. Provision of excluded services ___ yes ___ no

25. Physician certification and recertification ___ yes ___ no

26. Necessity of services ___ yes ___ no

27. Appropriate classification ___ yes ___ no

28. Appropriateness of medical appliances and/or medical supplies ___ yes ___ no

EXHIBIT II (Cont.)

Page 2 (INDIVIDUAL CASE WORKSHEET)

29. Visits Ordered on POT
30. Visits Rendered
31. Visits Billed as covered

SNC
PT
ST
OT
AIDE
MSS
OTHER

32. Visits Covered on Prepay Review
33. Visits Noncovered Prepay Review
34. Visits Noncovered Onsite Review

SNC
PT
ST
OT
AIDE
MSS
OTHER

35. MM/DD of Visits Not Documented

SNC
PT
ST
OT
AIDE
MSS
OTHER

36. Documentation of Beneficiary Home Visit

QUARTERLY REPORT OF COVERAGE REVIEW ACTIVITY

1) Intermediary Number ____________

2) Quarter Ending ____________

3) Region ____________

(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)						(12)						(13)						(14)						(15)
			# of Visits Billed As Covered for Sample Beneficiaries	Total Visits Denied For Sample Beneficiaries on Prepayment Review	# of Visits Considered in Onsite Review	Total Visits Denied Because of Onsite Review	Visits Denied Because of Onsite by Type of Visit						Charges for Denied Visits (Item 11) by Type of Visit						Visits Paid Under Waiver -Because of Onsite Review by Type of Visit						Amount Paid Under Waiver for Visits (Item 13) by Type of Visit						Cost for Performing Onsite Review
Provider Name	Provider Number	Code					SNC	HHA	PT	ST	OT	MSW	SNC	HHA	PT	ST	OT	MSW	SNC	HHA	PT	ST	OT	MSW	SNC	HHA	PT	ST	OT	MSW	

(16) Number of Visits Denied for Intermittent Services ____________
Number of Visits Denied for "Not Homebound" Services ____________

(17) Total Charges for Item 16 ____________

References are to Section Numbers

-A-

Abortion, 3101.12
Abuse cases, 3454.1B, H, 3455, 3460B, 3464, 3482
ABUSE REPORT, HCFA-51:
  exhibit, 3455.1
  full scale investigation, 3454.1G
  instructions for completion of form, 3455.1
Accepted Dental Therapeutics, 3101.3A
Accident, automobile, 3408.2B
ACCOMMODATIONS:
  all inclusive rates/no-charge structure providers, 3660.4A
  billing, 3602
  census taking hour, 3101.1
  charges, 3610.1
  defined, 3101.1
  deluxe, 3101.1A, D,
  differential charge, 3101.1A, C, D
  extended care services, 3133.1FF
  grneral, A3101.1
  isolation required, 3101.1B
  labor room, 3103.1,
  late discharge, 3103.2, 3135.2
  maternity inpatient days, 3103.1,
  nonavailability of SNF bed space, 3101.1C, 3421.1A,
  private:
    all-private room providers, 3101.1E,
    denial of payment, 3431B
    documentation 3783.2
    elimination, 3101.1
    most prevalent rate, 3101.1D, G
    not medically necessary, 3101.1A(1),
    only room available, 3101.1C
  rates, 3101.1D,
  routine services, A3101.1
  semi-private, 3133.2, 3410.2,
    most prevalent rate, 3101.1A, 3101.1F(2), G,
    not immediately available, 3101.1C
    ward, 3101.1A, F,
ACCREDITATION:
  American Osteopathic Association, 3121.1A
  hospitals, 3010
  Joint Commission on Accreditation of Hospitals (See Joint Commission on Accrediation of Hospitals)
  psychiatric hospitals, 3016

Active duty members of Uniformed Services, 3153.3D
Active treatment (See Psychiatric hospital services)
Activity programs, 3101.9D
Address change, 3808.1
Adjustment bills, 3816ff., 3664, 3825.6, 3828.2
Adjustment of bills, 3664, 3885
Administrative cost, 3117.4C(2)
Administrative error, 3004, 3307.3, 3312.1
Administrative finality, 3837.1
ADMINISTRATIVE LAW JUDGE:
  authority, 3786A
  consultation, 3790.4
  decision, 3786
  determining amount in controversy, 3785.1
  documentation of claim file, 3785.4
  effectuation of decision:
    reconsideration, results in overpayment, 3709.3D
    reversal, 3787
  good cause determination, 3781.7
  hearing, 3781.1
  reconsideration, 3790.2
  reopening determinations and decisions on claims, 3799
  request for information 3786F
  responsibility, 3786B
  reverses reconsideration determination, 3786E
Administrator (See Legal representative)
Admission packs, 3101.4
ADMISSIONS (See also Query and Reply Procedures; and Start of Care):
  ancillary services, 3610.2
  action on HCFA replies, 3518
  admission data, 3507
  before entitlement:
    discharge or death on first day of entitlement or hospital participation, 3103.1, 3103.4,
    extended stay for utilization review purposes, 3420.2
    psychiatric restrictions, 3104ff.
    timing of certification and recertification, 3324
  beneficiary identification, 3512.1
  benefits exhausted, 3714
  charges to beneficiaries, 3610.1
  claim number 3503, 3512.7(Codes 52 and 53)
  claim number discrepancies, 3504
  control record layout, 3838.8C
  covered/noncovered day and charges, 3620, 3637.15
  criteria, 3006
  date of admission, 3507.6, 3512.2
  day counted as inpatient day, 3103.1, 3520.3A
  defined, 3006

ADMISSIONS (CONT'D):
- delay in transmitting reply, 3307.2
- denied, 3610.1E
- dental services, 3316.1
- discharge, 3610.1
- discharge same day, 3103.1
- disposition code, 3512.7
- entitlement, 3001, 3001.1, 3501
- general, 3610
- inpatient bills, 3610
- Inpatient Hospital and Skilled Nursing Facility Admission and Billing, HCFA-1453, 3550(Ex. 2)
- non coverage notice, 3439.1
- noncovered prior stay, 3520.2
- notice, 3501ff., 3507, , 3828B
- open-item development, 3519ff.
- out-of-sequence admission notices, 3519.2
- policies, 3006
- prepayment requests, 3314ff.
- prior to and discharges, 3610.4
- query/query reply procedures, 3507.3
- query/query reply procedures, 3537
- repeated admissions, 3600C
- reply to notice of admission, 3510-3512.9, 3518, Addendum A, Chapter VI, Sec. 3 and 6
- report of eligibility, 3518.1, 3550(Ex. 2)
- request for payment, 3301ff., 3302.5
- signature of patient, 3302.3ff., 3302.5
- social security office contacts, 3502ff.
- spell of illness, 3622
- start of care, 3501
- temporary eligibility notice, 3502.1
- transfer requirement, 3131, 3610.5
- transmission of admission information, 3507
- waiver of Medicare as a condition of, 3313

Advanced Record System, Addendum A to Chapter VI

ADVERSE:
- claimant, 3715.1G, 3715.7
- coverage decision, 3442B, 3781.6
- payment decision, 3792.2A
- PRO determination, 3719.4

AGE:
- requirement:
  - age 65, 3001, 3001.4A(1), 3003.1, 3003.2, 3003.4A, 3121.1B, 3131.1, 3301, 3501, 3780.1A(1)
  - chronic renal disease, 3001.3, 3121.1B, 3131.1, 3780.1A(1)
  - disabled, 3001.2, 3121.1B, 3131.1, 3780.1A(1)

Agencies (See under specific type of agency)

AGREEMENT TO PARTICIPATE:
- arrangements by home health agencies, 3025.2
- change of provider ownership, 3009
- fraud, 3462(11)
- retroactive, 3005.1
- SNF term agreements:
  - cancellation, 3008.4B(3)
  - defined, 3005.3
  - expiration, 3008.3, 3008.4B(2),
  - nonrenewal, 3008.3
  - renewal, 3008.3
  - term of agreement with providers, 3005, 3005.2
- termination:
  - hospital, 3008.4A,
  - provider, 3401.3
  - SNF, 3008.4B(1),
  - violation of provider agreement, 3401

Aide, home health (See Home health aide services)

Alcohol and drug detoxification, 3610.13

ALIENS:
- nonpayment provision, 3512.7(Code 26), 3535(Code 26), 3716
- premium hospital insurance, 3001.4A
- transitional entitlement to Part A, 3001.1

Alphabetic Listing of Data Elements, Addendum B

Alzheimer's disease, 3102.1B, 3903G

AMBULANCE SERVICE:
- air, 3114C(11)
- billing, 3660.1
- certification by physician, 3322, 3335
- claims review, 3660.1A
- coverage guidelines, 3114, 3660.1A
- crew, 3114A
- deceased beneficiary, 3114C(9)
- destination, 3114C
- equipment and supplies, 3114A(3)
- explanation of service, 3660.1A
- furnished by:
  - home health agencies, 3114, 3127
  - hospitals, 3114
  - skilled nursing facility, 3114, 3138
- institution to beneficiary's home, 3114C(1)
- institution to institution, 3114C(2)
- locality, 3114C(5)
- medical necessity, 3114B
- outside United States, 3154C, 3310
- oxygen, 3114
- partial payment, 3114C(4),

AMBULANCE SERVICE (CONT'D):
  round-trip, 3114C(3)
  to renal dialysis facility, 3114C(10)
  transportation:
    outpatient as home health service excluded, 3119.5
    request by home health agency, 3114C(8)
    to appropriate facilities, 3114C(6)
    to physician's office excluded, 3114C(7)
  under arrangements, 3114, 3618A
  under supplementary medical insurance, 312F, 3212
AMBULATORY PERITONEAL DIALYSIS:
  continuous, 3170ff.
  drugs and biologicals, 3170.2C
  equipment and water testing, 3171.2E
  home dialysis equipment, 3170.1
  institutional services furnished, 3171.2
  laboratory tests, 3171.2A
  reimbursement method, 3170ff
  rental of equipment, 3170.2
  services and supplies, 3169
  supplemental dialysis, 3170.3
  training:
    furnished to inpatients, 3172.2A
    medical necessity, 3172.4
    nonroutine lab tests, 3172.4
    patients already trained, 3172.3B
    routine lab tests, 3170.2A, 3171.2A
Ambulatory Surgical Center (ASC), 3656.4
American Indian treated at Government expense, 3153.1B
American Medical Association Drug Evaluations, 3101.3
American Osteopathic Association, 3119.4, 3133.7
American Psychiatric Associations Diagnostic and Statistical Manual—Mental Disorders, 3104.4
ANCILLARY SERVICES:
  adjustments in charges, 3816.1A(3)
  beneficiary liability, 3444.1
  billing:
    all-inclusive rates or no-charge structure, 3660.4
    rental or purchase of DME, 3660.3
  blood, 3235.1
  census taking hour, 3103.1
  denial rates, 3444.5
  furnished by providers, 3110ff., 3112ff.
  medically unnecessary, 3444.2A,
  physical therapy, 3101.8D
  provider liability, 3444.2
  under Part A, 3135.4
  under Part B, 3444,
  waiver of liability provisions, 3444, 3674.1

ANCILLARY SERVICES (CONT'D):
Anesthesiology services, 3112.4C
Anesthetist services, 3101.2A, 3618A
Anesthetists, non-physician, 3101.2A
Annual Contract Evaluation Reports (ACER), 3774A
Appeals Council, 3781.1, 3781.7, 3786A
Appeals of involuntary terminations, 3008.2
APPEALS OF PAYMENT DETERMINATIONS:
  appeal processes--general, 3780
  claim not timely filed, 3309
  custodial care, 3430
  date of determination, 3799.3
  determination reopened:
    actions necessary to reopen, 3799.6
    "change of position," 3799.12
    clerical error, 3799.9
    conditions, 3799.2
    "error on face of the evidence," 3799.10
    fraud or similar fault, 3799.13
    good cause, 3799.7
    issues, 3799.1
    new and material evidence, 3799.8
    notice of results, 3799.15
    reevaluation, 3799.14
    revised, 3799.18
    time limitation, 3799.2, 3799.6
    who may reopen, 3799.5
    "unfavorable determination," 3799.11
  effectuation of reconsideration results in overpayment, 3709.3D
  Part A:
    additional medical evidence, 3784.1C
    amount in controversy, 3781.1, 3785.1
    Appeals Council review, 3781.1., 3786D
    appeals process, 3781.5, 3786F
    authority of Bureau of Hearings and Appeals, 3786A
    court decisions, 3786B, 3788
    deceased beneficiary, 3789.2
    documentation, 3783
    evaluation, 3784
    full allowance, 3781.8B(3)
    full reversal determinations, 3784.6
    general, 3781
    hearing requests (See request for hearing)
    incapacitated beneficiary, 3789.1
    oral contacts, 3782.1A
    party to initial determination, 3781.2
    prior reconsideration request received, 3735.1C
    process, 3780

APPEALS OF PAYMENT DETERMINATIONS (CONT'D):

- Part A (cont'd):
  - Professional Review Organizations (PROs), 3790ff.
  - provider's right to appeal, 3781.4
  - reconsideration determination, 3784.4, 3784.5
  - Reconsideration Determination, HCFA-2501, 3784
  - reconsideration request:
    - acknowledging receipt, 3782.4
    - appeal before initial action, 3782.7
    - appeals process, 3781.1
    - assembling file, 3783.8
    - by beneficiary, 3781.6
    - Congressional inquiries, 3735ff.
    - correspondence received, 3784.13
    - dismissal, 3782.8
    - dismissed request for hearing, 3782.1E
    - documentation, 3783
    - effect of determination, 3784.14
    - filing, 3782ff.
    - follow-ups, 3784.12
    - initial determination questioned, 3784.2B
    - more than one component, 3782.6
    - overpayment decision, 3711.3A
    - prehearing case review, 3785.5
    - reopening rules, 3710.4C
    - reversal, 3790.2A
    - revision, 3785.6
    - routing, 3782.3
    - sixty days of receipt of letter, 3784
    - sixty days of receipt of notices, 3710.1, 3710.3D, 3711.6E, 3735, 3781.1, 3781.7 3790.3A, 3799.15
    - withdrawal, 3782.9, 3782.10A
  - referral to BHI, 3785.4
  - reopening and revision of determination, 3799ff.
- representation, 3789ff.
- request for hearing, 3785ff.
- request for reconsideration, 3782, 3784
- reversal cases, 3784.9
- reversal decisions, 3782.5, 3784.3. 3786E, 3787
- role of intermediary, 3735ff.
- steps in appeals process, 3781.1
- time limitation for filing appeals, 3781.7
- unsigned written requests, 3782.1A
- utilization review committee decision, 3781.6
- written complaint, 3782.1B

APPEALS OF PAYMENT DETERMINATIONS (CONT'D):
- Part B:
  - amount in controversy, 3794.1B, 3794.8B(9)
  - authorized representative, 3794
  - eligibility for hearing, 3794.1A
  - filing, 3795
  - HCFA review, 3794.8
  - hearing, 3794ff.
  - issues for determination, 3794.6
  - law or regulations citation, 3794.8B(7)
  - notice of time and place of hearing, 3794.2
  - procedures, 3794.5
  - Professional Review Organizations (PROs), 3790ff.
  - protests and appeals of payment determinations, 3791
  - reopening and revision of determination, 3799ff.
  - review, 3792ff.
  - scope of decision, 3786
- reasonable and necessary services, 3430
- refusal to reopen, 3799.17
- right to appeal:
  - beneficiary, 3432.1A
  - notification, 3711.6E
  - provider, 3432.2B
- services not reasonable and necessary, 3430

APPLIANCES:
- as covered extended care service, 3133.6
- as covered home health services, 3119.3B, 3127.1
- as covered inpatient hospital services, 3101.4
- excluded appliances, 3158

Application (See Request for payment)
Application of Fee Schedule, 3624A, 3628A
Appointment of Representative, SSA-1696, 3789A, 3795
Arm brace, 3110.5, 3127

ARRANGEMENTS FOR SERVICES:
- ambulance service, 3114, 3660.1
- billing, 3660
- covered services under hospital insurance, 3101.5, 3116, 3120.2, 3130, 3146D
- covered services under supplementary medical insurance, 3112.3C, 3116, 3120.2, 3130,
- definition, 3007
- extended care services, 3130
- home health services, 3116, 3120.2
- independent laboratory, 3101.5B
- independently practicing physical therapist, 3149
- inpatient hospital services, 3101.5
- occupational therapy, 3101.9, 3118.2,
- other participating hospital laboratory, 3101.5C
- outpatient diagnostic services, 3112.3C

- **ARRANGEMENTS FOR SERVICES (CONT'D):**
  - outpatient physical therapy services, 3147.1, 3149
  - outpatient services by home health agency, 3025.2, 3119.5, 3120.4
  - physical, speech, and occupational therapy, 3118, 3133.8
  - physical therapy, 3101.8
  - postdischarge care, 3431.1B(1), 3441,
  - speech pathology services, 3147.1
- **ARTIFICIAL:**
  - limbs, eyes, devices, etc., 3101.4, 3110, 3110.5, 3112.4C, 3127C, 3157,3212
- ASCMSA Wage Index and Constituent Counties, Addendum G
- Assignment claims, 3312.5, 3794.8B(3)
- Audiologist, 3101.5
- Audits, 3774C
- **AUTHORIZATION:**
  - combined billing, 3668.2
  - disclosure of information (See Disclosure of information)
  - payment to:
    - home office, 3703.1
- Authorized representative, 3794
- Automatic Data Processing Systems, 3504(2), 3700
- Automatic notifications by SSA, 3511
- AUTOMOBILE MEDICAL, NO FAULT INSURANCE:
  - ambulatory surgical center (ASC), 3656.4
  - automobile medical, 3679ff, 3489.4
  - deductible or coinsurance provision, 3489.5, 3680C
  - definitions, 3489.2
  - general, 3680A
  - processing of claims, 3489.4
- Autopsy services, 3145A, B

-B-

- Back brace, 3110.5, 3127
- Batch Clearance Tape, HCFA-2181, 3562
- Batching Bills (See Claims records)
- Baths, 3117.4G
- Bed and board (See Accommodations)
- **BENEFICIARY:**
  - complaints about charges, 3780.1B(2)
  - contacts for additional information, 3559
  - deceased, 3711.8, 3712.2(Item 4)
  - definition of beneficiary's home, 3113.6
  - incapacitated, 3106.2E, 3440.1A, 3766
  - liability, 3432.1, 3708.1, 3708.2B, C, 3708.3, 3712.6

BENEFICIARY (CONT'D):
  noncoverage notce, 3440, 3440.1A, 3444.1
  notification when recovery is sought, 3710.3D
  obligation for blood, 3235.4
  overpayments, 3708.3(3)
  protests overpayment decision, 3711.11A
  refund letter, 3711.6A
  under Welfare, 3711.1
  without fault, 3708.4, 3708.5, 3709.2C, 3709.3A, 3712.4(2)
Benefit checks, 3703
BENEFIT DAYS:
  admission and discharge same day, 3103.1, 3620.1
  admission day counted as, 3103.1
  available, 3104.5, 3104.6
  benefit period, 3035
  continuation, 3308C
  covered per spell of illness, hospitals, 3103
  days of admission, discharge and leave deducted, 3104.3
  exhausted (See Benefits exhausted)
  extended care benefit days, 3135, 3620.2
  late discharge, 3103.2
  leave of absence, 3103.3
  lifetime limitation, inpatient psychiatric hospital services, 3105
  lifetime reserve days, 3106, 3512.4, 3518.1(Item D),
  psychiatric reduction, 3104
  psychiatric restriction, effect on, 3104
  utilization day defined, 3620
Benefit maximums, 3107
Benefit period (See Spell of illness)
BENEFITS EXHAUSTED:
  before discharge or death, 3620
  discharge bills, 3839
  Discharge Notificiation, HCFA-2196 (See Title of form)
  guarantee of payment provisions (See Guarantee of payment)
  no-payment situations (See No payment billing)
  overpayment resulted, 3707, 3708.2B, 3709.1B
  Part A benefits exhausted, 3115A, 3148.4,
  Part A exhausted, change to Part B, 3110, 3120.3, 3122.1,
  workers' compensation, 3415C, 3416
BEST (See Health Insurance Beneficiary State Tape)
BILL REVIEW:
  adjustment, 3610.8
  admission denied, 3610.1E
  alcohol and drug detoxification, 3610.13
  ambulance service, 3660.1
  analysis of forms, 3693.5

BILL REVIEW (CONT'D):
  benefits exhausted, 3624
  foreign claims, 3121.1C, 3698.7
  claim process, 3600.1
  computer programs, 3656
  cost outliers, 3610.7(B)
  data exchange record layout, 3674.5A
  day outliers, 3610.7A
  deductible not met, 3695
  deductible previously met, 3695
  electronic media claims, (EMC), 3602.1
  employment information guidelines, 3604 Item 70A
  end-stage renal dialysis, 3644ff
  enteral and parenteral nutritional therapy, 3660.6
  ESRD bills, 3644.1
  ESRD network, 3644C(3)
  frequency, 3603
  general requirements, 3600
  home dialysis equipment, 3490.8(B)
  hospital medical review, 3674.2
  hospice, 3648
  intermediaries medical review, 3674.2
  inpatient Part B services, 3626.1
  invasive diagnostic and therapeutic procedures,
  kidney transplant, 3612
  medical, 3618A
  medicare as secondary payer, 3407.2, 3407.3, 3693, 3696A
  medicare cod editor (MCE), 3656.1
  MSP data exchange layout, 3696.2
  no-payment bills, 3624A
  outpatient clinical diagnostic laboratory services, 3628
  outpatient services. 3626.2
  outpatient speech pathology services,
 Part A review, 3626.2
  Part B services, 3603
  payment by ESRD - EGHP, 3681B
  payment denial, 3600.3
  payment for home dialysis patients, 3644A
  PRO adjustment claim, 3604, 3674.6
  PRO medical review, 3674.2, 3674.5
  secondary payers claims, 3682, 3694
  special billing situations, 3660
  specific billing forms (See Title of form)

BILL REVIEW (CONT'D):
timely processing of bills and control, 3600.1
unibill record layout, 3674.5(B), 3679
utilization chargeable, 3718(4)
validation, DRG, 3610C
waiver of liability, 3610.9
BILLING:(see also entries under individual billing forms):
adjustments, 3600.1D, 3610.8, 3718.2, 3803(28), 3816, 3816.1A, 3817, 3825.6, 3828.2, 3885
after suspension, 3600.3
ambulance service, 3660.1
ancillary physical therapy service, 3101.8D
automatically corrected by SSA, 3804, 3828E, 3828.3, 3833B
automobile medical, no fault or liability insurance, A3419ff
batches (See Claims records)
beneficiaries rather than Medicare, 3462
"cancel only" adjustment bill, 3816F
cancellation of bills, 3803, 3816
cancellation of provider agreement, 3600.3
cardiology services, 3302.4
change of intermediary, 3600.4
change of provider number, 3600.5
chronic renal disease bills, 3512.8
combination covered and noncovered days, 3620
combined billing method (See Combined billing)
consistency edits (See Consistency edits)
control, 3600.1C, 3804
corrected bills, 3308C, 3460C, 3718.1B, 3784.11, 3786E, 3804.2, 3816ff.
credit (See Credit bill)
debit (See Debit bill)
deceased beneficiary, 3718
deleted bills, 3820
denied bills, 3603, 3718, 3719.1
discharge bill, 3839
discharge or death on first day of entitlement, 3101.1, 3102.4,
dummy bills, 3839
duplicate billing, 3302.4B, 3462, 3708.2C
electronic media claims, 3602.1
emergency services, 3519.4
enteral and parenteral therapy, 3661
error report, 3845
first-in-first-out, 3525.4
follow-up notices for rejected bills, 3804.3

BILLING (CONT'D):
- forms:
  - as request for payment, 3302.1
- frequency, 3603
- "front-end" review, 3434.3
- Health Maintenance Organizations bills, 3555ff.
- home health agency bills, 3630, 3638, 3722.3
- hospital bills, 3722.1
- incorrect billings, 3312.3,
- inpatient,3835
- in-sequence processing (first-in-first-out), 3525.4, 3828C, 3835
- interim billing, 3510.2(Ex. 4), 3520.1, 3624A
- limitations on payment for inpatient services, 3421ff.
- magnetic tape, 3801, 3820
- management report for returned and resubmitted bills, 3804.4
- manually, 3799.3A(1)
- multiple provider numbers, 3600.5
- no charge, Part A or Part B services, 3626
- no-payment cases (See No payment bills)
- nonparticipating providers, 3698A
- open-item (See Open item)
- outpatient services, 3610.3, 3626.2
- overlapping bills, 3708.2C
- Part A Bill History, 3840ff.
- Part A bills automatically corrected by SSA, 3804
- Part B billing on HCFA-1487, 3555.3
- pathology services, 3104.1, 3146B, A3146
- Pending Returned Bill Notice, 3804.3
- periodic interim payment, (PIP), 3603
- physicians' services, 3146B, 3668.1
- processing, 3600.6C, 3624
- prospective payment, 3490ff, 3679, 3685, 3693
- provider-based physicians' services (See Hospital-based physician)
- provider requirements, 3602.1B
- providers no longer participating,
- PRO codes, 3873.2, 3876.1,
- PRO relationship, 3676A
- purged, 3828.3, 3837
- radiology services, 3146B, A3146
- receiving operations, 3822
- refunds, 3401
- refusal to sign request for payment (See Request for payment: refusal to sign)
- rehabilitation and detoxification, 3610.3, 3639.1
- reimbursement, 3616A
- reinstated by SSA, 3718.1B(Item 2(3))
- rejected bills, 3804ff, 3830, 3833A, 3838

BILLING (CONT'D):
- repeated admissions and discharge, 3610
- request for payment, 3302ff.
- resubmitting rejected bills, 3804.1, 3804.2, 3804.4
- returned bills, 3804.4
- RTI (Returned to Intermediary) number, 3804
- room number requirement, 3501.1,
- Rural Health Clinics, 3642
- sample bills, 3670, 3676 3883
- skilled nursing facility bills, 3630, 3722.2
- special instructions, 3660, 3610
- special situations, 3610, 3660
- split bills, 3610.5
- submission after purge, 3836.4, 3837.1
- submit report, 3693.1
- termination of provider agreement, 3600.3
- test bills, 3866.1
- two-calendar years involved, 3542B,
- utilization edits (See Utilization edits)
- utilization notice, date of receipt, 3421B
- void, 3804.1, 3804.2
- workers' compensation cases, 3409ff., 3679, 3685

Biologicals, 3101.3, 3112.4B, 3119.3C, 3133.5
Birth date, 3507.7
Black Lung Benefits, 3157, 3414ff, 3415ff
Black Lung disease, 3414A(3)
Black Lung Program 3407
Bladder training, 3117.4E(1)

BLOOD:
- all-inclusive rate, 3660.4
- beneficiary obligation, 3235.4
- charges, 3235.4B
- costs, 3235.5A
- deductible, 3518.2
- excess donation, 3235.4B
- fibrinogen, 3235.3
- furnished by provider, 3660.4B
- furnished by SNF, 3137, 3235.6
- gamma globulin, 3235.3
- open-item development, 3519.1
- outpatient, 3235.2,
- overapplied Part A deductible, 3828E
- packed red cells, 3235.1, 3235.3, 3235.4
- Part A deductible, 3235.1
- Part B deductible, 3235.2

BLOOD (CONT'D):
  plasma, 3235.3
  platelets, 3535.3
  processing charges, 3235.1,
  processing costs, 3235.5B
  prohibition on charging for replacement, 3235.4A
  query procedures, Part B, 3526
  query reply on blood deductible status, 3512.4C, 3535e
  replacement, 3235.4,
  serum albumin, 3235.3
  under hospital insurance, 3518.2(Item G)
  underapplied Part A deductible, 3828E
  unfit, 3235.4A
  unreplaced blood, 3235.4, 3718.1B(Item 2)
  whole blood, 3235.3
Braces, 3110E, 3110.5, 3112.4C, 3127C, 3212(12),
Brassiere, surgical, 3110.4
Breast prostheses, 3110.4
Bribe, 3460A(1d), 3462(13)
Budget Distribution, HCFA-2598, 3775A(11)
BUYING INTO:
  hospital insurance, 3001.4A
  supplementary medical insurance, 3003ff

-C-

Canadian hospitals, 3154, 3519.5
Canadian claims, 3698.7(A)
"Cancel only" bill (See Billing: cancellation of bills)
Cancelled checks (See Checks)
CARDIAC PACEMAKER:
  prosthetic device, 3110.4
  supplies, appliances and equipment, 3101.4
Carrier Alphabetic State List (CAST), 3504(1), 3505ff., 3506, 3728.1
Carrier or Intermediary Request for SSA Assistance, HCFA-1980, 3307.3B, 3512.7(Code 43), 3512.8(Code B), 3535(Code 02), 3535.1(Code B),3706B, 3781.8D(1),(4), 3816F(2a)
CARRIERS, MEDICAL INSURANCE:
  coordination with Part A intermediary, 3912, 3672
  coordination with Part A intermediary in fraud cases, 3474
  coordination with Part A intermediary whose provider ambulance services provided under arrangements, 3618.1
  hearing, Part B, 3791
  informational copies of provider billing forms, 3912.3
  payment for services by suppliers, 3618
  provider-based physicians' services, 3145C, 3910.1, 3912
  reconsideration requests, 3782.6B(4), 3782.6C(4)
  transfer of funds, 3711.1

Carryover deductible (See Deductible: carryover)
CAST (See Carrier Alphabetic State List)
Casts, 3101.5, 3110, 3110.3, 3112.4C, 3127, 3212
CATARACT:
  sunglasses, 3110.4A
  surgery convalescence, 3132, 3157
Catheters, 3117.4E, 3132.4
Christian Science Sanatorium, bills, 3698.11(B)
Census taking hour, 3103.1,
Cerebral vascular accident (CVA), 3117.4D
CERTIFICATION BY PHYSICIANS (See also Recertification by physicians):
  admission to skilled nursing facility, 3137
  ambulance service, 3322, 3335
  chiropodist excluded, 3316, 3334
  content, 3317A
  delayed, 3323, 3329, 3338
  dentists, 3316, 3316.1, 3334
  disposition of, 3315, 3327, 3339, 3350C
  durable medical equipment, 3322
  failure to obtain, 3315.1, 3333
  format, 3102.1, 3317B, 3322, 3327, 3333
  general provisions, 3315
  home health services, 3102.1, 3317B, 3322, 3327, 3333
  inpatient hospital services, 3315-3324
  inpatient psychiatric hospital services, 3315, 3320
  inpatient hospital services, 3315, 3321
  lifetime reserve days, 3106F
  medical insurance services, 3322
  nursing care on intermittent basis, 3121.3, 3326B
  osteopathy, doctor of, as physician, 3030, 3030.1
  outpatient physical therapy, 3148.1, 3322, 3350
  outpatient speech pathology services, 3148.1, 3322, 3350
  Part B services, 3626
  podiatrist excluded, 3030.3, 3316
  prior inpatient stay, 3326
  PSRO physician certification, 3315.2
  psychiatric services, 3102.1
  refusal of physician to certify, 3315.1, 3333, 3803
  requirement for payment, 3315, 3333
  services counting toward maximums, 3107A, 3136
  signature requirement, 3316, 3334
  skilled nursing facility services, 3139.1, 3333-3339
  timing, 3319
  visits counting toward maximum, 3124.2

Certification of parts of institution, 3148.4
Chain operation, 3464B
Chain organization, 3703.1
CHAMPUS (See Civilian Health and Medical Program of the Uniformed Services)
CHAMPVA (See Civilian Health and Medical Program of the Veterans Administration)
CHANGE OF:
  address, 3808.1
  corporate name, 3808.1
  intermediary, 3600.4
  position reopenings, 3799.12
  provider number, 3600.5
  provider ownership, 3005.2, 3009, 3507.6,
  residence, 3121.4, 3122.2, 3728.1
Charges imposed by immediate relative of patient, 3161
CHECKS:
  benefit, 3703
  cancelled, 3703.2, 3715.2B, 3728.1B(2)
  civil fraud settlement, 3479
  forgery of endorsement, 3476
  Medicare identification, 3701
  outstanding, 3703.2
  separate checks, 3715.2C, 3715.3C
  theft of Medicare checks, 3478
  unnegotiated, 3703.2, 3715.1A, E, 3728.1B(1)
  voided check procedure, 3703.2
Chest X-rays, 3152, 3157
Children of beneficiaries, 3001.3
Children of veterans, 3153.3D
Chiropodist, 3030.3
Chiropractor, 3030
CHRISTIAN SCIENCE:
  data record, 3873
  Inpatient Admission and Billing, HCFA-1486, 3698.9, 3803(21 thru 24), 3825.3, 3832C(3)
  practitioner, 3030
  prior inpatient stay exclusion 3121.1B
  Record Layout, 3881
  Sanatorium, 3023, 3121.1B, 3131.1, 3512.7, 3718.1B
Chronic renal disease (See Renal disease, chronic)
Civil Litigation and Hearings Branch, 3786F
Civil Rights Act of 1964, 3005, 3025.2C
Civil service annuitants, 3001.1, 3003.7B
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),3153.3D, 3711.1

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA), 3153.3D, 3711.1
Claim number (See Health insurance claim number)
Combined billing, 3668.2A
Comprehensive Outpatient Rehabilitation Facility (CORFs):
  claims review, 3903B1
  general, 3903A
  offsite services, 3650D
  outpatient rehabilitation, 3650
  psychiatric services, 3903G
  reasons for denial of claims, 3903F
  report of medical review activity, 3903H
Computer programs, 3656
Consistency return codes, 3882
CLAIMS (See also Forms):
  administrative error, 3307.3
  collection of overpayment, 3707, 3710.2B
  complementary, 3769D
  contacts for additional information, 3559
  definition of Part B claim, 3312.1
  denied, 3792.1
  documentation, 3446.3, 3710.2C, 3785.4, 3786B
  duplicates, 3302.3B(3), 3670
  emergency (See Emergency services)
  ESRD, 3165, 3644C(3)
  filing, 3301, 3305:
    date, 3305.2
    emergency hospital services (See Emergency services)
    hospital-filed, 3312.3
    late, 3308A, C, 3309.2,
    patient filed, 3724, 3786E
    subscriber files matched against Medicare, 3769D
    time limit, 3112
    time limit expired, 3309, 3312.5, 3525, 3816E
    time limit extended, 3307.3C, 3312.1
    timely, 3305.2, 3307, 3310
  flag "HIIB referred Congressional inquiry—Direct response required," 3735.1A
  fraud, 3460ff.
  history file, 3504(3), 3670A
  home dialysis, 3644B
  identify and correct errors, 3560
  indemnification procedures, 3430, 3446ff.
  informal, 3302.6
  integrating Title XVIII claims with complementary claims, 3769A
  liability, 3432
  mailed, 3305.3, 3312, 3312.2
  medical review, CORP, 3903
  Medicare and Medicaid involved, 3790.3

CLAIMS (CONT'D):
- overpayments liability, 3708
- recovery of payment for automobile medical, A3419.5
- request for payment, 3301ff., 3302.6, 3305.1
- sample study, 3799.6
- services outside of the U.S. (See Emergency services)
- signature, 3302.3, 3302.5

CLAIMS DATA:
- Christian Science data record, 3873
- control by intermediaries, 3602.2A(1)
- control by provider, 3602.2A1
- editing, 3602
- errors, 3602.1A
- home health agency data record, 3874
- inpatient hospital data record, 3871
- machine readable, 3602
- outpatient data record, 3872
- retention by intermediaries, 3602.1A
- retention by providers, 3602.1B(2)
- return of beneficiary data, 3602.1A(4)
- secondary payee for end stage renal disiease, 3490.4
- skilled nursing facilities data record, 3871
- submission by providers, 3602.B(2)

CLAIMS RECORDS:
- batch:
  - clearance control record, 3830.1D
  - clearance detail record, 3830.1E
  - clearance file structure, 3830.1B
  - clearance record, 3830, 3843
  - clearance tape file, 3830.1A
  - final batch record, 3830
  - interim batch record, 3830
  - RTI Reject file, 3830.1A
  - status report, 3804.3B(5), 3842, 3842.1
  - summary record layout, 3881
- batching:
  - bills, 3803, 3884
  - no payment bills, 3803(Item 25)
  - preparing bills, 3801
  - resubmitted bills, 3804.2
  - void bills, 3803(6)
- bill history, 3840ff.
- bills, 3883
- documentation of files, 3786B, 3792.2H

CLAIMS RECORDS (CONT'D):
  intermediary:
    header record, 3830.1C
    trailer record, 3830.1F
  marking claims files prohibited, 3783.7
  monthly batch status report, 3842
  preparing bills, ESRD, 3883.1
  prehearing case review, 3785.8
  reporting bills to SSA, 3801
  request for hearing file, 3785.9
  timely transmission of bills, 3805
  written complaint or inquiry, 3782.1B
Clerical error, 3464A, 3799.9
Clinic services (coverage), 3112.4A, 3112.5, 3147,
Clinical laboratory, defined, 3101.5
Codes (See Disposition codes; and Query procedures)
Coding Structures, Addendum C
COINSURANCE:
  billing, 3626
  CHAMPUS/CHAMPVA
  days become lifetime reserve days, 3709.3D
  effect of workers' compensation, 3409.3
  erroneous payment, 3711.4A
  extended care services, 3210, 3512.4B
  home health services, 3225
  hospice care, 3141, 3142
  incorrect application, 3707(2)
  incorrectly collected, 3401
  incorrectly paid, 3708.2C
  indemnification requests, 3446.4
  inpatient hospital services, 3107A, 3203, 3512.4B,
  late filed claim, 3308A
  lifetime reserve days, 3104.5, 3106A, 3512.4B, 3709.3D
  misapplication, 3708.2B
  no payment bills,
  overpayment, 3711.7A
  Part A amounts, 3211
  radiology services, 3146C
  supplementary medical insurance, 3146D, 3212, 3214
  utilization edits, 3828E
  workers' compensation, effect of, 3409.3
Colostomy bag and accoutrements, 3110.3, 3110.4
COMBINED BILLING:
  intermediary responsibilities in implementing reimbursement policies, 3912ff.
  pathology services, 3146B, A3146
  querying Part B eligibility, 3512.6B
  radiology services, 3146B, A3146
  time limit, 3312.4

Communications, 3701
Community hospitals, 3153.1A
Compendia, drug, 3101.3A
Compensation arrangements (See Physician: compensation arrangements)
Complaints, 3459
Comprehensive Outpatient Rehabilitation Facility (CORF), 3180 - 3183, 3370ff, 3903ff
Computer Programs Supplied by HCFA, 3656
CONDITIONS OF PARTICIPATION:
  home health agencies, 3025
  hospitals, 3010,
  psychiatric hospital, 3016
  skilled nursing facilities, 3020
  subdivision of agencies, 3025.1
  utilization review plan, 3420, 3420.2
Confidentiality of information (See Disclosure of information)
CONGRESSIONAL CORRESPONDENCE:
  affirmation, 3735(Ex. 5)
  close-out letter, 3735(Ex. 5A)
  Congressional inquiries, 3735ff.
  general instructions, 3736A
  interim response, 3735, 3735.1D
  Part A reconsiderations, 3735
  provider cost reports requests, 3773C
  query procedures, 3537
  special handling, 3736B
  substantive interim responses, 3735, 3735.1E
  waiver of beneficiary liability, 3735
CONSISTENCY EDITS:
  adjustment bills, 3825.6
  all bill types, 3606, 3868
  bill error report, 3845ff.
  Christian Science data record, 3873
  claims, 3824
  defined, 3830
  error, 3832
  error codes, 3828.1, 3828.3
  explanation of error codes, 3825
  failed, 3827.1
  final nonpayment bill record, 3875, 3880.6
  home health agency data record, 3874
  inpatient hospital data record, 3871
  magnetic tape batches, 3824, 3825, 3825.5
  magnetic tape files, 3868
  noncovered bills, 3825.7
  outpatient data record, 3872
  passed, 3827.2
  RTI Void:
    bill record, 3876
    Record Layout, 3881

CONSISTENCY EDITS (CONT'D):
  SNF data record, 3871
  specialized, 3825.5
  testing, 3561, 3563
Contact lenses (See Lenses)
CONTRACT:
  cost reimbursement, 3360B
  Performance Review reports (CPR), 3774B
Convicted physicians, 3484, 3486
CORP claims, 3903
Corrected bills, 3106.2C, 3460C, 3803(26), 3816ff.
Cosmetic Surgery:
  exclusion from coverage, 3160
  face repaired after accident, 3160
  waiver of liability not applicable, 3431B(1)
Cost basis (See Reasonable cost basis)
Cost Classification Report, HCFA-2580, 3775A(11)
Cost reports (See Reports)
Cost Accrued During Quarter, Cummulative Costs by Contract and FY, Schedule III, HCFA-1822B, 3775
Council of Dental Education of the American Dental Association, 3101.6, 3119.4,
Council of Podiatry Education of the American Podiatry Association, 3101.6, 3119.4
Counselors, religious, 3421.1E
Counting home health visits, 3124ff.
Court decisions (See Appeals of payment determinations)
Covered Ambulatory Surgical Procedures, Addendum F
COVERED SERVICES :
  ambulatory, 3138
  automobile medical, 3408.2
  chronic kidney failure, 3165
  coinsurance, 3142
  comprehensive outpatient rehabilitation facility (CORF), 3180 - 3183
  counting toward maximum, 3107, 3136
  deductible satisfied by, 3235
  dental, 3101.7
  End Stage Renal Disease Group Health Plans, 3490ff
  election procedures, 3141ff
  extended care services, 3130, 3130.1, 3132, 3133ff., 3135
  foot surgery, 3158
  foreign hospitals, 3121.1
  general, A3101.1
  health maintenance organizations, 3360
  hearing determination issue, 3794.6
  home dialysis equipment, 3170.1, 3170.5
  home health services, 3116, 3120, 3122ff., 3638
  hospice care, 3142
  hospital "admission packs," 3101.4, 3107C

COVERED SERVICES (CONT'D):
  inpatient services, 3101
  inpatient services, 3107
  interns or residents-in-training, 3101.6
  kidney transplantation, 3001.3
  lifetime reserve days, 3106ff
  medical/health services to SNF patients, 3137
  occupational therapy, 3101.9B, 3118
  outpatient hospital services, 3112
  outside the U.S., 3154, 3310
  physical therapy, 3101.8, 3118
  preadmission diagnostic, 3112.3
  pregnancy, 3101.12
  presumed coverage:
    extended care services, 3139ff.
    home health services, 3129ff.
  prosthetic devices, 3110.4
  prosthetic lenses, 3110.4
  providers of extended care, 3130.1, 3432.2
  provider-based physicians, 3145,
  psychological services, 3183.8
  rehabilitation care, 3101.10
  requirements, general 3130
  requirement for payment under guarantee, 3714.2A
  Rural Health Clinics, 3642
  Skilled Nursing Facility level care, 3132, 3630
  standards for coverage, 3439.2
  swing-bed, 3634A, B
  workers' compensation law, 3163, 3407
"Credit" bill, 3803(28), 3816F(1)
Criminal intent, 3454.1A
Criminal violation of Act, 3460A(2)
Critical case procedure, 3538-3538.2
  defined, 3132, 3159ff.
  extended care services, 3131.1, 3133, 3159.1, 3431.1A,
  overpayment, 3707(3), 3708, 3708.5, 3710.1(I), 3710.3C(2), 3711.6F
  provider:
    liable, 3432.2A, 3710.4A
    right to appeal, 3430, 3781.4
  psychiatric hospitals, 3105
  utilization review, 3421.1
  waiver of liability, 3431A(2)
Customary charges, definition, 3101.1D, G, 3410.1, 3410.2

-D-

Daily skilled services, 3132.1
Data Elements:
  alphabetic listing, Addendum B
Day patient, 3112.1
DEATH:
  admission date after month of, 3512.7
  after check-out time, 3103.2
  ambulance service to deceased beneficiary, 3114C
  before request for payment is filed, 3302.5B, 3302.6
  before settlement of claim, 3715A
  counting coverage days, 3103.1, 3103.4
  day of, 3103.1, 3135.4
  "dead on arrival," 3112.1
  disclosure of information, 3767
  entitlement for month of, 3001
  expense month after, 3535
  Explanation of Medicare Benefit (EOMB) form returned because of, 3728.1
  first day of entitlement, 3103.4,
  first day of SNF participation, 3135.4
  legal representative of estate may sign, 3302.5B, 3302.7
  month of, 3001.4D, 3003.5D
  notice, 3715.1A, 3728.1
  refund due deceased, 3401.1A
  refund request to estate of deceased, 3711.8
  revocation of election not to use reserve days, 3106.3
"Debit" bill, 3106.2C, 3803(28), 3816F(1)
DEDUCTIBLES:
  allocating expenses toward, 3213, 3225, 3525.4
  annual, Part B, 3213
  blood deductible (See Blood)
  carryover, 3213, 3525.1
  CHAMPUS/CHAMPVA may pay, 3153.3D(3)
  charges for home health services satisfy, 3225B
  coinsurance, 3203,3214
  effect of workers' compensation, 3409.3
  erroneous payment, 3711.4A
  exceptions, 3215
  first-in-first-out, 3525.4
  hearing determination issue, 3794.6
  home health services, 3225

DEDUCTIBLES (CONT'D):
  improperly applied, 3708.1
  incorrect application, 3707(2)
  incorrectly collected, 3401
  incorrectly paid, 3708.2C
  incurred expenses basis, 3212, 3527
  indemnification requests, 3446.4
  inpatient hospital, 3107A, 3201, 3518.2(Item F),
  late filed claim, 3308A
  not met, 3525.3,
  outpatient hospital diagnostic, 3527
  overapplied Part A, 3828E
  overpayment, 3708.1, 3708.2B, C, 3711.7A, A3419.5, A3419.6
  Part A deductible, 3201, 3211, 3235.1, 3512.4B
  Part B deductible, 3146, 3213, 3225B, 3512.6A, 3518.2(Item E), 3525.2, 3525.8, 3535, 3537A, 3545H, A3419.6
  radiology services, 3146C
  reviewed, 3718.1B(Item 2(3))
  secondary payer, 3695
  utilization edits, 3828E
Defective delinquents, 3153.3C(2)
Delayed physician certification (See Certification by physician)
DENIAL:
  disallowance form letters, 3721
  notice:
    beneficiary not personally liable, 3719.1, 3719.2
    beneficiary refused to sign, 3722.4
    full denial (HCFA-1954), 3781.8B
    partial denial (HCFA-1955), 3719.1B, 3781.8B
    preparation, 3443
    PRO determination, 3719.4
    status queries, 3525
    total denial (HCFA-1954), 3719.1
  patterns, 3444.6
  Preprinted Stock Denial Letter, HCFA-1954E, 3722.3
  rate:
    calculation, 3434.4, 3434.7
    criterion, 3444.2, 3444.5
    drastic fluctuations, 3433.3
    End Stage Renal Disease Facilities claims, 3444.5
    excessive, 3433.4, 3444.2A
    home health agencies, 3433, 3434.1
    hospitals, 3433, 3434.1
    outpatient physical therapy, 3444.5
    skilled nursing facilities, 3433, 3434.1
    statistics, 3434.2

DENTISTRY:
  stock paragraphs:
    home health agencies, 3722.3
    hospitals, 3722.1
    miscellaneous, 3722.4
    skilled nursing facilities, 3722.2
  certification for hospital admissions for dental services, 3316.1
  certification or recertification by doctor of dentistry, 3316, 3334
  dental services exclusion, 3162, 3431B
  dental splints, 3110.3
  dentures, 3110.4B
  doctor of dental surgery, 3030, 3030.2
  documentation, noncovered dental stays, 3783.1C
  drug unfavorably evaluated, Accepted Dental Therapeutics, 3101.3A
  inpatient hospital services, 3101.7
  intern or residents-in-training, 3101.6, 3119.4, 3133.7
  noncovered dental care, 3431B
Department of Housing and Urban Development (DHUD), 3153.1
Department of Justice referral, 3468.1A, 3468.2
Department of Labor Acceptable List, 3415.3E
Dependent children, 3001.3
Dependent children of veterans, 3153.3D
Determination of Amount of Provider-Based Physician Compensation Reimbursable Under Part B, 3912.3
Determination of Uniform Optional Percentage (Ex. IIA), 3912.3
Development Needed, Addendum F
Devices for reduction of fractures and dislocations, 3110.3, 3127A
DHEW Public Information Regulation, 3760,
Diagnosis-Related Group(DRG), 3798
DIAGNOSTIC SERVICES AND TESTS:
  Department of Labor Acceptable List, 3415.3E
  hospital, 3133.8
  independent clinical laboratory, 3101.5B
  items and services, 3101.5
  mental illness, 3104.4
  outpatient hospital services, 3112ff., 3212, 3322
  X-ray and laboratory tests, 3110A, 3212
DIALYSIS:
  appropriate facilities, 3114C
  equipment as prosthetic device, 3110.4
  Group Health Plan Payment, 3490ff,
  hospitalization, 3101B
  medical supplies, 3212
  self-dialysis training, 3001.3
  under Part A, 3001.3
  under Part B, 3110.4, 3212

Direct Dealing Group Practice Prepayment Plans (See Group practice prepayment plans)
Direct Deposit Form, SF-1199, 3718
Directory, Health Maintenance Organizations, 3558
Directory of Medical Facilities, 3520.2, 3547, 3555,
DISABILITY:
  automatic enrollment to SMI, 3003.2
  hospital insurance coverage, 3001.2
  provision, 3121.1B, 3131.1
  railroad claims (See Railroad disability annuitants)
  service-connected, 3153.3D
  VA benefits, 3153.3D(1)
DISALLOWANCE LETTER:
  disposition of undeliverable HCFA-1954 or HCFA-1955, 3728.1A
  general, 3721
  intermediary sent, HCFA-1954 and HCFA-1955, 3719.1, 3719.4, 3721, 3781.8B
  stock denial paragraphs, 3722ff.
DISCHARGE:
  complaint, 3782.1D
  day of admission, 3103.1,
  first day of entitlement, 3103.4,
  first day of SNF participation, 3135.4
  fourteen-day transfer period, 3131.3
  individual has no home, 3421.1B
  last discharge date, 3520.1, 3545J, 3546
  late, 3103.2, 3135.2
  noncovered discharge bill, 3832C
Discharge Notification, HCFA-2196, 3512.7
DISCLOSURE OF INFORMATION:
  about:
    individuals, 3763, 3764A
    physicians, 3773D
    providers and suppliers, 3773
    suppliers of services, 3773D
  administrative necessity, 3764, 3765, 3768, 3773B
  after death of beneficiary, 3767
  audit reports, 3774C
  authority for disclosure, 3002.1B, 3002.2, 3763.2
  authority for refusal to disclose, 3763.1B
  authorization form, 3768C

DISCLOSURE OF INFORMATION (CONT'D):
- **BEST** use, 3506.1
- **CAST** use, 3505.1
- fees, 3761ff., 3765C, 3773C
- Freedom of Information Act (See Freedom of Information Act)
- general, 3760
- good cause, 3766B
- intermediary use of claims information, 3768C
- medical information, 3765B, 3768B
- Medicare reports, 3773C
- methods for handling requests, 3768C
- names of providers, physicians, and suppliers, 3773E
- nonmedical information, 3765A, 3768A
- ordered by U.S. District Court, 3773C
- penalties for unauthorized disclosure, 3764B
- penalty for failure to comply, 3763.1C
- procedures for handling requests, 3760.1
- procedures for release, 3772C
- program materials, 3762
- prohibited, 3763.1
- provider payment data, 3773.1
- Provider Payment List for public disclosure, 3773.1E
- reports about named contractors, 3774
- sample letter, 3764B
- statistics, 3775
- statutes and regulations, 3760
- to:
  - individual or authorized representative, 3765
  - Internal Revenue Service, 3771
  - members of patient's household, 3766A
  - source of medical evidence, 3768B
  - third parties, 3764B, 3773B(2)
  - third parties, nonprogram purposes, 3768
  - whom information may be released, 3766
- unauthorized disclosure, 3764B
- unethical conduct by practitioner, 3480A
- violation of disclosure provisions, 3763.1C
- written request for information, 3760.1, 3773C

Discrimination prohibited, 3005, 3025.2C(7), 3101.1F

DISPOSITION CODE:
- interest amount, 3640, 3871
- Part A, 3512.7, 3550
- Part B, 3535C
- Procedure codes for alcohol rehabilitation, 3610.13D
- SSA's reply to notice of admission, 3512.7, 3535

- **DISTINCT PART:**
  - of hospital, 3121.1B
  - of institution, 3101(Note), 3120.5, 3148.4
  - of institution as psychiatric hospital, 3104.1, 3104.2
  - of institution as skilled nursing facility, 3020, 3020.1, 3501.1
- District office (See Social security office)
- Divorce, wife's benefits terminated, 3001
  - Coverage guidelines, 3116
  - interns and residents, 3115
  - medical equipment, 3119.3
- Doctor (See Physician)
- **DOCUMENTATION PROCEDURES:**
  - bills, 3816.1A(3)
  - evidence from providers, 3783.5
  - evidentiary requirements, fraud cases, 3460C
  - failure to submit documentation, 3912.1B
  - file documentation requirements, 3912.2
  - follow-up, 3783.6
  - guide list, 3401.5
  - marking claim files prohibited, 3783.7
  - pertaining to:
    - home health services care, 3783.1F
    - inpatient dental services, 3783.1C
    - inpatient hospital care, 3783.1A
    - post operative cataract patients, 3117.4A
    - private room issue, 3783.2
    - skilled nursing facility care, 3783.1D
  - recording overpayment cases, 3711.10
  - waiver of liability:
    - beneficiary, 3783.3
    - provider, 3783.4
  - work-related condition, 3414B
- Drainage tubes, 3101.4
- Draining wounds, 3117.4A
- **DRUGS:**
  - administered by physician, 3119.3C
  - administration of medications, 3117.4H
  - combination, 3101.3C, 3133.5C
  - compendia, 3101.3A
  - durable medical equipment use, 3112.4B, 3113.4
  - furnished by SNF, 3020, 3133.5, 3137,
  - furnished to inpatients, 3101.3
  - furnished to outpatients, 3112.3B
  - immunosuppressive, 3660.8
  - insulin injections, 3117.4H

DRUGS (CONT'D):
  Laetrile, 3101.3B
  oral medications, 3117.4H
  prosthetic device use, 3110.4C, 3112.4B
  reasonable and necessary, 3101.3, 3133.5, 3133.5B
  safety and effectiveness, 3101.3B
  self-administered drugs excluded, 3112.4B, 3119.3C
  specially ordered for inpatients, 3103.3D
  therapy, 3102.1A
  unfavorably evaluated, 3101.3A
Duplicate HCFA-1483, Claims controls, 3670
DURABLE MEDICAL EQUIPMENT (See also Equipment):
  coverage guidelines, 3113.5,
  decision to rent or purchase, 3113.7A
  defined, 3113A, 3113.1, 3119.3B
  delivery, 3113.3D
  drugs, biologicals, 3112.4B, 3113.4
  drugs, biologicals, nutrient solutions, 3110.4C, 3113.4
  enrollee:
    died, 3113.7B
    institutionalized, 3113.7B
    outside United States, 3113.7B, 3154
  exception items, 3113.1B
  hemodialysis equipment—home use, 3113.7E
  home use, 3113C, 3113.7E, 3212
  incurred expenses, 3113.7B
  inexpensive equipment, 3113.7A, 3113.7D
  lump-sum payment, 3113.7A
  maintenance, 3113.3B,
  medical equipment, 3113.1B
  medical necessity, 3113B, 3113.7E,
  necessary and reasonable, 3113.2
  nonmedical equipment, 3113.1B
  Part B, 3113
  Part B query, 3525.2, 3525.7
  periodic payment, 3113.7A
  physician's certification required, 3322
  presumptively medical, 3113.1
  purchase, 3113, 3113.7A, 3127E, 3127.1B, 3137, 3212(9), 3322, 3525.2
  purchased before coverage begins, 3113.7B
  rental, 3113, 3113.7A, 3137E, 3212, 3322
  repairs, 3113.3A,
  replacement, 3113.3C
  reporting monthly charges for, 3525.7
  selected revenue center codes, 3872.1
  supplies, incident to equipment, 3113.4

DURABLE MEDICAL EQUIPMENT (CONT'D):
  three-month tolerance rule, 3113.7E
  title, 3113.5
  use in institution, 3113.7D
  use in patient's home, 3113.7C, 3137,

-E-

Economic Index Data, 3772B
Edema, 3117.4A
Edits (See Consistency edits or utilization edits)
Election lifetime reserve days (see Lifetime reserve days)
Electronic Billing File and Record Formats, 3602, 3602.1
Eligibility notice, 3502.1, 3510ff.,
Eligibility testing, 3560, 3562
EMERGENCY SERVICES:
  beneficiary-filed claims, 3724, 3786E
  billing, 3310
  "dead on arrival," 3112.1
  denials and partial approval of claims, 3725
  effect on spell of illness, 3035A
  excess costs, 3780.1B
  Federal hospitals, 3153.1
  foreign hospitals, 3012, 3718
  health maintenance organizations, 3360.1
  inpatient services, 3012, 3718
  lifetime reserve days, 3106E
  nonparticipating hospitals, 3012.1, 3715A, 3780.1A
  notices for hospital filed claims, 3725
  notices for patient filed claims, 3724
  open-item provider, 3519.4
  outpatient services, 3012, 3112.4A, 3715A
  outside United States, 3310, 3520.2
  psychiatric hospitals, 3012.1
  request for reconsideration, 3780.1A
  skilled nursing facilities, 3020
  veteran without prior authorization, 3153.2
End-of-year settlement, 3101.1F
End-stage renal disease (ESRD), 3001.3, A3040.1, 3113.7B, 3170, 3444.4, 3490.1,
Enemas, 3117.2A, D, 3117.4F
Enrollment periods, 3004
  not entitled to Part A, 3708.2E
  CHAMPUS/CHAMPVA and Medicare, 3153.3D
  dependent children, 3001.3
  individual not entitled, 3707
  interrupted period, 3532

- **ENTITLEMENT:**
  - Medicare benefits, 3711.7C
  - Part A, 3001, 3302.6, 3518.2, 3768C
  - Part A instead of Part B, 3538, 3794.6
  - Part B, 3003.1, 3518.2, 3538,
  - questions involving, 3780.1A
  - retroactive, 3401B(1)
  - social security benefits, 3001.3, 3780.1A
  - spouse of HIB, 3001.3
  - status, 3537
  - testing, 3560, 3562
- **EOMB** (See Record of Part B Medicare Benefits Furnished by Provider and Your Record of Part B Medicare Benefits Used)
- **EQUIPMENT** (See also Durable medical equipment):
  - as covered:
    - extended care service, 3133.6, 3133.9A,
    - home health services, 3119.3B,
    - inpatient hospital services, 3101.4
- Error codes (See Consistency edit: error codes)
- Error on face of evidence, 3799.10
- Estimate of Administrative Costs and Credits, HCFA-1523, 3775A
- **EVIDENCE OF PROOFS:**
  - additional evidence submitted, 3785.5
  - cancelled checks, 3715.2B
  - conflict in evidence, 3715.1G, 3784.2
  - documentation by foreign hospital, 3131.2
  - error in file, 3785.5
  - "error on face of the evidence," 3799.10
  - evaluating evidence, 3784ff.
  - new or material evidence, 3799.8
  - order of appointment, legal representative, 3715.4B
  - proof of payment, 3446.3
  - providers serviced by other intermediaries, 3783.5
  - receipted bills, 3715.2B
  - statement from provider, 3715.2B
  - weight of physician's evidence, 3784.1C
- "Excess cost" provider, 3780.1B
- Excessive services, 3772B, 3773E(3)
  - automobile medical or no fault insurance, A3419
- **EXCLUSIONS FROM COVERAGE:**
  - cataract sunglasses, 3110.4A
  - charges imposed by immediate relatives of patient, 3161
  - comprehensive outpatient rehabilitation facility (CORF), 3180 - 3183
  - cosmetic surgery (See Cosmetic surgery)
  - custodial care (See Custodial care)

EXCLUSIONS FROM COVERAGE:
- dental services (See Dentistry)
- dentures, 3110.4B
- drug:
  - unfavorably evaluated, 3101.3A
- foot care exclusion, 3158, 3431B
- general exclusions, 3150
- governmental entities paid or authorized services, 3152ff.
- infant care, 3101.11
- medical necessity lacking, 3421B
- personal comfort items, 3156
- services not reasonable and necessary (See Services: not reasonable and necessary)
- war, services resulting from, 3155
- workers' compensation, 3163, 3407

Executor (See Legal representative)

Exercises, 3101.8C, 3117.4D, 3118.1C

Exhaustion of benefits (See Benefits exhausted)

EXHIBITS (For forms, see specific title of form):
- Abuse Report, HCFA-51, 3455.1
- Batch Status Report, 3842
- Batch Summary Record Layout, 3881
- Christian Science Record Layout, 3880.4
- Final Nonpayment Bill Record Layout, 3880.6
- Freedom of Information Inquiry, HCFA-3179, 3776
- Full Denial—Hospital-Filed or Beneficiary-Filed Emergency Claim, 3725
- Guide Language to Beneficiary or His Representative Explaining Waiver of Liability and Possible Right to Indemnification, 3445
- Guidelines for Mailing Material in Response to Freedom of Information Requests, 3776
- Health Insurance Cards, 3550
- HI Bill Retrieval Listing—Format, 3840
- Home Health Agency Query Reply Codes, 3550
- Home Health Agency Record Layout, 3880.5
- Hospital/SNF Model Letter, 3730.1
- Inpatient (General) Query Reply Codes, 3550
- Inpatient Hospital and Skilled Nursing Facility Admission and Billing, HCFA-1453,
- Inpatient (Hospital or SNF) Query Reply Codes, 3550
- Inpatient Hospital/SNF Record Layout, 3880.2
- Intermediary Transmittal of Uncollected Medicare Overpayments, HCFA-2382, 3712.1
- Intermediary Workload Report, HCFA-1566, 3894.4
- Letter to Accompany Reconsideration Determination, 3784
- Letter to Beneficiary Who Requests Indemnification, 3446.9
- Letter to Provider, 3446.9
- Letter to Provider Which is Party to Reconsideration and Medicare Payment Is Being Made under Waiver of Liability Provision, 3784(Ex. 7)
- Letter to Someone Other Than Beneficiary Who Requests Indemnification, 3446.9

EXHIBITS (CONT'):

Medicare Hearing Information Sheet, 3795
Medicare Hospital, Extended Care and Home Health Benefits Record, HCFA-1533, 3718.1
Medicare Hospital, Extended Care and Home Health Benefits Record, RR-100, 3718.1
Model Letter to Provider Who Is a Party to a Reconsideration Request Filed by the Beneficiary, 3784
Notice of Medicare Claim Determination, HCFA-1954, 3721
Notice of Medicare Claim Determination, HCFA-1954C, 3721
Notice of Medicare Claim Determination, HCFA-1955, 3721
Notice of Medicare Claim Determination, HCFA-1955I, 3721
Notification of Internal Adjustment Action(s) Taken by SSA, SSA-L1001, 3816.2
Offices of the U.S. Railroad Retirement Board, 3550
Outpatient (Part A Intermediary) Query Reply Codes, 3550
Outpatient Record Layout, 3880.3
Part A Deductible and Coinsurance Amounts, 3211
Part A Disposition Codes by Query Codes, 3550
Part A Quarterly Report of Program Integrity Complaints, 3459.2
Part A Reconsideration Status, HCFA-2442, 3784
Partial Denial—Hospital—Filed or Beneficiary-Filed Emergency Claim, 3725
Quarterly Supplement to Intermediary Workload Report, HCFA-1566A, 3898.4
Query/Query Reply Telegram Data Sheet, 3557
Reconsideration Determination, HCFA-2501, 3784
Regional Map—U.S. Railroad Retirement Board, 3550
Request for Hearing—Part B Medicare Claim, HCFA-1965, 3795
Request for Part B Query History, 3537
Request for Reconsideration of Part A Health Insurance Benefits, HCFA-2649, 3784
Request for Review of Part B Medicare Claim, HCFA-1964, 3795
Requests for HI Bill Retrieval Listing (Bill History), 3840.2
RTI Void Record Layout, 3880.7
Sample Letter-Full Payment, Revised Reconsideration Determination After Request for Hearing has Been Filed, 3785.7
Sample Letter—Partial Revision, Revised Reconsideration Determination After Request for Hearing Has Been Filed, 3785.7
sample letter to beneficiary (reversal), 3784
sample letter to provider (reversal notification), 3784
Sample Notice to the Resident Intermediary of Full or Partial Reversal, 3784
SSA Requests for Adjustment Bills, SSA-L389,
Statement of Claimant or Other Person, HCFA-795, 3446.9
Summary Totals Report, 3890
Temporary Notice of Medicare Eligibility, 3550
Trailer Record Layout, 3882
Transmittal and Report Form, 3890

EXHIBITS (CONT'D):
- Your Record of Part B Medicare Benefits Used, 3726.1
- Explanation of Medicare Benefits (EOMB) (See Record of Part B Medicare benefits furnished by a provider)

EXTENDED CARE SERVICES:
- ambulance, 3114
- benefit days, 3135, 3136
- biologicials, 3133.5
- coinsurance, 3203
- covered services, 3132, 3133ff.
- custodial care, 3131.1, 3133, 3159.1, 3431.1A,
- documentation pertaining to services, 3783.1D
- drugs, 3133.5
- duration, 3135ff.
- equipment, 3133.6
- hospital providers, 3130.1
- inpatient day, 3135.1
- intern and resident-in-training services, 3133.7
- maximum benefit days, 3136
- medical and other health services, 3133.9A, 3137
- medical social services, 3133.4
- nursing care, 3133.3
- physical therapy, 3132.8
- prior inpatient stay, 3103.2, 3139.1, 3431.1
- request for payment, 3301
- skilled nursing services, 3132.2
- spell of illness, 3035A
- supplies, 3133.6
- under arrangements, 3119.5, 3133.8
- unreplaced blood, 3235.6

EXTENDED STAYS IN HOSPITALS:
- failure to timely review cases, 3421.2
- recertification by physicians, 3315, 3317D
- utilization review, 3420

EYES:
- artificial, 3110E, 3110.5, 3112.4C, 3127C, 3212
- contact lenses (See Lenses)
- drops, 3117.4H(3)
- eye care exclusion, 3157
- eyeglasses, 3110.4A, 3157

-F-

- Face surgery after accident, 3160
- **FACILITIES:**
  - availability and appropriateness, 3421.1
  - location, 3421.1C
- Fair hearing, Part B (See Also Appeals of payment determinations), 3791, 3794ff.
- False Claims Act, 3468A
- Fault, similar, 3707.1, 3709.2B, 3799.13
- Fecal impaction, 3117.1
- **FEDERAL:**
  - agencies requests for cost report information, 3773C(3cl)
  - Black Lung Program, 3409.4
  - Claims Collection Act of 1966, 3707
  - Employees Compensation Act, as workers' compensation plan, 3407
  - Employees Health Benefit Plan, 3001.1
  - Employee's Health Benefits Program, 3711.1
  - Employer's Liability Act not a workers' compensation plan, 3407
  - "Government in the Sunshine Act," 3773.1A
  - Government research grants, 3152B, 3153.3B
  - governmental entities paid or authorized services, 3153ff.
  - holidays (See Non-work days)
  - holidays, guarantee of payment provision, 3714.1
  - Hospital Insurance Trust Fund, 3476B
  - providers of services, 3121.1B, 3153.1
  - State agreement, welfare patients, 3003.1, 3003.5C
  - Supplementary Medical Insurance Fund, 3476B
  - workers' compensation, 3431B
- Fees for information, 3761ff., 3765C, 3773C
- **FILES MAINTENANCE:**
  - annotation, 3728.1A
  - commingling of records, 3769C
  - documentation of files, 3783ff., 3785.4, 3786B, 3792.2H, 3912.2
  - HMO history file maintenance, 3654
  - HMO master file corrections, 3537.1
  - hearing file, 3785.9
  - history files, 3654
  - inclusion of billing forms, 3783.9
  - reconsideration file, 3784.1, 3784.13
  - request for hearing file, 3785.9
  - RTI Removal Notice, 3804.3C
  - RTI suspense file, 3804.3C
  - RTI Utilization Reject File, 3831.1
  - SNF claims file, 3630
- SSA's Health Insurance Master Record, 3512.7

Filing claims (See Claims)
Final Summary of Audits Completed During Quarter-Schedule II, HCFA-1822A, 3775A
First-in-first-out bill processing (See Billing: insequence processing)
Flat feet, 3158A
Foley catheter, 3110.4
FOOD AND DRUG ADMINISTRATION:
  safety and effectiveness of drugs, 3101.3B
Foot care exclusion, 3158ff., 3431B(1)
FOREIGN HOSPITALS:
  beginning a spell of illness, 3035A
  effect of spell of illness on coverage, 3121.1A
  emergency inpatient hospital services, 3310, 3698
  noncovered stay, 3520.2
  processing claims, 3698.12
  services in nonparticipating hospitals, 3121.1
  services not provided within U.S., 3154, 3310
  skilled nursing facility admission, 3520.3
  termination of emergency services, 3698.16
  three-day prior hospitalization, 3121.1C, 3121.2
  time limitation for filing claims, 3698.16
Foreign medical schools, unlicensed graduates, 3115A
Foreign service exclusion, 3154
Forgery investigations, 3476
FORM:
  G-43, Health Insurance Card, Railroad Retirement Board (See title of form)
  HA-501.1, Request for Hearing Part A Health Insurance Benefits (See title of form)
  HCFA-51, Abuse Report (See title of form)
  HCFA-60, Postpayment Medical Review (Abuse Cases) Summary Report—Medicare (See title of form)
  HCFA-352, Part A Reconsideration Input Record (See title of form)
  HCFA-485, Home Health Certification and Plan of Treatment, Addendum D
  HCFA-795, Statement of Claimant or Other Person (See title of form)
  HCFA-1450:
    Inpatient and Outpatient Bills (See title of form)
    Uniform Bill (See title of form)
  HCFA-1490, Request for Medicare Payment (See title of form)
  HCFA-1491, Ambulance
  HCFA-1522, Monthly Intermediary Financial Report (See title of form)
  HCFA-1523, Estimate of Administrative Costs and Credits (See title of form)
  HCFA-1527, Operations Schedule—Cummulative Interim Expenditure Report and Budget (See title of form)
  HCFA-1533, Medicare Hospital Extended Care and Home Health Benefits Record (See title of form)
  HCFA-1561, Provider Agreement (See title of form)
  HCFA-1566, Intermediary Workload Report (See title of form)
  HCFA-1566, Supplement (1972 Amendment Supplement to Intermediary Workload Report) (See title of form)

FORM (CONT'D):
HCFA-1568, Reply to Notice of Admission (See title of form)
HCFA-1577, Part B Inquire Coding Sheet, Addendum A, Chapter VI (See title of form)
HCFA-1577a, Part A Notice of Admission Coding Sheet, Addendum A, Chapter VI (See title of form)
HCFA-1615, Operations Schedule—Final Administrative Cost Proposal (See title of form)
HCFA-1660, Statement of Person Regarding Medicare Payment for Medical Services to Deceased Patient (See title of form)
HCFA-1771, Attending Physician's Stataement and Documentation of Medicare Emergency
HCFA-1822, Monthly Provider Audit Activity Report—Schedule I (See title of form)
HCFA-1822A, Final Summary of Audits Completed During Quarter—Schedule II (See title of form)
HCFA-1822B, Costs Accrued During Quarter, Cummulative Costs by Contract and FY, Schedule III (See title of form)
HCFA-1885A, Provider Chain/Operator Data (See title of form)
HCFA-1954, Disallowance Letter from Intermediary (See title of form)
HCFA-1955, Partial Disallowance Letter from Intermediary (See title of form)
HCFA-1964, Request for Review of Part B Medicare Claim (See title of form)
HCFA-1965, Request for Hearing—Part B Medicare Claim (See title of form)
HCFA-1966, Health Insurance Card (See title of form)
HCFA-1980, Carrier or Intermediary Request for SSA Assistance, (See title of form)
HCFA-2181, Notice of Intermediary HI Bill Batch Processing Status (See title of form)
HCFA-2196, Discharge Notification (See title of form)
HCFA-2382, Intermediary Transmittal of Uncollected Medicare Overpayments (See title of form)
HCFA-2442, Part A Reconsideration (See title of form)
HCFA-2501, Reconsideration Determination (See title of form)
HCFA-2580, Cost Classification Report (See title of form)
HCFA-2582, Plan of Expenditures (See title of form)
HCFA-2584, Monthly Cost Report (See title of form)
HCFA-2598, Budget Distribution (See title of form)
HCFA-2628, Foreign HI Claim or Emergency Services Accessibility Documentation and Determination
HCFA-2743, Medicare Chronic Renal Disease and Service Information (See title of form)
HCFA-3179, Freedom of Information Inquiry (See title of form)
HCFA-3208, Provider Audit Cost Report (See title of form)
HCFA-3286, Monthly Actuarial Sample of Hospital Reimbursement (See title of form)
RR-100, Medicare Hospital Extended Care and Home Health Benefits Record (Railroad Retirement version of HCFA-1533) (See title of form)
SF-1199, Direct Deposit Form, available at checking and savings institution (See title of form)
SSA-1560, Petition to Obtain Approval of a Fee for Representing a Social Security Claimant (See title of form)
SSA-1696, Appointment of Representative (See title of form)

FORM (CONT'D):
- SSA-1938, SSA Request for Carrier or Intermediary Assistance (See title of form)
  - wrong form used, 3305.1
  - by intermediaries re "provider payment list," 3773.1
  - correcting improper deductible information, 3534
- denied Part A claim:
  - affirmation, 3735
  - close-out letter, 3735
  - full reversal, 3735
  - interim response, 3535
  - partial reversal, 3735
  - substantive interim responses, 3735
- Denial Letter - Beneficiary Consenting to Placement in Noncertified or Certified Bed, 3431.3 (No. 5)
- Denial Letter - Beneficiary Did Not Receive Otherwise Covered Hospital Services, 3431.3 (No. 3)
- disallowance form letters, HCFA-1954 and HCFA-1955, 3719.4, 3721
- explanation of data content, 3773.1C, 3773.1
- explanation of SSA-L 389, 3817.1
- HI-2 to intermediary enclosing congressional inquiry, 3735, 3735.1
- Letter to Accompany Reconsideration Determination, 3781.1, 3784
- Letter to Beneficiary Where Recovery Is Being Sought from Provider, 3710.4
- Letter to Beneficiary Who Requests Indemnification, 3446.9
- Letter to Provider, 3446.9
- Letter to Provider which is Party to Reconsideration and Medicare Payment is Being Made Under Waiver of Liability Provision, 3784
- Letter to Someone Other Than Beneficiary Who Requests Indemnification, 3446.9
- Model Letter to Provider Who Is a Party to a Reconsideration Request Filed by the Beneficiary, 3784
- Notice of Decision to Beneficiary Where Covered Services Furnished in a Noncertified or Certified Bed, 3431.3
- optional paragraphs in refund letters, 3711.7
- Provider Liable for Medically Unnecessary or Custodial Care Services, 3710.4A
- refund request to beneficiary, 3711.5, 3711.6
- refund request to estate of deceased, 3711.8
- request for return of orbit bills, 3838
- requesting adjustment bills, 3817
- Sample Acknowledgement Letter to Beneficiary, 3431.2 , 3431.3
- Sample Denial Letter to Beneficiary did not receive Required SNF Level of Care, 3431.3
- Sample Letter from Intermediary to Third Party, 3773B
- Sample Letter to Beneficiary (Reversal), 3784
- Sample Letter to Provider (Reversal Notification) 3784
- Sample Notice to the Resident Intermediary of Full or Partial Reversal, 3784
- Sample of Response to Home Office of Member of Congress, 3736
- SSA-L 389, SSA Requests for Adjustment Bills, 3817
- SSA-L 495, Letter to Adjust Improper Deductible Given in Query Reply, 3537A, 3550
- SSA-L 1001, Notification of Internal Adjustment Action(s) Taken by SSA, 3816.2

FOURTEEN DAY LIMIT:
- exceptions, 3131.3B
- home health plan establishment, 3120.3, 3121.1,
- readmission to SNF, 3131.3A(1), 3131.3B
- SNF transfer requirement, 3131ff., 3431B, 3520.3, 3719.1

FRAUD:
- abuse, 3454, 3454.1B, 3460B, 3470
- Abuse Report, HCFA-51, 3454.1G
- billing beneficiaries rather than Medicare, 3462
- bribe, 3460A(1d), 3462(13)
- chain operation, 3464B
- charging nonprogram activities, 3462(8)
- civil fraud settlement check, 3479
- claims related, 3460
- control and records:
  - closed cases, 3472
  - pending cases, 3472
  - potential fraud, 3470C
- coordination with Part B carriers, 3474
- criminal intent, 3454.1A
- criminal violation of act, 3460A
- development, 3456B
- documents not annotated, 3460C
- duplicate billing, 3462
- exclusion/termination, 3482
- false statements, 3460A, 3460A
- falsifying provider records, 3462
- fee rebate, 3460A
- forgery of check endorsement, 3476
- full scale investigation, 3454.1G
- identification, 3456A, 3462
- integrity review, 3454.1C
- intent to defraud, 3454.1A
- intermediary reports to regional office, 3459
- intermediary responsibilities, 3460C, 3464
- intermediary role, 3458
- interview with subject, 3456C
- investigations, 3460C
- key terms, 3454.1
- kickbacks, 3454, 3460A, 3462
- knowingly, 3454.1E, 3460A
- material, 3454.1D, 3460A
- misrepresentation, 3470
- misuse, 3460A
- obtain Medicare payments, 3708.2A
- overcharging the health insurance program, 3462(7)
- overpayment, 3308C, 3454.1H, 3468, 3707.1, 3709.2B

FRAUD (CONT'D):
- overutilization of medical services, 3462
- penalties, 3460A
- physician or other practitioner, suspension of convicted, 3484-3484.3
- P.L. 95-142 (Section 7) provisions, 3484
- Program Integrity Complaints, 3459
- prosecution, 3456D
- quarterly reports, 3459.1
- rebate, 3462(13)
- referral to a professional society, 3480D
- reopenings, 3799.13
- repeaters, 3459
- resumption of payments, 3470
- services furnished under arrangements, 3468.1C
- statute of limitations, 3707.1
- suspected, 3709.4
- suspension of payment, 3466, 3470
- undeliverable notices, 3728.3
- unethical conduct by practitioners, 3480
- U.S. Criminal Code, 3460A
- unrestricted reopening of determination, 3799.13
- willfully, 3454.1F, 3460A(1a)
- withholding payment in potential fraud cases, 3466

Free hospitals, 3719.1B(Note), 3719.2

Free services exclusion, 3152, 3153.3A, B

FREEDOM OF INFORMATION ACT:
- activity report, 3760.3
- disclosure of information:
  - about beneficiaries, 3763
  - about providers and suppliers, 3773
  - cost report information, 3773C
  - provider payment data, 3773.1A
- fees:
  - collection and disposition, 3761.2
  - information, 3761
  - requests without remittance, 3761.3
- general, 3760
- handling requests, 3760.1, 3773C(3g)
- processing requests, 3760.2
- restrictions, 3764B

Freedom of Information Inquiry, 3760.2, 3760.3, 3776

Free-standing clinic, 3112.5

"Front end" intermediary review, 3434.3

-G-

Gait-training, 3101.8C, 3117.4D, 3118.1C

best copy available

Gastrostomy feedings, 3132.5B
Gel pads, 3113.1B
General Account Office for collection, 3710.2B, 3712.6
General Enrollment Period (GEP), 3001.4C(3), 3003.3, 3003.4B, 3003.6
GOOD CAUSE:
  conditions for indemnification, 3446.2
  conditions which establish, 3781.8C
  disclosure of information, 3766B
  examples, 3781.8E
  failure to pay premium timely, 3003.7
  late filing of reconsideration appeals, 3781.8, 3790.3B
  not found, 3781.8F
  procedure to establish, 3781.8D
  reconsideration processed, 3781.8B(4)
  reopening determinations, 3799.2B, 3799.7
  telephone inquiries, 3792.1A
  time limit for filing appeals, 3781.7
Good faith, 3430, 3714.2
Government (See Federal)
GRACE PERIOD:
  examples, 3441
  premium payment, 3003.7
  seventy-two hours, 3421A
  twenty-four hours, 3431.1B(1), 3441
  two days required for post-discharge care, 3431.1B(1), 3441
Group health insurance plan, 3768C
Group practice prepayment plans, 3145.1, 3152C, 3161B
GUARANTEE OF PAYMENT:
  benefits exhausted, 3445A
  Federal holidays, 3714.1
  good faith, 3714.2B
  inpatient hospital billing, 3636
  lifetime reserve days, 3106B, 3626
  maximum number of days under guarantee, 3714.1
  overpayment made under, 3708.3(2)
  Part A:
    extended care services, 3135
    posthospital home health visits, 3129.1
  provisions, 3714
  recovery of funds advanced, 3401.1, 3714.3
  refunds to patient, 3714.2D
  requirements, 3714.2
  unrecovered overpayment, 3712
Guidelines for Mailing Material in Response to Freedom of Information Requests, 3776

-H-

Hardship cases, 3538D, 3709.5(a), 3711.6F, 3711.9A, 3711.11B, 3712.2
Harnesses, 3110.5
HEALTH CARE FINANCING ADMINISTRATION:
  approval of integrated claims processing system 3769A
  common procedure coding system, 3627ff
  disclosure of information, 3760, 3773C
  examination of hearing records, 3794.8
  Health Insurance Master Record, 3512.7
  hearing records examination, 3794.8
  Program Integrity Regional Offices, list of, 3486
Health Insurance Beneficiary State Tape (BEST), 3504, 3506.5
Health Insurance Bill Retrieval Listing, 3840
Health Insurance Cards, 3302.6, 3502, 3550
HEALTH INSURANCE CLAIM NUMBER:
  admission notice processing, 3507.5
  changes, 3503.1
  cross-referring, 3534
  different HI claim number, 3534
  explained, 3503
  incorrect, 3504
  invalid, 3840.2
  missing, 3504
  Part B query procedures, 3503.1
  utilization edits, 3828A
  utilization under more than one number, 3537B
  verification, 3537B
Health Insurance Inquiries Branch (HIIB), 3735
Health Insurance Master Record, 3512.7(Code 43), 3538, 3718, 3831
Health Insurance printout (HIPO), 3838.8
HEALTH MAINTENANCE ORGANIZATIONS:
  admission and query procedures, 3512.7, 3537.1, 3555ff, 3558
  bill processing jurisdiction, 3520.3B, 3654
  blood charges, 3726
  Claims Review for HMO Members-Condition-Decision Tables, 3556
  codes:
    defined, 3360.2, T3870
    enrollment, 3535.1,
    error, 3828.1
    home health services, 3555.3B
    identification, 3512.9, 3535.1
    option, 3535.1
    "R-trailer," 3360.2, 3512.8, 3518.2, 3535.1, 3546

HEALTH MAINTENANCE ORGANIZATIONS (CONT'D):
- defined, 3360
- directory, 3558
- general billing instructions, 3600
- inpatient services, 3555.1,
- master file corrections, 3537.1
- notices:
  - denial, 3555.1
  - Medicare, 3717, 3718, 3719.1
  - undeliverable, 3728.1
- outpatient services, 3555.2
- paid bill, 3555.2,
- Part B:
  - inpatient services, 3555.2
  - master file corrections, 3537.1
  - record of Medicare benefits, 3726
- provider billing for services,
- quality control, 3728.3
- report of eligibility, 3518.1, 3546
- status query, 3507.3
- unibill and probill, 3770.1

Hearing aids, 3157
Hearing Examiner (See Administrative law judge)
Hearing Information Sheet, 3795(Ex. 3)

HEARING OFFICER:
- compliance with provisions of Title XVIII, 3794, 3794.7
- decision, 3794.7, 3799.3
- decision reopened, 3799.5B
- decision reviewed by SSA, 3794.8
- defined, 3794.3
- determining date of decision, 3799.3
- disqualification, 3794.4
- request for hearing, 3795
- stand-in officer, 3794.9
- time limitation on reopening decision, 3799.6

Hearings (See Appeals of payment determinations)
Heat treatment, 3113.1B, 3132.5
Hemodialysis, 3001.3
Hemodialysis Equipment-home use, 3110.4
Hernia support (See Trusses)
HEW Audit Agency Reports, 3774C
HI bill history, 3512.7(Code 27), 3840ff.

HOME HEALTH AGENCIES (See also Home Health Agency Report and Billing Home Health Plan of Treatment; Home Health Services):
  arrangement for services, 3025.2, 3120.2, 3120.4
  billing, 3722.3
  data record, 3874
  defined, 3025
  denial paragraphs, 3722.3
  denial rate, 3433, 3434.1
  excessive denial rates, 3433.4
  improper coverage decisions, 3439.2
  meets prior stay requirement:
    extended care services, 3131.1
    home health, Part A, 3121.1B
  mental disease agencies not covered under hospital insurance, 3025
  model letters to beneficiary re Medicare noncoverage, 3730.2A
  noncoverage notice date, 3440.1A
  occupational therapy, 3118.2
  outpatient physical therapy services, 3147
  outpatient speech pathology services, 3148
  participating providers of services, 3005
  personnel, 3116
  preentitlement stay, 3104.6A
  prior inpatient stay, 3121.1B
  Railroad Retirement Act covered services, 3519.5
  Record Layout, 3880.5
  Report of Eligibility, HMO, 3546
  services denied, 3431B(3)
  subdivision of, 3025.1, 3025.2B
  termination of provider participation, 3008.4C
  transfer to another agency, 3302.1B, 3541D,
  transportation requests, 3114C
  Twenty-four hour grace period, 3431.1B
  visits (See Home health services)
HOME HEALTH AGENCY REPORT AND BILLING:
  adjustment bills, 3803
  authority for disclosure of information, 3302.1B, 3302.2
  batching bills, 3803
  consistency edits, 3825.4, 3832C
  denied, 3638.7
  error codes, 3825.4
  exhibit, 3550
  filed timely, 3638.7
  HMO beneficiaries, 3654.1
  home health services to HMO members, 3555.3
  information which may be released, 3768C
  intermediary review, 3638.8

HOME HEALTH AGENCY REPORT AND BILLING (CONT'D):
- medical supplies, 3119.3A
- no payment bill, 3638.7
- nonvisit charges, 3638.2
- notices for Part A bills, 3719.1
- Part A and Part B HHA Claims, 3430
- Part A home health bills, 3835
- Part B billing, 3555.3
- Part B services, 3702, 3719.2
- processing Part B home health bills, 3835
- "Reconsideration/Appeal Decision--Overpayment for Subsequent Billing Periods Involved," 3816D
- refused certification, 3803
- refused payment, 3803
- reply to home health agency, 3546
- request for payment, 3302.1
- separate bills for Part A and Part B services, 3638.4
- services by more than one agency, 3638.5
- services suspended or terminated and then reinstated, 3638.6
- start of care notice, 3501, 3540, 3541, 3542
- use of billing form, 3638.9

Home health aide services, 3117, 3117.4C, 3119.2, 3119.6, 3129.5

HOME HEALTH PLAN OF TREATMENT:
- attending physician establishes, 3120.1, 3148.2, 3148.3
- bill denied, 3658.1
- certification by physician, 3129.2, 3139.2A, 3326C
- established after termination of provider agreement, 3008.4C
- establishment by podiatrist excluded, 3030.3
- fourteen-day limit on establishment, 3121.2
- HMO beneficiaries, 3654.1
- home health aide services, 3119.2
- inappropriate, 3129.3, 3139.1
- modification, 3117.4A
- new physician establishes new plan, 3122.2B
- new plan established, 3541C
- nursing services, 3117A
- outpatient physical therapy, 3148.3
- physician's signature required, 3120.3
- presumed coverage provision, 3129.1A, 3139.1
- psychiatric nursing, 3117.6
- recertification by physician, 3328
- reinstatement, 3638.6
- required patient care information, 3638.9
- services must be furnished under, 3120.3
- suspended, 3541G, 3638.6

HOME HEALTH PLAN OF TREATMENT (CONT'D):
- terminated, 3122.2, 3638.6
- transfer from Part A to Part B,
- transfer of patient, 3121.4
- transfer to another agency, 3121.4

HOME HEALTH SERVICES:
- alternative to institutionalization, 3421.1B
- ambulance service, 3114, 3127F
- appliances, 3127.1B
- arrangements for, 3007
- billing, 3302.2C,
- certification by physician, 3120.1, 3128, 3326
- condition unrelated to previous hospitalization, 3120.3
- conditions for coverage, 3120ff., 3121
- counting visits, 3124ff.
- covered services, 3116
- deductible and coinsurance, 3225
- documentation pertaining to, 3783.1F
- duration, 3123ff.
- exclusions from coverage, 3125
- fourteen-day limit on plan establishment, 3121.2
- HMO members, 3555.3
- homebound requirement, 3120.4
- listing of conditions and periods covered, 3129.4C
- medical and other health services, 3127
- medical conditions covered, 3129.4
- no-payment billing, 3309.1,
- Part A coverage, 3121ff., 3129, 3431.3
- Part B coverage, 3122ff., 3127ff.,
- patient's residence, 3120.4, 3120.5
- physician sees patient every sixty days, 3117.4A
- posthospital, 3129
- prior inpatient stay, 3103.2, 3121.1B, C, 3431.3, 3547ff.
- qualifying stay, 3541A
- querying procedures, 3512.6, 3525
- recertification by physician, 3120.3, 3327,
- record of Part A services used, 3717.1, 3717.3A, 3718
- record of Part B services used, 3717.3A, 3718.1B
- reinstatement, 3638.6
- related illness or impairment, 3121.3
- request for payment, 3301

HOME HEALTH SERVICES (CONT'D):
  spell of illness provisions, 3121.1A, C
  suspended, 3541G, 3542C, 3638.6
  termination of participation, effect on services, 3540, 3638.6
  transfer from Part A to Part B, 3542A,
  transfer of patient, 3121.4
  under care of physician, 3116
  under hospital insurance, 3121
  under hospital insurance and supplementary medical insurance, 3116, 3120ff.
  under supplementary medical insurance, 3122ff., 3541B,
  verifying prior stay, 3547
  visits:
    available under hospital and medical insurance, 3121.1, 3409.2, 3518.2
    available under medical insurance, 3212, 3718.1B
    counting visits, 3117.5, 3124.2
    defined, 3124.1
    evaluation, 3124.3
    excess Part A changed to Part B, 3843
    exhausted, 3638.9(A)
    hearing determination issue, 3794.6
    overutilization of Part A, 3833B, 3843
    Part A posthospital, 3129.1
    Part A to Part B, 3638.2
    physician, 3117.4A
    postoperative cataract patients, 3117.4A
    presumed number covered, 3129.4C
    psychiatrically trained nurse, 3117.6
    skilled services, 3129.4C
    temporary suspension, 3542C
Home Health Start of Care Notice (See Start of care notice)
Homebound patient, 3120.4,
HOSPICE:
  billing, 3648
  coverage, 3140-3143
  coinsurance, 3142
  exhausted benefits, 3648.2
  HCPCS, 3624D, 3626.4
  hemofiltration, 3174
  hemoperfusion, 3175
  nonhospice medicare reimbursement, 3648.1
  requirements for coverage, 3143
  respite care, 3143.2(B)

HOSPITAL-BASED PHYSICIANS :
- allocation agreement, 3912.1
- allocation of compensation, 3912.1
- authorization for combined billing, 3146B,
- billing method:
  - combined billing, 3912.3
  - general, 3912ff.
  - independent billing, 3912.3
  - schedule of charges, 3912.3
- defined, 3145
- file documentation, 3912.3
- intermediary responsibilities, 3600.4, 3912
- professional and provider components, 3161B, 3910.1
- provider-physician agreement, 3600.6, 3912.1
- reimbursement policies, 3912
- request for payment, 3302.2D
- teaching services, 3145A, B, 3910ff.

HOSPITAL INSURANCE (PART A):
- adjustment bills, 3610.8
- billing history, 3840ff.
- blood deductible, 3235.1
- buying-in, 3001.4A
- coinsurance, extended care services, 3210
- coinsurance, hospital, 3203
- deductible, inpatient hospital, 3201, 3512.4B
- defined for spell of illness, 3035A
- diagnostic services, 3101.5B
- disability beneficiaries, 3001.2
- disallowed, 3512.7
- eligibility for coverage, 3001.3
- emergency hospital defined, 3010A, E, and G, 3012, 3101.5B
- entitlement, 3001, 3518.2, 3538
- exclusions from coverage, 3150
- extended care services, 3130, 3131ff, 3235.6
- foreign, 3131.2
- home health services, 3116, 3120ff., 3121.1B, 3123.1, 3431.1, 3431.3,
- inpatient hospital dental services, 3101.7
- insurance entitlement, 3001
- inpatient hospital services, 3012, 3101ff., 3145B
- interns or residents-in-training services, 3101.6
- premium payment, 3001.4, 3003.7
- provider agreements, 3005
- social security work requirements, 3001.1
- split bills, 3610.6
- supplementary medical insurance, 3003.1
- termination of coverage, 3001, 3003.6
- waiver of enrollment period, 3004
- waiver of right to claim, 3313

Hospital notices, lifetime reserve days, 3106.2A
HOSPITALS:
  arrangements made by, 3007
  billing, 3722.1
  Christian Science Sanatorium, 3023
  community, 3153.1A
  conditions of participation, 3421.1B
  custodial care, 3159.1,
  defined, 3010
  denial paragraphs, 3722.1
  denial rate, 3433, 3434.1
  direct-dealing, 3301
  disclosure of information, 3760
  emergency services hospital, 3012.1, 3301, 3310
  excessive denial rates, 3433.4
  foreign (See Foreign hospitals)
  free, 3719.1B(Note), 3719.2(Note)
  general, defined, 3010
  improper coverage decisions, 3439.2
  Indian Health Service, 3153.1B
  long-stay cases, 3421.2
  model letters to beneficiary re Medicare noncoverage, 3730
  no charge structure, 3719.1B, 3719.2
  noncoverage notice date, 3440.1A
  nonparticiapting (See Nonparticipating hospitals)
  outpatient physical therapy services, 3147
  participating, 3005, 3017
  pharmacy and drug therapeutics (P&DT), 3101.3B, 3133.5B
  physician certification requirements (See Certification by physician)
  prepayment requests and requirements, 3314ff.
  prior stay, 3121.1B, 3123.1, 3131.1, 3326, 3431.1, 3520,
  psychiatric (See Psychiatric hospitals)
  query procedures, Part B outpatient, 3525
  reduction for psychiatric services in general hospitals, 3104.4
  renal dialysis facility located on premises, 3114C
  spell of illness, 3035
  State and local government operated, 3153.3A
  State financed, 3719.1B
  transfer agreements with, 3020.2
  Veterans Administration, 3153.1A
Hot pack, 3101.8C, 3118.1C

-I-

ICD-9-CM, 3871, 3872, 3874, 3875, 3880.2, 3880.3, 3880.5, 3880.6
Illegal profits, 3462(7)
Immediate relative defined, 3161D
Immunizations excluded, 3152, 3157
Incapacitated beneficiary (See Beneficiary: incapacitated)
Incident to physicians' services (See Services and supplies incident to physicians' services)
Incidental household services defined, 3119.2
Incompetent to stand trial, 3153.3C
Incurred expenses, 3113.7B, 3212
INDEMNIFICATION PROCEDURES:
  amount of indemnifications, 3446.6
  conditions for indemnification, 3446.2
  financial interest in claim, 3446.4
  indemnification requests, 3446.3
  Letter to Beneficiary Who Requests Indemnification, 3446.9
  Letter to Someone Other Than Beneficiary Who Requests Indemnification, 3446.9
  notifying provider, 3446.7
  payment under indemnification, 3446.8
  questionable requests, 3446.5
  waiver of liability provision, 3446
Independent laboratory (See Laboratory, independent)
INDEPENDENT RURAL HEALTH CLINCS:
  bills submitted, 3894.4
  employees, physician, 3642A
  EOMB form in duplicate, 3726
  monthly intermediary workload reports, 3895
  provider number, 3800, 3974
  reporting instructions, 3895.5
  transfer of information, 3642.1
Indian Health Service, 3153.1B
Indigents, 3003.4C(2), 3152A, 3153.3A
Infant care, 3101.11
Infectious diseases, 3153.3A
Infertility, 3101.13
Infra-red treatments, 3101.8C, 3118.1C
Inhalation therapists, 3116, 3133.9B
Inhalation therapy, 3101.10,
Initial Enrollment Period (IEP), 3001.4C, 3003.3, 3003.4A
Initial General Enrollment Period (IGEP), 3001.4C
Inpatient Admission and Billing—Christian Science Sanatorium, HCFA-1486, 3825.3, 3832C
Inpatient, defined, 3101, 3103.1, 3133

INPATIENT HOSPITAL AND SKILLED NURSING FACILITY ADMISSION :
  - adjustment bills, 3803(28)
  - appeal before initial action, 3782.7
  - batching bills (See Claims records)
  - combined billing, 3604(3),
  - consistency edits, 3825.1, 3832C
  - "contained in provider's record," 3302.2
  - denial notice, 3719.1
  - exhibit, 3550(Ex. 2),
  - information which may be released, 3768C
  - inpatient services, 3430, 3702, A3419.7
  - intermediary tentative decision, 3104.4
  - no payment cases, 3555.1,
  - notice of payment, 3701
  - prior inpatient stay, 3520ff.
  - private room medically necessary, 3101.1A
  - "Reconsideration/Appeal Decision-Overpayment for Subsequent Billing Periods Involved," 3816D
  - refused certification, 3803
  - refused payment, 3803
  - remaining inpatient deductible, 3518.2
  - reply to admission notice, 3518ff.
  - request for payment, 3302.1
  - room number required, 3501.1
  - tolerance guides for adjustment bills, 3816.1
  - underpayments, 3715.2A

INPATIENT HOSPITAL SERVICES (See also Psychiatric hospital services, inpatient:):
  - accommodations, 3101.1, 3103.1
  - appliances, 3101.4
  - arrangements for, 3007, 3101.5
  - bed and board, 3101.1
  - benefit days, 3103ff., 3781.3D
  - billing, 3302.2A, 3610
  - certification by physician, 3315, 3324
  - coinsurance (See Coinsurance)
  - cosmetic surgery, 3431B
  - covered services, 3101ff.
  - criteria for continued stay, 3317C
  - custodial care, 3159.1
  - deductible (See Deductibles)
  - deductible, blood, (See Blood)
  - defined, 3101
  - dental services, 3101.7, 3162, 3316, 3316.1, 3431B
  - diagnostic services, 3101.5, 3315
  - documentation pertaining to, 3783.1A

INPATIENT HOSPITAL SERVICES (CONT'D):
- drugs specially ordered, 3101.3D
- duration of covered services, 3103
- emergency services (See Emergency services)
- episodic dialysis, 3101B
- equipment, 3101.4
- extended care services, 3101(Note)
- foot care exclusion, 3431B(1)
- foreign hospital, 3154B
- further stay not necessary, 3421B, 3421.1A, D,
- guarantee of payment, 3714
- inpatient day defined, 3135.1
- inpatient one institution, outpatient another, 3112.1
- inpatient status, 3146A
- intern services, 3101.6, 3115
- length of stay (LOS), 3782.1D
- limitation on payment, 3107A, 3421
- maximum benefit days, 3107
- medically unnecessary, 3421B
- minor surgery, considered outpatient, 3101A,
- number of days available, 3103.2, 3135.2
- Part B services to HMO members, 3555.2
- pathology services, 3146,
- radiology services, 3110B, 3146,
- recertification by physician, 3315, 3324
- rehabilitation care, 3101.10
- residents' services, 3101.6
- spell of illness, 3035, 3409
- supplies, 3101.4
- termination of hospital participation, 3008.4A
- therapeutic services by hospital under arrangements, 3101.5
- under Part B, 3110

Inpatient Hospital/SNF Record Layout, 3880.2
Inpatient stay requirements, 3520
Insanity, 3153.3C
Installment payments (See Refunds)
Insulin injection, 3117.2C, 3117.4H, 3132.5A
Insured provisions met, 3780.1A(4)
Insured status, work requirements, 3001.3
Integrated claims processing system, 3769
Interim payment computation (See Periodic interim payment)

INTERMEDIARIES:
  control number procedures, 3527b
  disclosure of information, 3760
  fraud:
    initial action, 3464A
    role of intermediaries, 3458
  internal guidelines, 3762.2
  medical review, 3674.2
  out-of-area hearing, 3794.8B(5)
  Program Integrity complaints resolved, 3459
  record:
    annotation, 3439D(2), 3440.1B
    header, 3830.1C
    trailer, 3830.1F
  reimbursement for HMO services, 3360.2
  Requests for HI Bill Retrieval Listing (Bill History), 3840.2
  source of noncoverage notice, 3440C
  workload reporting, 3445B, 3455
Intermediary Systems Testing Project (ISTP), 3560
INTERMEDIARY TRANSMITTAL OF UNCOLLECTED MEDICARE OVERPAYMENTS, HCFA-2382:
  amount of overpayment, 3712.2
  annotations, 3712.4
  attachments, 3712.3
  beneficiary deceased, 3712.2
  cause of overpayment, 3712.2
  ompletion and distribution, 3712.2
  dates of services, 3712.2
  exhibit, 3712.1
  hardship cases, 3711.9A
  "Nonentitlement Case—For BHI Development and/or Waiver Consideration," 3711.11A
  offset not made against provider, 3712.2
  recovery efforts, 3712.2
  referring overpayments to Medicare Bureau, 3708.2B, 3712.1
  remarks, 3712.2
  welfare number, 3712.2
INTERMEDIARY WORKLOAD REPORT, HCFA-1566:
  completing, 3894ff.
  completing Quarterly Supplement, 3898ff.
  exhibit, 3895
  exhibit Quarterly Supplement, 3898.4
  monthly, 3892ff.
  Quarterly supplement, 3896ff.
  RO referral, 3775A

Intermittent peritoneal dialysis, 3112.6
Intermittent skilled nursing care, 3117.1
INTERN AND RESIDENT SERVICES:
  coverage under hospital insurance, 3101.6, 3115, 3133.7, 3910.2
  coverage under supplementary medical insurance, 3101.6, 3115, 3119.4, 3145
  home health services, 3119.4
  moonlighting, 3115B
  not in approved training programs, 3115A
  supervising attending physicians, 3910
Internal organ replacements, 3110D, 3110.4, 3212
Internal Revenue Service Form W-2,
Intramuscular injections, 3117.4H
Intravenous feedings, 3117.4I, 3132.5A
Intravenous injections, 3117.4H
IPPB Machines, 3117.2C
Irrigating Kit, 3110.4

-J-

Joint commission on Accreditation of Hospitals, 3010G, 3016, 3121.1A, D, 3520.2
Judicial review (See Appeals of payment determinations)

-K-

Kickbacks, 3454, 3460A, 3462
Kidney transplantation, 3001.3, 3612, 3612.2

-L-

Labor room, 3103.1
LABORATORY, INDEPENDENT:
  arrangements:
    cost to hospital, 3101.5B
    emergency hospital, 3112.3C
    hospital, 3101.5B, 3112.3C, 3322
    SNF, 3112.3C, 3137.1
  definition, 3101.5B, 3146E
  status, 3146D
Late discharge, (See Discharge)
Late filing, 3816D(2)
Law or Regulations citation, 3794.8B
Leave or absence, 3103.1,3103.3, 3104.1, 3135.3,

Leg brace, 3110.5, 3127
Legal counsel, 3794.5
Legal representative of deceased patient, 3106.2C, 3302.5B, 3302.7, 3715C, 3715.4
LENSES:
  contact, 3157
  permanent prosthetic lenses, 3157
  post-surgical, 3110.4A
  prosthetic, 3030.5, 3110.4A
Letter (See Form letter)
LEVEL OF CARE IN SKILLED NURSING FACILITY:
  covered, 3131.3B, 3132
  covered before January 1, 1973, 3132.11
  definition of covered care, 3132
  medically not predictable, 3131.3B
  medically predictable, 3131.3B
  PSRO approved, 3635.1
  questionable coverage cases, 3132.11C
  utilization review committee determination, 3421.1A
Levine tube, 3132.5B
Lifetime limitation on inpatient psychiatric hospital services, 3104ff., 3105, 3106D 3107C, 3714, 3718.1(Item 3), 3781.3D
LIFETIME RESERVE DAYS:
  become "no payment" days, 3709.3D
  benefit maximums, 3107
  billing, 3106C,
  coinsurance, 3106A
  election:
    format, 3106.3
    format revocation, 3106.5
    incapacitated beneficiary, 3106.2E
    not to use, 3106.2A, 3110, 3235.1, 3610B, 3709.1B, 3839
    period covered, 3106.2D
    prospectively, 3106.2B
    retroactive, 3106.2C
    revocation, 3106.4
  emergency services, 3106E
  error code, 3825.3(Item 25)
  guarantee of payment, 3106B, 3714
  inpatient hospital benefit days, 3103, 3107B
  overpayment, 3708.2B, 3709.1B
  physician certification, 3106F
  provisions, 3106ff.
  psychiatric limitations, 3106D
  remaining, 3518.2(Item D)
  reply to notice of admission, 3512.4
  request for payment, 3106.1
  VA or PHS authorized care, 3153.2
  workers' compensation, 3409.2

Limitations on payment for inpatient services, 3421ff.
LIVING IN SAME HOUSEHOLD:
  surviving spouse, 3715C(1), 3715.6B
  underpayment, 3715C(1)
Longshoremen's and Harbor Workers' Compensation Act, as workers'compensation plan, 3407
Low utilization providers, 3434.6
Lump-sum settlement (See Workers' compensation: lump-sum settlement)

-M-

MAGNETIC TAPE:
  consistency edits, 3868
  deletions, 3887
  (HCSSACL), 3830
  Health Insurance Beneficiary State Tape (BEST), 3506.2
  operational billing tapes, 3867
  packing and mailing, 3808
  Provider Payment List, 3773.1F
  recording characteristics, 3866.2
  reel external label, 3867.1
  specifications, 3801, 3865
  submissions, 3805
  test tape, 3866
  use, 3799.3A
Maintenance programs, 3101.8B(2), 3118.1B(2)
Male orderlies, 3117.4E(2)
Malformed body member, 3430, 3431A
Master:
  Health Insurance Record, 3827, 3845.2B
  identification record layout, 3838.8A
  Part A record layout, 3838.8B
  record, 3525, 3538
Maternity inpatient days, 3103.1,
Maxillofacial devices, 3110.4
Maximum benefit days in beneficiary's lifetime, 3105, 3106, 3153.2
Maximum days under guarantee of payment, 3714.1
Maximum inpatient hospital benefit days per spell of illness, 3101ff., 3107, 3153.2
Maximum inpatient psychiatric hospital benefit days in patient's lifetime, 3105
MCE edit types, Addendum E

MEDICAID:
  Abuse Report, HCFA-51, 3454.1C
  lifetime reserve days, 3106.2A
  master file, 3770B
  recovery of overpayment, 3711.1
  waiver of liability does not apply, 3446
  welfare number, 3712.2(Item 5)
MEDICAL:
  appliances (See Appliances)
  automible, no fault or liability insurance, 3419
  conditions covered under presumption provision, 3129.4, 3139.5
  equipment (See Durable medical equipment)
  file, 3440.1A
  gases, 3132.5H
  information, 3439F
  insurance (See Supplementary medical insurance)
  other health services, 3110, 3127, 3128, 3137,
  social services, 3025A, 3101.2B, 3116, 3119.1, 3119.6, 3120.3, 3133.4
  social workers, 3421.1E
  supplies (See Supplies)
MEDICAL NECESSITY:
  ambulance service, 3114B
  establishing period of, 3113.7E
  exclusion of services for lack of, 3114B, 3151, 3421B, 3708.5, 3710.1
  hearing determination issue, 3794.6
  immediate hospitalization, 3101.1C
  isolation required, 3101.1B
  only private rooms available, 3101.1C
  physician certification and recertification, 3007, 3120.1, 3315ff., 3326ff., 3333, 3335, 3336,
  private accommodation, 3101.1A,
  three-day prior hospitalization, 3121.1B, 3131.1, 3518.1
  utilization review, 3420, 3421B
MEDICAL RECORDS:
  documentation, 3783
  inpatient psychiatric hospital services, 3102.1A(3), 3345.1,
  inpatient tuberculosis hospital services, 3345.2
MEDICAL REVIEW:
  comprehensive outpatient
  general, 3903A
  rehabilitation facility claims

MEDICARE:
- Abuse Report, HCFA-51, 3454.1G
- admissions, 3006
- bank account, 3761.2
- beneficiaries who are veterans, 3153.2, 3153.3C
- beneficiary inquiries, 3894.4
- beneficiary not entitled, 3709.3C, 3711.7C
- benefit notices, 3718.1
- CHAMPUS/CHAMPVA relationship, 3153.3D
- Code "R", 3816D
- conditional payment, 3415D
- Coordinator, 3784
- covered services furnished without charge, 3153.3C
- designation on communications, 3701
- development of claims, secondary payer, 3694
- disclosure of information, 3773C
- eligibility, CHAMPUS/CHAMPVA entitlement, 3153.3D
- error re beneficiary's entitlement, 3708.1
- fraud attempt, 3708.2A
- Health Maintenance Organizations participation, 3360
- Hearing Information Sheet, 3794.8, 3795
- insurance, legal obligation to pay, 3152B
- law (See Social Security Act, title XVIII)
- level of care requirements, 3719.4
- noncoverage notice to provider, 3439B, 3730ff.
- notices sent to beneficiary (See Notices to beneficiary)
- paid provider for noncovered services, 3708.2F
- paid Workers' Compensation case, 3416.1
- payment and cost data, 3773C(4)
- processing of provider overpayments, 3712.6
- reports, 3773C
- secondary payor, A3040.2
- waiver of recovery, 3709.5
- waiver of right to claim, 3313

Medicare Chronic Renal Disease and Service Information, HCFA-2743, 3512.8 (S Code)

MEDICARE HOSPITAL EXTENDED CARE AND HOME HEALTH BENEFITS RECORD, HCFA-1533:
- beneficiary's liability waived, 3432.1B
- emergency inpatient services, 3725
- exhibit, 3718.1
- notices for Part A bills, 3719.1
- SSA notices, 3718ff.
- time limit for filing, 3781.8B
- utilization edits, 3828E

Medicare Hospital Extended Care and Home Health Benefits Record, RR-100, 3718ff., 3781.8B
Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142, Section 7), 3484, 3455ff.
Medicare Secondary Payer (MSP), 3490ff, 3679, 3682ff, 3693
Members of patient's household, 3766A
Members of patient's household, exclusion of charges by, 3161A
Members of religious orders, 3152E
Microfilm 3505
Microwave diathermy treatments, 3101.8C, 3118.1C
Milieu therapy, 3102.1A
Military medicare, 3772
Minor surgery, 3101A,
Misinformation, 3709.3B
MOBILE:
Monthly Actuarial Sample of Hospital Reimbursement, HCFA-3286, 3773C
Monthly Batch Status Report, 3842
Monthly Cost Report, HCFA-2584, 3775A
Monthly Intermediary Financial Report, HCFA-1522, 3401.4A, 3711.2, 3775A, 3816.1
Monthly Provider Audit Activity Report—Schedule I, HCFA-1822, 3775A
Monthly Report on Intermediary Workloads, HCFA-1566, 3816.1B
"Moonlighting" interns and residents, 3115B
MOST PREVALENT SEMIPRIVATE RATE:
  defined, 3101.1D
Mothers caring for child beneficiaries, 3001.2

-N-

Naso-pharyngeal, 3132.5C
National Formulary, 3101.3
National Institute of Health grant, 3152B, 3803
National Oceanic and Atmospheric Administration, 3153.3D
Naturopath, 3030
Neck brace, 3110.5, 3127
Negotiable instruments, 3479
Neurology, 3302.4
Next of kin, 3421B
No fault (See Without fault)
No obligation to pay cases, 3152
No-payment bills, 3624A
Noncovered Procedures, Addendum F

NO PAYMENT BILLING:
  batching, 3803
  correction bills, 3803
  disposition Code 46, 3512.7
  dummy discharge bill, 3839
  HCFA-1453 billing, 3555.1
  HCFA-1483 billings, 3309.2
  home health services, 3309.1
  inpatient services, 3501
  late filing, 3309.1
  noncovered bills, 3803
  notice of admissions and start of care, 3501
  notice to beneficiary, 3719ff., 3722ff., 3724ff.
  provider notices, 3439B(2)
No-charge structure, 3719.1B, 3719.2
Non-certified beds, 3431.3
NONPARTICIPATING HOSPITALS:
  emergency services, 3212, 3715A, 3780.1A
  prior inpatient stay, 3121.1B, 3131.1, 3520.2
  spell of illness, 3035, 3520.2,
Nonphysician anesthetist services, 3101.2A
Nonprovider ESRD (End-Stage Renal Disease) Facilities, 3114C, 3444.4
Nonreusable supplies, 3110.4, 3113
Nonwork days, 3305.2, 3305.3, 3714.1
NOTICE:
  further inpatient stay not medically necessary, 3421B
  hearing, 3794.2
  late receipt, 3781.8B
  noncoverage, 3433.3
  payment, 3702
Notice of Intermediary HI Bill Batch Processing Status, HCFA-2181, 3840.2
Notice of Medicare Claim Determination, HCFA-1954, 3719ff., 3721
Notice of Medicare Claim Determination, HCFA-1955, 3719ff., 3721
NOTICE TO BENEFICIARY:
  amended notice, 3718.2
  appeal rights, 3784.7
  denial notice, 3443, 3525, 3704, 3719ff., 3728, 3781.8A
  denial paragraphs, 3722ff
  disallowance form letters, 3721
  full denial, 3781.8B(1)
  Full Denial-Hospital-Filed or Beneficiary-Filed Emergency Claim, 3725
  general, 3717
  Home Health Agency model letter re Medicare noncoverage, 3730.2
  hospital model letter re Medicare noncoverage, 3730.1A

NOTICE TO BENEFICIARY (CONT'D):
- illegible, 3718
- incorrect, 3718
- intermediary notices, 3719.1
- intermediary reconsideration notices, 3790.2C
- Letter to Beneficiary Who Requests Indemnification, 3446.9
- Medicare notices, 3701, 3702, 3717, 3719ff.
- noncoverage:
  - date, 3440.1A
  - denial (See Denial)
  - documentation, 3440.2
  - establishing source of notice, 3440
  - notifying providers, 3433.3
- outpatient services, 3718A
- Part A and Part B services, 3719.3
- Part A bills, 3719.1
- Part B bills, 3719.2
- partial denial, 3719ff., 3781.8B
- patient filed claims for emergency services, 3724
- Public Health Service Indian Hospital, 3718.1B
- recovery of overpayment from provider, 3710.3
- release of copy for complementary insurance purposes, 3768C
- results of reopening determination, 3799.15
- "Second Mailing," 3728.1
- SNF model letter re Medicare noncoverage, 3730.1A
- SSA notices, 3718ff
- undeliverable, 3504, 3721, 3728
- utilization notice, 3781.8A

Notification of Internal Adjustment Action(s) Taken by SSA, SSA-L 1001, 3816.2

Nursing home as skilled nursing facility, 3020

NURSING SERVICES:
- anesthetist, 3101.2A
- arrangements by home health agencies, 3025.2A
- continuing services, 3132.11, 3335
- counting visits, 3124.2
- daily skilled services, 3132.1
- defined, 3117ff.
- evaluation, 3117.4A
- extended care services, 3133.1, 3133.9A, 3333
- frequency of services, 3132.11A
- guidelines, 3117.4, 3132.4
- home health agency, 3025
- home health services covered, 3116
- insertion of catheter, 3117.4E
- intermittent nursing services, 3116, 3117B, 3117.1, 3119.6, 3121.3, 3129.5, 3326B

NURSING SERVICES (CONT'D):
  male orderlies, 3117.4E
  Nutrition personnel, 3116
  observation, 3117.4A
  outpatient diagnostic services, 3112.3B
  outpatient therapeutic services, 3112.4C
  part-time care, 3117.1, 3119.6
  postoperative cataract patients, 3117.4A
  presumed coverage, 3129.5
  private duty nursing services excluded, 3101.2, 3125A, 3133.1
  psychiatric nursing under home health, 3117.6
  public health nurses, 3421.1E
  questionable situations, 3132.7
  reasonable and necessary, 3117D, 3117.3
  registered professional nurse, 3117C
  reimbursable, 3117.2
  respiratory therapy, 3101.10B
  restorative nursing procedures, 3132.5I
  skilled services defined, 3117ff., 3132.2, 3132.3, 3132.5
  student nurse, 3117C 3117.4C, 3117.5, 3651
  supervisory services, 3117.4C
  teaching and training, 3117.4B
  unskilled services defined, 3132.6

-O-

Obturator, 3110.4B
OCCUPATIONAL THERAPY:
  cardiac rehabilitation programs, 3101.8, 3101.9
  defined, 3101.9
  furnished by home health agency, 3118
  home health aide, 3119.2
  home health services, 3025A, 3116, 3118.2, 3129.5
  inpatient psychiatric hospital services, 3102.1A
  part-time or intermittent services, 3119.6
  patient activity programs, 3101.9D
  rehabilitation service, 3132.9
  under arrangements, 3118
Offices of the U.S. Railroad Retirement Board, 3550
Offset action, 3470, 3709.1, 3710.1G, H
Offset not made against provider, 3712.2
Omnibus Budget Reconcilation Oct, A3040.1

OPEN-ITEMS:
  aged:
  deletion of selected orbiting bills, 3838
  disposition code, 3512.7
  information, 3518.2
  start-of-care notices, 3548ff.
Operations Schedule—Cumulative Interim Expenditure Report and Budget, HCFA-1527, 3775A
Operations Schedule—Final Administrative Cost Proposal, HCFA-1615, 3775A
Opthalmologist services, 3157
Optometrist, 3030, 3030.5
Oral medications, 3117.4H
Orderlies, 3117.4E
Orthopedic shoes excluded, 3158.2
Osteopathy, doctor of, as physician, 3030, 3030.1, 3334, 3420.1
Out-of-scope procedures, Addendum F
Outliers, 3637.9
Outpatient, defined, 3112.1, 3148.2
Outpatient home health services, 3119.5
Outpatient hospital diagnostic services (See Outpatient hospital services)
Outpatient surgery, 3626.4
OUTPATIENT HOSPITAL SERVICES:
  alcoholism treatment, 3112, 3151
  arrangements by home health agency, 3120.4
  beneficiary liability, 3444.1
  billing, 3302.2B, 3302.5A, 3912.3
  certification, Part B services, 3322
  data record, 3872
  defined, 3112ff.
  diagnostic services, 3112, 3112.3, 3212
  dialysis inpatient to outpatient status, 3101B
  dialysis services, 3114C
  distinguishing Part A and Part B outpatient services, 3112
  emergency services (See Emergency services)
  HMO members, 3555.2
  hospitalization for minor surgery, 3101A
  incident to physicians' services, 3212
  intern and resident services, 3115A
  medically unnecessary, 3444.5B
  outpatient defined, 3112.1, 3148.2
  outside hospital premises, 3112.2
  Part B blood deductible, 3235.2
  patient not physically present for tests, 3302.5A

OUTPATIENT HOSPITAL SERVICES (CONT'D):
  - preadmission diagnostic services, 3112.3
  - physical therapy (See Physical therapy)
  - provider liability, 3444.2
  - query procedures, 3525
  - under supplementary medical insurance, 3112, 3145B, 3148.4, 3212, 3444, 3525.6, 3740.2B
  - Unibill, A626
  - waiver of liability, 3444
  - waiver of liability for hospitals, A3432.2

Outpatient physical therapy (See Physical therapy)
Outpatient Record Layout, 3880.3
Outpatient services, 3119.5
Outpatient speech pathology (See Speech therapy)

OVERPAYMENTS:
  - abuse, 3468.2
  - amount, 3712.2
  - appeals decision results, 3709.3D
  - beneficiary deceased, 3712.2
  - beneficiary liable, 3708.3, 3709.5
  - beneficiary not entitled to Part A benefits, 3708.2E, 3709.3C
  - benefits exhausted, 3707, 3708.2B
  - cause, 3712.2
  - clerical error, 3708.2C
  - coinsurance misapplication, 3708.2B
  - computation, 3711.4
  - continuation of benefit period, 3308C
  - custodial care, 3707, 3708, 3708.2F, 3708.3, 3708.5, 3710.1, 3710.4
  - dates of services, 3712.2
  - deceased beneficiary, 3711.8
  - deductible improperly applied, 3708.1
  - does not exceed $15, 3709.2A
  - fourth year after overpayment, 3708.1
  - fraud, 3308C, 3454.1H, 3468.1, 3707.1, 3709.4
  - general, 3707
  - General Accounting Office for collection, 3710.2B
  - guarantee of payment provision, 3708.3
  - indemnification payments, 3430, 3446
  - liability, 3707, 3708
  - mathematical error, 3708.2C
  - Medicaid beneficiary, 3712.2
  - medically unnecessary services, 3707, 3708, 3708.2F, 3708.3, 3708.5, 3710.1, 3710.3C, 3710.4
  - misinformation, 3709.3B
  - more than $15, not over $20, 3709.2A, 3711.3F
  - noncovered services, 3709.3A
  - nonentitlement, 3712.4
  - notice to beneficiary, 3710.3

OVERPAYMENTS (CONT'):
- offset action, 3470, 3709.1, 3710.1G, H
- offset not made against provider, 3712.2
- prior utilization, 3708.2B
- provider liability, 3708.1, 3708.2
- recording cases, provider not liable, 3711.10
- recoupment action, 3470
  - against equity and good conscience, 3709.5
  - another Government health benefits program, 3711.1
- recovery:
  - barred expiration of 48 months, 3708
  - beneficiary deceased, 3711.8
  - beneficiary liable, 3711, 3711.6B
  - covered under Welfare, 3711.1
  - determining liability, 3708
  - efforts, 3712.2
  - fraud suspected, 3709.4
  - general, 3709
  - incorrect CHAMPUS/CHAMPVA payments, 3153.3D
  - indemnification payment, 3446.8
  - individual overpayments from provider, 3710
  - limitation on recovery from beneficiary, 3799.16
  - not entitled to Medicare, 3711.1
  - notification to beneficiary, 3710.3D
  - outpatient services, 3711.6A
  - provider liable, 3446.7
  - provider services, 3707
  - sought by provider, 3710.3D
  - time limits, 3707.1, 3708.4
  - uncollectable, 3787
  - waived, 3708, 3709.3, 3709.5, 3710.3D, 3712.6
- referral to Medicare Bureau, 3708.2B, 3710.2, 3712, 3816D
- refund letter, 3711.6A
- refund offered after referral, 3712.5
- secondary payments under workers' compensation 3407.3
- services in nonparticipating portion of facility, 3708.2G
- services not received by beneficiary, 3708.2D
- statute of limitations, 3707.1, 3709.2B
- supplemental health insurance, 3711.1
- suspension of recovery efforts, 3711.3
- third calendar year, 3708.4
- third party payers, 3714.3
- tolerance rule, 3709.2A
- uncollected, 3708.2B, 3710.2B, 3711.2, 3712.1
- unrecovered, 3712

OVERPAYMENTS (CONT'D):
  waived, 3707, 3711.3B, 3794.6
  without fault, 3708
  workers' compensation, 3408
  workers' compensation involved, 3416, 3679, 3711.1
  written explanation, 3710.1
Ownership, provider change of, 3009, 3507.6,
OXYGEN:
  ambulance service supply, 3114
  durable medical equipment supplies, 3113.4
  inhalation therapy, 3133.9B
  medical supplies, 3119.3A
  outpatient services, 3112.4C
  tents, 3133.9B
  under Part A, 3101.4
  under Part B, 3112.4C

-P-

Pacemaker Registry Records, 3676
Pace track (See Digital electronic pacemaker monitor)
Pamphlet, SSA-75-10085, "Your Right to Question the Decision on Your Hospital Insurance Claim." 3721
Parenteral nutrition system, 3110.4C
Parkinson patient, 3101.8B(2), 3118.1B
Part A Deductible and Coinsurance Amounts, 3211
Part A Disposition Codes by Query Codes, 3550
Part A HI Bill History, 3840ff.
Part A Quarterly Report of Program Integrity Complaints, 3459, 3459.1
Part A Reconsideration Status, HCFA-2442, 3784, 3784.12
Part B (See Supplementary medical insurance)
Partial Denial—Hospital-Filed or Beneficiary-Filed Emergency Claim, 3725
Partial Disallowance Letter from Intermediary, HCFA-1955, 3719.1, 3781.8B
Participation agreement (See Providers: participation agreement)
Part-time or intermittent services, 3119.2, 3119.6
PATHOLOGY SERVICES:
  billed on HCFA-1453, 3512.6,
  billed on HCFA-1483 by hospitals, 3146A
  combined billing, 3912.3
  field of pathology, 3146D
  inpatient services, 3146
  Part B expenses, 3525.5
  request for payment in hospital record, 3302.4

PATIENT:
covered care unnecessary, 3440A
noncoverage notice, 3439.1
PAYMENT DISTRIBUTION:
Payment limitation, 3421A
Payment notice, 3702
PAYMENT PROCEDURES:
alien non-payment cases, 3716
assurance of payment procedures (See Assurance of payment procedures)
automatic data processing system, 3700
authorized representative, Part B, 3797
beneficiary inquiries, 3792.1
benefit checks, 3703
bill review, 3610
comprehensive outpatient rehabilitation facilities (CORF), 3370.1
corrected bills (See Billing: corrected bills)
denials, 3704, 3792.1
disclosure to PROs, 3770.1
electronic reporting of crossover claims, 3770C
employer group health plans, 3490.1,
entitlement to payment after patient's death, 3715C
guarantee of payment provisions, 3707, 3714
integration of Title XVIII and complementary insurance claims, 3769
legal representatives, 3715.4
Medicare identification, 3701
non-certified bed, 3431.3
notice of payment, 3702, 3717
overpayments, 3707, 3708ff.
payment limitation, 3421A
prospective/nonprospective requirement, 3850
secondary payments under workers' compensation 3407.3
services not paid for, 3715B
stock denial paragraphs, 3722
survivors, 3715.5
underpayments, 3715ff.
under PPS, 3798
utilization chargeable, 3718
Waiver of Liability for Hospitals, A3432.2
withholding payment in potential fraud cases, 3466
workers' compensation 3407.3
PEER REVIEW ORGANIZATIONS (PRO):
adjustment bills, 3664ff, 3674.6
bill type codes, 3873.2, 3876.1
claims processing requirements, 3674.4C
coding structures, 3871
denial notices, 3674.3, 3719.4
determination, 3719.1, 3719.4
disapproval, 3432.3B

PEER REVIEW ORGANIZATION(PRO) (CONT'D):
- electronic exchange of data, 3674.4
- general, 3790A
- hearings, 3790.3
- jurisdiction claims, 3432.3, 3790.2B
- medical review, 3635
- misfiled reconsideration requests, 3790.2D
- noncoverage notice, 3432.3, 3439E, 3440.1B
- noncovered level of care:
  - hospital, 3722.1
  - SNF, 3722.2
- pass thru perdiem amount, 3870
- physician certification, 3315.2
- prepayment review system, 3634
- reconsideration, 3790.2
- rehabilitation claims, 3638.1
- review, 3315.2,
- source of noncoverage notice, 3440
- statewide PRO Council, 3790.2, 3790.3
- submission of data, 3674.4
- waiver of liability, 3630

Penal statute, 3153.3C
PENS (See Percutaneous Electrical Nerve Stimulation)
Per diem cost of routine services, 3101.1

PERIODIC INTERIM PAYMENT (PIP):
- batching resubmitted bills, 3804.2
- report of eligibility, 3518.2

Personal comfort items, 3101.1D, 3125, 3156,
Petition to Obtain Approval of a Fee for Representing a Social Security Claimant, SSA-1560, 3789
Pharmacy and drug therapeutics committee approval, 3101.3B
Physical examinations, routine, excluded, 3157

PHYSICAL THERAPIST:
- consultation, 3148.3
- covered physical therapy, 3101.8, 3118.1A
- exercise program, 3117.4D
- independent practitioner, 3147, 3149
- nonqualified, 3708.2F
- range of motion tests, 3101.8C, 3118.1C

PHYSICAL THERAPY:
- ancillary services, 3101.8D
- arrangements for services, 3101.8, 3118, 3147, 3147.1
- certification by physician, 3148.1, 3326B, 3350
- conditions of coverage, 3101.8A, 3118.1A, 3129.4C, 3148ff.
- coverage of services, 3101.5A
- guidelines, 3101.8C, 3118.1C
- home health aide services, 3119.2, 3127D, 3129.5

PHYSICAL THERAPY (CONT'D):
  home health service, 3025A, 3116, 3118
  independent facility, 3444.3, 3444.5
  inpatient ancillary services, 3622
  maintenance programs, 3101.8B(2), 3118.1B(2)services, 3007, 3008.4D, 3110F, 3127D, 3127.1A, 3132.8, 3147, 3148.2, 3148.4, 3212, 3301, 3322,
  outpatient services to inpatients, 3148.4,
  outpatient speech pathology services, 3110F, 3148.4, 3640.9
  presumed coverage, 3129.5
  provider not required to furnish, 3148.4
  related illness or impairment, 3121.3
  restorative, 3101.8B, 3118.1B
  therapeutic services (See Therapeutic services)
  time per visit, 3119.6
  under arrangements, 3101.8, 3118, 3147.1
PHYSICIAN:
  billing for, 3104.1,
  certification (See Certification by physician)
  chiropractor, 3030
  Christian Science practitioner, 3030
  compensation arrangements, 3912.3
  compensation for utilization review services as allowable cost, 3420.1
  consulting physician, 3784.1B
  convicted, 3484
  defined, 3030
  dentists as physicians, 3030, 3030.2, 3101.7, 3316, 3316.1
  disclosure of information, 3763.1A, 3773D
  doctor of medicine, 3030.1
  doctor of optometry, 3030, 3030.5, 3110.4A
  doctor of osteopathy, 3030.1
  Federal employment, 3030.4
  home health plan, 3120.3, 3148.2, 3148.3
  home health services, 3117.4A
  hospital-based (See Hospital-based physician)
  incident to physician's services, 3110, 3112ff., 3212
  naturopath, 3030
  optometrist as physician, 3030, 3030.5
  osteopathy, doctor of, 3030, 3030.1, 3420.1
  overcharging, 3480B(3)
  physical therapist as independent practitioner, 3147, 3149
  podiatrist as physician, 3030.3, 3101.6, 3119.4, 3316, 3334, 3420.1
  recertification (See Recertification by physicians)
  reinstatement, 3484.3
  revocation of presumption, 3139.4
  services:
    assigned claims, 3302.3A
    billed, 3302.2D

PHYSICIAN (CONT'D):
- services:
  - fee-for-time basis, 3302.3A
  - furnished in home setting, 3117.4A
  - out-of-plan, 3360C
  - outside United States, 3154C, 3310
  - questionable, 3432.3B
  - request for payment on provider record, 3302.2
  - salary basis, 3302.3A,
  - teaching, 3115A,
  - unassigned claims, 3302.3B
  - under supplementary medical insurance (See Supplementary medical insurance)
- specialist, 3302.4,
- suspension, 3484ff.
- teaching services, 3115A, 3145A, B,
- time limit for filing Part B claims, 3312
- transfer of patient to different physician, 3121.4
- unethical or unprofessional conduct, 3480A
- unlicensed graduates of foreign medical schools, 3115A
- utilization review committee determination notice, 3421B
- violations, 3480B

Physician certification (See Certification by physicians)

Pick's disease, 3102.1B

Plan of Expenditures, HCFA-2582, 3775A

Plan of treatment by physician (See Home health plan of treatment)

Plastic surgery (See Cosmetic surgery)

PODIATRY:
- certification signature, 3334
- interns and residents-in-training, 3101.6, 3119.4
- podiatrist defined, 3030.3
- utilization review committee, 3420.1

Policy or rule, 3708.2F

Post-cataract surgery convalescence, 3132.7B

Postdischarge care, 3431.1B(1), 3441,

posthospital extended care services, 3421.2, 3431.1

Postmastectomy, 3110.4

Postoperative cataract patients, 3117.4A

POSTPAYMENT MEDICAL REVIEW (ABUSE CASES) SUMMARY REPORT—MEDICARE, HCFA-60:
- exhibit, 3455.2
- instructions for completion of form, 3455.2
- reporting title XVIII requirements, 3455

Post-surgical lenses, 3110.4A

Pregnancy, 3101.12

Prehearing case review, 3785.8

PREMIUM HOSPITAL INSURANCE:
- beginning of coverage, 3001.4C
- eligibility requirements, 3001.4A, 3780.1A
- end of coverage, 3001.4D
- erroneous enrollment, 3004
- General Enrollment Period (GEP), 3001.4C
- grace period for premium payment, 3001.4D
- Initial Enrollment Period (IEP), 3001.4C
- Initial General Enrollment Period (IGEP), 3001.4C
- premiums, 3001.4B
- termination of coverage, 3001.4D
- voluntary withdrawal, 3001.4D
- waiver of enrollment period requirements, 3004

PREMIUMS:
- hospital insurance, 3001.4
- supplementary medical insurance, 3003.7, 3212

Prepayment plan, 3145.1, 3152C
Prepayment requests, 3314ff.
Press and public, releases of audit reports, 3774C

PRESUMED COVERAGE:
- conditions and periods covered under presumption, 3129.4C
- medical conditions covered under presumption, 3129.4, 3139.5
- Part A posthospital extended care services, 3139
- Part A posthospital home health services, 3129
- revocation of presumption for certain physicians, 3129.3, 3139.4

PRIOR INPATIENT STAY:
- as related to physician's certification, 3326
- extended care services, 3131ff., 3431.1, 3431.1A
- foreign hospital, 3131.2, 3520.2
- fourteen-day limit on home health plan establishment, 3121.2
- home health services, 3121.1B, 3122.1, 3123.1, 3431.3
- medically necessary, 3121.1B, 3131.1
- SNF admission, 3518.2
- three-day stay requirement, 3431.1A,
- verification, 3520ff.,

Prisoner defined, 3153.3C
Privacy Act, 3763
Private duty nursing service, 3101.2, 3125A, 3133.1
Private health insurance plan, 3152C, 3711.1, 3711.3D, 3711.6
Private research foundation, 3152
Processing-Reports-Records, 3825.1

PROGRAM INTEGRITY:
  - abuse, 3433.4, 3452, 3460B
  - complaints, 3459.1
  - defined, 3452
  - fraud distinguished from abuse, 3454
  - general, 3450
  - investigations, 3458
  - Regional Offices, 3486
  - role of intermediaries, 3458

Program materials, 3762

PROSTHETIC DEVICES:
  - billing, 3110.4
  - cardiac pacemakers, 3101.4, 3110.4
  - covered items, 3112.4C,
  - defined, 3110.4
  - dentures, 3110.4B
  - Foley catheter, 3110.4
  - general, 3127B
  - hemodialysis equipment, 3110.4
  - home health services, 3127
  - internal organ replacements, 3110D, 3110.4A, 3212
  - irrigation kits, equipment, 3110.4
  - lenses (See Lenses)
  - maxillofacial devices, 3110.4
  - obturator, 3110.4B
  - parenteral nutrition system, 3110.4C
  - supplies, repairs, adjustments and replacement, 3110.4C

Protest of payment determination, 3791
Provider Agreement, HCFA-1561, 3005, 3462
Provider Audit Cost Report, HCFA-3208, 3775A
Provider-based physicians (See Hospital-based physicians; and Provider billing for patient services by physician)

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES:
  - ancillary services, Part B, 3444ff.
  - batching bills, 3803
  - claim number discrepancies, 3504
  - combined billing, 3704
  - consistency edits, 3825.2, 3832C
  - "contained in provider's record," 3302.2
  - date of noncoverage notice, 3440.1B
  - denial rate, 3444.5

PROVIDER BILLING FOR MEDICAL AND OTHER HEALTH SERVICES (CONT'):
  equipment:
  exhibit, 3726.1
  health maintenance organizations:
    paid, 3555.2
    services, 3360.2,
  hospital signs on behalf of patient, 3302.5A
  information which may be released, 3768C
  inpatient services, 3146A, 3702
  intermediary query to SSA, 3525, 3527ff.
  no payment bill, 3309.2,
  nonparticipating hospital-filed claim, 3312.2
  nonprovider facility, 3444.4
  notices (See Notices to beneficiary)
  outpatient services, 3444ff.
  Part B services, 3106.2A, 3430, 3501, 3719.2, 3726ff.
  patient not visited, 3302.5A
  provider rural health clinic use,
  reimbursement rate for Part B services,
  request for payment, 3302.1, 3302.5A,
  services not paid for, 3715B
  skilled nursing facility use,
  submitted by provider rural health clinics, 3894.4
  tolerance guides for adjustment bills, 3816.1
  underpayments, 3715.2A
PROVIDER BILLING FOR PATIENT SERVICES BY PHYSICIANS:
  billing procedures, 3525.6
  combined billing method preferred,
  erroneously received by carriers,
  Group Practice Prepayment Plans, 3145.1
  hospital authorization to bill for physician, 3302.3B
  hospital-filed claim, 3312.3
  hospital or payee signs on behalf of patient, 3302.5
  independent billing by provider-based physicians, 3912.3
  request for payment, 3302.1, 3302.2
Provider Chain/Operator Data, 3703.1
Provider numbers, 3507.2,
Provider Payment List, 3773.1
Provider payments to chain organization, 3703.1
PROVIDER RURAL HEALTH CLINICS:
  bills received for initial processing, 3894.4
  HCFA-1483 bills submitted, 3894.4
  monthly intermediary workload report, 3894.4
  provider number, 3975

PROVIDERS:
- agreement provisions not met, 3008.2
- agreement terminated, 3401.3
- at fault, 3708.4, 3708.5, 3710.4B
- chain operation, 3464B
- chain organization, 3703.1
- change of intermediary, 3433.2,
- change of ownership, 3005.2, 3009, 3507.6,
- Christian Science Sanatorium, 3023
- cost report:
  - Congressional requests, 3773C
  - disclosable information, 3773C
  - exception to ten-day notice requirement, 3773C
  - Federal or State agencies requests, 3773C
  - requests for disclosure, 3773C
  - ten-day notice requirement, 3773C(3b)
- deals directly with Government, 3302.1
- defined, 3005
- denial rate, 3433, 3434ff.
- disclosure of information, 3760, 3763.1A, 3773
- discrimination prohibited, 3005
- examination of records refused, 3008.2D
- "excess cost" provider, 3780.1B
- excessive denial rates, 3433.4
- foot care exclusions application, 3158ff.
- former participating provider, 3401.4
- fraud, 3462
- furnished erroneous information, 3708.2A
- hearing request, 3780.1C
- home health agencies, 3025
- hospitals, 3010
- improper coverage decisions, 3439.2
- indemnification action, 3446.7
- liability:
  - change in waiver status, 3434.5
  - criteria for waiver, 3433
  - determination, 3432-3432.3
  - favorable waiver presumption, 3444.2
  - overpayments, 3708.1, 3708.2, 3710.4A
  - waiver status, 3433.3, 3433.5
- low utilization, 3434.6

PROVIDERS (CONT'D):
  newly participating, 3433.1
  noncoverage:
    date of notice, 3440.1B
    knowledge of services, 3439
    notice, 3433.3, 3439B(3), 3440.1B
    notice retention, 3440.2
    PSRO notice, 3439E
    source of notice, 3440A
  nongovernmental exclusion, 3553.3B
  nonparticipating portion, 3708.2G
  overpayment:
    liability, 3708.1
    no longer participating, 3710.2
    not liable, 3711.10
  numbers, 3507.2
  participation agreement, 3005, 3025.2, 3462
  party to reconsideration, 3782.1C
  provider-based physicians' services, 3145
  provider numbers, 3507.2
  Provider Payment List, 3773.1
  provider-physician agreement, 3912.1
  psychiatric hospital, 3016
  recovery of overpayment, 3710ff.
  representative certification,
  representative letter,
  responsible for late filing, 3308A
  sample study of claims, 3799.6
  skilled nursing facilities, 3020
  termination of agreement to participate:
    involuntary, 3005.2, 3008.2,
    term of participation, 3008ff.
    voluntary, 3005.2, 3008.1,
  unaware of patient's entitlement, 3308B
  without fault, 3708.1, 3708.3, 3708.4, 3709.2C, 3709.3A
PRO (See Peer Review Organizations)
PSYCHIATRIC HOSPITAL SERVICES, INPATIENT:
  active treatment, 3101.9A, 3102.1, 3320,
  active treatment ended,
  admission form,
  benefit days, 3102, 3104

PSYCHIATRIC HOSPITAL SERVICES, INPATIENT:
- certification by physician, 3102.1, 3315, 3320, 3324
- coinsurance, effect of inpatient service restriction, 3104.5, 3203, 3512.4
- custodial care, 3159.2,
- days of admission, discharge and leave deducted, 3104.3
- eligibility notice updating, 3510.3
- guarantee of payment, 3714
- inpatient benefit day restriction, initial spell of illness, 3104ff., 3203, 3510.3
- lifetime limitation, 3105, 3106D, 3107C, 3714, 3718.1 (Item 3),3719.1, 3781.3D
- limitations on payment, 3107, 3421
- medical records, 3345.1,
- nonpsychiatric care, 3102.2
- patient status on first day of entitlement, 3104.1
- physician certification, 3102.1
- recertification by physician, 3315, 3320, 3324
- rendered in rural health clinic,
- termination of hospital participation, 3008.4A

PSYCHIATRIC HOSPITALS:
- admission notice, 3507.6
- certification of part of institution, 3017ff.
- custodial care, 3104.2, 3159.2,
- days remaining, 3104.4ff., 3518.2
- defined, 3016
- defined for spell of illness, 3035A
- emergency qualifications, 3012.1
- general hospital facility, 3017.2
- first spell of illness after December 31, 1967, 3104.6B
- guarantee of payment provisions, 3714
- individuals committed under penal statute, 3153.3C
- limitation on psychiatric services (See Lifetime limitation on inpatient psychiatric hospital services)
- medical records, 3345
- meets prior stay requirement:
  - extended care services, 3131.1
  - home health, Part A, 3121.1B
- nonpsychiatric care, 3102.2
- preentitlement stay, 3104.6B
- State and local government operated, 3153.3A(1), 3153.3C
- status in determining days deducted, 3104.2
- termination of participation, 3008.4A
- utilization review, 3420

PSYCHIATRIC HOSPITALS (CONT'D):
Psychiatric treatment, 3132.7A
Psychiatric restrictions, 3104, 3201, 3510.3, 3520
Psychologists, 3101.5A, 3112.3B, 3112.4C, 3116
Psychoses, organic brain syndromes,
Psychotherapy, 3102.1A
PUBLIC:
  assistance recipients, 3003.1
  expense items and services, exclusion, 3153.2
  health agency, 3147, 3149, 3444.3,
  Information Regulations, DHEW, 3760, 3763
  organization buy-in, Part A, 3001.4B
  requests for copy of provider cost report, 3773C)
PUBLIC HEALTH SERVICE (PHS)
  authorization to non-Federal providers, 3153.2, 3708.2F
  hospitals, 3030.4
  hospitals as community institutions, 3153.1A
  safety and effectiveness of drugs, 3101.3B
Purchase of durable medical equipment (See Durable medical equipment)

-Q-

Quality control, 3728.3
Quarterly Report of Freedom of Information Activity, 3776
Quarters of coverage, 3001.1
QUERY AND REPLY PROCEDURES, PART A (SEE ALSO ADMISSIONS: AND START OF CARE):
  Advanced Record System, Addendum A to Chapter VI (Sec. 1-9)
  automatic notifications by SSA, 3511
  beneficiary identification, 3512.1
  codes, Part A:
    disallow disposition, 3538A(1)
    disposition, reply, 3512.7
    query codes, 3507.3
    reject, 3538A(1)
    reply contents, 3512ff.
  contents of reply, 3512.1-3512.7, 3545
  data in notice of admission, 3507-3507.7
  disposition codes, 3512.7
  Disposition Codes by Query Codes, 3550
  inpatient services to HMO members, 3555.1
  open-item development, 3518.2, 3519ff., 3548
  query-related conditions, 3512.7
  "R-trailer" code, 3360.2, 3512.8
  requery, 3501, 3510ff., 3512.7, 3538.1
  status query, 3507.3

QUERY AND REPLY PROCEDURES, PART B:
  - Advanced Record System, Part B, Addendum A to Chapter VI (Sec. 10ff.)
  - assistance requested from SSA, 3537
  - automatic notifications by SSA, 3511
  - codes, Part B, 3527
  - data in reply, 3512.6, 3535
  - deductible status, 3525ff
    - carryover, 3525.1, 3525.4
    - first-in-first-out, 3525.4
    - improper deductible reply, 3534
    - incurred expenses, 3527G
  - durable medical equipment payment, 3525.7
  - HMO blood claim for query, 3555.2
  - home health, 3525, 3542, 3545H,
  - intermediary control number, 3527B
  - intermediary number, 3527A
  - interrupted period of entitlement, 3532
  - outpatient hospital, 3525
  - reply data, 3535
  - requery, 3536, 3538.1
  - requesting SSA assistance, 3537
  - skilled nursing facilities, 3525
  - SSA record maintenance, 3531

Query/Query Reply Telegram Data Sheet, 3557

R

RADIOLOGY SERVICES:
  - billed on HCFA-1450, 3512.6,
  - billed on HCFA-1450 by hospitals, 3146A,
  - combined billing, 3912.3
  - defined, 3146C
  - field of radiology, 3146D
  - inpatient services, 3110B, 3146,
  - Part B expenses, 3525.5
  - request for payment in hospital record, 3302.4
  - SNF, 3137.1

Railroad disability annuitants, 3001.2

RAILROAD RETIREMENT BENEFICIARIES:
  - covered services, Canadian hospitals, 3154, 3519.5
  - entitlement:
    - hospital insurance, 3001
    - medical insurance, 3303.1
    - RRB, 3505.3H
  - health insurance card, 3502, 3550
  - health insurance claim number, 3503
  - hearing, 3795
  - qualified, 3780.1A

RAILROAD RETIREMENT BOARD:
- assistance, 3537C
- investigation, 3512.7, 3535
- Offices of the U.S., 3550
- recovery waived, 3712.5
- Regional Map--U.S., 3550
- unrecovered overpayment, 3712

Range of motion tests, 3101.8C, 3118.1C

RATES:
- accommodations, 3101.1D,
- Part A deductible, 3512.4B

REASONABLE COST BASIS:
- determination, 3780.1C
- durable medical equipment, 3113
- extended care services, 3130
- Health Maintenance Organizations, 3360B
- inpatient hospital services, 3101
- interns and residents services, 3101.6, 3115, 3145, 3910.2
- laboratory services under arrangements, cost defined, 3101.5C
- provider-based physicians' services, 3145B, 3910.1

Rebate, 3462(13)

RECERTIFICATION BY PHYSICIANS (See also Certification by physician):
- admission before entitlement, effect on, 3324
- content, 3317A
- delayed, 3319A, 3323, 3329, 3338
- disposition of, 3315, 3327, 3339
- extended care services, 3139.2B, 3333-3339
- failure to obtain, 3315.1, 3333
- general provisions, 3315
- home health services, 3120.3, 3326-3329,
- inpatient hospital services, 3317
- inpatient psychiatric hospital services, 3320
- inpatient hospital services, 3315, 3321
- outpatient services, 3350B
- physical therapy, 3350
- podiatrist excluded, 3030.3
- presumed coverage cases, 3129.2B
- requirement for payment, 3315
- signature requirement, 3316
- speech pathology, 3350
- timing, 3319, 3324, 3328, 3337

Reconsideration Branch, Division of Special Operations, 3786F

Reconsideration Branch, Medicare Bureau, 3784.10, 3784.12, 3785.5, 3785.6, 3785.8, 3790.2B, 3790.3C

Reconsideration Determination, HCFA-2501, 3784

Reconsideration Determination Language, 3784.15

Reconsiderations (See Appeals of payment determinations)

Record of Part B Medicare Benefits Furnished by a Provider, 3719.3, 3726

RECORDS:
  action code, 3880.1
  admission control layout, 3838.8C
  batch control layout, 3879.6
  batch number, 3879.2
  Batch Summary Record Layout, 3881
  bill tape batch control, 3879
  bill tape internal record, 3878
  bill-type code, 3879.3
  bill-type data, 3880
  Christian Science data record, 3873
  Christian Science Record Layout, 3880.4
  disclosure (See Disclosure of information)
  EDP date fields, 3870
  file sequencing, 3877
  final nonpayment bill, 3875
  Final Nonpayment Bill Record Layout, 3880.5
  HI bill retrieval, 3840
  home health agency data, 3874
  Home Health Agency Record Layout, 3880.5
  identification code, 3879.1
  inpatient hospital data, 3871
  Inpatient Hospital/SNF Record Layout, 3880.2
  internal label layout, 3878.2
  master identification layout, 3838.8A
  master Part A record layout, 3838.8B
  Outpatient Record Layout, 3880.3
  payment data to central office, 3850
  saturated, 3838.7
  special bill identification code, 3879.5
  Trailer Record Layout, 3882
  Void Record Layout, 3880.7
  void RTI bill, 3876
Recovery of overpayments (See Overpayments: recovery)
Recovery of Payments, Automobile Medical, 3419.5
Recreational therapy, 3102.1A(2)
REFUNDS:
  after referral to Medicare Bureau or RRB, 3712.5
  beneficiary protests overpayment decision, 3711.11
  by former providers, 3401.4
  final disposition, 3401.1, 3401.2
  fraud suspected, 3709.4
  installments, 3711.6D, 3711.9
  monies incorrectly collected from beneficiaries, 3401, 3446.7
  monies set aside, 3401.1B

REFUNDS (CONT'D):
  overpaid amount, 3709.1B
  recoupment action, 3470
  recurring failure to refund, 3401.3
  time limits re disposition, 3401.2
  to patient by hospital, under guarantee of payment provision, 3714.2D
  to patient by intermediary, 3401B
  to patient by provider, 3005, 3025.2A, 3401ff
    3714.2D, 3786E
  written requests for refunds, 3710.2B
Refusal to sign request for payment (See Request for payment: refusal to sign)
Regional Map—U.S. Railroad Retirement Board, 3550(Ex. 8)
REGIONAL OFFICE, MEDICARE BUREAU:
  assistance, 3520.2
  bill submission, 3801
  change of provider ownership, 3009
  civil fraud settlement check, 3479
  collection of overpayment, 3710.2C
  Congressional correspondence, 3735.1(I), 3735.2
  critical cases, 3538.1
  disclosure of information:
    authority for refusal, 3763.1B
    copy of provider cost report, 3773C
    cost report information, 3773C
    names of provider, suppliers, physicians, 3773E
    review use of BEST, 3506.1
    review use of CAST, 3505.1
    statistics, 3775
    to Internal Revenue Service, 3771
    to Office for Civilian Health and Medical Program of Uniformed Services (CHAMPUS), 3770B
    to State agencies, 3770B
    written request for information, 3760.1
  emergency claims:
    determinations, 3121.1C, 3121.2, 3310, 3780.1B, 3786E
    reconsideration requests, 3782.6B, 3782.6C
  excessive denial rates, 3433.4
  fair hearing, 3794.9, 3795
  fraud:
    abuse, 3468.2
    active fraud investigation, 3468.1B
    chain operations, 3464B
    Congressional interest, 3464B
    intermediary role, 3458
    press interest, 3464B
    reports, 3458, 3460C, 3462

REGIONAL OFFICE, MEDICARE BUREAU (CONT'D):
    surveillance, 3470
    unethical conduct by practitioners, 3480C
    withholding payment, 3466
  hospital-based physician files, 3912.2
  indemnification claims, 3446.1
  intermediary advised of term of SNF agreement, 3005.3
  intermediary reports, 3459
  intermediary request for status of provider, 3547
  investigations of prepayment requests, 3314.4
  issues re provider information, 3912.1
  ninety days no reply, 3512.7(Code 43)
  Part A bills for mental disorders, 3117.6
  prepayment policy, 3314.4
  provider termination, 3401.3,
  questionable indemnification requests, 3446.5
  reconsideration cases, 3784.2A
  test coordinator, 3560, 3562
  welfare office contact, 3711.1
Regulation No. 1, 3761, 3763, 3763.1B, 3763.2
Regulations No. 1 and 22, 3760
REHABILITATION:
  agencies, 3147, 3444.3,
  basis for extended care, 3132.9
  centers, 3025.3, 3119.5
  covered level of care, 3132
  daily skilled services, 3132.1
  detoxification, 3639.1
  injured, disabled or sick, 3010A, 3020, 3035C, 3120.5
  inpatient hospital care, 3101.10
  outpatient services, 3025.2A
  potential, 3132.2
Reimbursement (See Billing method under Hospital-based physicians)
Reinstatement of Part B coverage of home health services, 3689
Rejected bills (See Billing: rejected bills)
RELATIONSHIP:
  child, 3715C(2), (5), 3715.6C
  determination of relationship, 3715.1F
  entitlement allegation, 3715.5B
  entitlement to payment after patient's death, 3715C
  general, 3715.6A
  "immediate relative" defined, 3161C, 3766A
  in-law relationship, 3161C
  members of patient's household, 3161A, 3161D, 3766A
  parent, 3715C(3), (6), 3715.6D
  persons who evidence concern, 3766A

RELATIONSHIP (CONT'D):
  signer's relationship to patient, 3302.5C
  step-relationship, 3161C
  surviving spouse, 3715C(1), 3715.5F, 3715.6B
  surviving spouse not living with, 3715C
  widow, 3715.1F
Relative to patient, exclusion of charges by, 3161
Release of information (See Disclosure of information)
Religious counselors, 3421.1E
Religious orders, payment to, 3152E
Renal dialysis facility, 3114C
RENAL DISEASE, CHRONIC:
  appeals, 3780.1A
  billing, 3512.8(S. Note)
  denial rate ESRD facilities claims, 3444.5
  dialysis, 3001.3
  episodic dialysis, 3101B
  hemodialysis equipment, 3110.4
  hospitalization for renal dialysis, 3101B
  kidney transplantation, 3001.3
  Part A services, 3001.3
  Part B services, 3626.1
  prior inpatient stay, 3121.1B, 3131.1
  renal dialysis equipment, 3113.7
  three-month tolerance rule for DME, 3113.7E
  VA hospital services to nonveterans, 3153.1A
  waiver presumption, nonprovider ESRD facilities, 3444.4
Rental of durable medical equipment (See Durable medical equipment)
Reopening of determinations, 3799
REPLY TO NOTICE OF ADMISSION, HCFA-1568:
  Part A benefits available, 3512.4
  Part B benefits, not entitled, 3626
  query procedures, 3510ff.
REPORT OF ELIGIBILITY (ROE):
  Admission Notice—Report of Eligibility, HCFA-1453, 3550
  copy to HMO, 3546
  defined, 3518.1
  documentation, 3783.1
  inpatient hospital admission, 3518.2
  reply to start of care notice, 3546
  SNF admission, 3518.2
  Start of Care Notice—Report of Eligibility, HCFA-1487, 3550
REPORTS:
  Annual Contract Evaluation Reports (ACER), 3774A
  audit, 3774C
  batch status report, 3842
  Bill Error Report, 3845ff.
  Contract Performance Review Reports (CPR), 3774B
  cost reports, 3773C
  Final Report of Test Results, 3560, 3562

REPORTS (CONT'D):

- HEW Audit Agency reports, 3774C
- Intermediary Workload Report, HCFA-1566:
  - completing, 3894
  - general, 3892
  - independent rural health clinics, 3894.4, 3895
  - provider rural health clinics, 3894.4
- Operations Schedule—Cumulative Interim Expenditure Report, 3775A
- Report of Eligibility, 3518.1, 3518.2, 3546, 3783.1
- reporting bills to SSA, 3801
- reporting definitions, 3895.4
- reporting instructions, 3895.5
- Returned and Resubmitted Bill Analysis, 3804.4
- summary totals report, 3867.2, 3890
- survey reports, 3773C
- transmittal and report form, 3890
- validation review reports, 3773C

REPRESENTATIVE:
- authorized, Part B, 3797
- disclosure of information, 3765
- election where beneficiary incapacitated, 3106.2E
- filing request for payment, 3301
- good cause, 3781.8
- hearing notice, 3794.2
- next of kin, 3421B
- retroactive election, 3106.2C
- signature, 3302.5

REQUEST FOR HEARING:
- dismissed, 3782.1E
- Part A, 3785ff
- Part B, 3795
- withdrawn, 3794.2

Request for Hearing Part A Health Insurance Benefits, HA-501.1, 3785
Request for Hearing--Part B Medicare Claim, HCFA-1965, 3794.1C, 3795
Request for Medicare payment, HCFA-1490, 3145.1, 3302.1, 3302.2, 3302.4B, 3312.1, 3912.3
Request for Part B Query History, 3537

REQUEST FOR PAYMENT:
- defined, 3302ff., 3305.1
- denied, 3704, 3792.2A
- execution of, 3106.2C, 3106.3, 3302.5
- filing, 3301
- informal, 3302.6
- initial determination, 3781.3
- late filing, 3308C

REQUEST FOR PAYMENT (CONT'D):
  patient's signature in hospital record, 3302.4A
  provider signs, 3302.5A
  provider unaware of entitlement, 3308B
  refusal to sign, 3302.7, 3308,
  statute of limitations, 3794.6
  time limitation, 3307ff.
PART A RECONSIDERATION INPUT RECORD:
  appointment of representative, 3789A
  completion of form, 3782.2
  Congressional interest cases, 3735.1B
  dismissal, 3782.8
  disposition of reconsideration, 3784.8
  entitlement or emergency services, 3780.1
  exhibit, 3784
  filing, 3782ff.
  good cause not found, 3781.8F
  inclusion of billing forms in file, 3783.9
  jurisdiction, 3782.6C
  misfiled reconsideration requests, 3790.2D
  more than one component, 3782.6
  overpayment, 3711.11A
  "6 months expired," 3781.8D
  "timely filing questionable," 3781.8B
  withdrawal, 3782.9
REQUEST FOR REFUND:
  content of letter to beneficiary, 3711.5
  optional paragraphs in refund letters, 3711.7
  recovery sought from provider, 3710.4
  sample letter to beneficiary, 3711.6
REQUEST FOR REVIEW OF PART B MEDICAL CLAIM, HCFA-1964:
  exhibit, 3795(Ex. 1)
  filing Part B appeal requests, 3795
  overpayment, 3711.11A
  personal inquiries, 3792.1B
  SSO assistance, 3792.2A
  written inquiries, 3792.1C
Research government grant, 3153.3B
Research project furnishes treatment, 3152B
RESIDENCE:
  change of, 3121.4, 3122.2, 3728.1
  corrected address, 3728.1
  defined, 3113.6, 3120.5,
  individual has no home, 3421.1B
  interns, 3669
  patient confined to, 3116, 3120.4
Resident services (See Intern and resident services)

RESPIRATORY THERAPY:
  covered service, 3101.10B, 3112.4C
  definition, 3101.10A
  diagnostic testing, 3101.10A(4)
  drugs and biologicals, 3112.4B
  exercises, 3101.10A(2)
  monitoring services, equipment 3101.10
  nursing services, 3101.10B, 3112.4C
  outpatient services, 3112.4
  postoperative inpatient, 3101.10C)
  preoperative inpatients, 3101.10C
  qualification for Medicare, 3101.10A, 3101.10B
  reasonable and necessary, 3101.10C
  respiratory therapist, 3101.10B
  skilled nursing facility services, 3101.10B
  teaching, 3101.10A
  transfer hospital, 3101.10B
  use of gases or drugs, 3101.10A
Restoration potential, 3101.8B, 3118.1B
Restorative therapy, 3101.8B, 3118.1B
Retroactive entitlement, hospital insurance, 3001, 3001.1, 3501
RETURNED TO INTERMEDIARY (RTI):
  adjustment bills, 3885.5
  bills tape action, 3836
  code, 3879.4
  consistency reject, 3830.1, 3832
  control number, 3886.1
  correction action bills, 3886.2
  number, 3804, 3804.1B, 3804.3C
  Pending Returned Bill Notice, 3804.3
  removal notice, 3804.3C
  suspense file, 3804.3C
  utilization reject, 3830.1J, 3831, 3831.1., 3840
  void action bills, 3886.3
  void bill record, 3876
  void record layout, 3880.7
Reversal of appeal decision, 3787
Review of appeals, 3791
Review of determination, 3792ff.
Revision of payment determinations, 3799
ROUTINE SERVICES:
  and appliances, 3157
  extended care services, 3133.9A
  foot care, 3158C
  hospital "admission packs," 3101.4
  routine physical checkups, 3157
  routine restorative services, 3101.8D

RTI voids, 3804.1, 3804.3, 3833
Rural community hospitals, 3149
RURAL HEALTH CLINICS:
  bill review, 3642
  coordination intermediaries and carriers, 3642.1
  durable medical equipment, 3642D
  independent, 3894.4
  items or services paid by governmental entity, 3153.3
  physician employees, 3642B
  provider, 3642.1C, 3894.4

-S-

SAMPLE:
  consistency edit exception listing:
    Christian Science format, 3832C
    home health format 3832C
    inpatient format, 3832
    noncovered bill, 3832C
    outpatient format, 3832C
    SNF format, 3832
  denial paragraphs, 3722ff.
  form letters to Members of Congress (See Form letters)
  Guide Language to Beneficiary or His Representative Explaining Waiver of Liability and Possible Right to Indemnification, 3445
  HI alpha microfilm, 3505.3
  Intermediary Report on Independent Rural Health Clinic Bill Workloads, 3843
  Letter A, 3843
  letter from intermediary to third party, 3773B
  Letter to Accompany Reconsideration Determination, 3784
  letter to beneficiary, 3710.4
  letter to beneficiary (reversal), 3784
  letter to provider (reversal notification), 3784
  Letter to Provider Which is Party to Reconsideration and Medicare Payment Is Being Made under Waiver of Liability Provision, 3784
  letter to third party, 3764B
  Model Letter to Provider Who is Party to a Reconsideration Request Filed by the Beneficiary, 3784
  Notice to the Resident Intermediary of Full or Partial Reversal, 3784
  optional paragraphs in refund letters, 3711.7
  paragraphs, 3722ff., 3724, 3799.15B
  refund request to beneficiary, 3711.6
  refund request to estate of deceased, 3711.8

SAMPLE (CONT'D):
  Sample Letter—Full Payment, Revised Reconsideration Determination After Request for Hearing Has Been Filed, 3785.7
  Sample Letter—Partial Revision,Revised Reconsideration Determination After Request for Hearing Has Been Filed, 3785.7
  special letters for denied claims, 3725
  utilization exception listing, 3831
Seaman treated at Government expense, 3153.2
Secondary coverings, 3110.3
Secondary Payer (See Medicare secondary payer)
SERVICES:
  furnished without cost,
  in-plan and out-of-plan, 3360C
  medically unnecessary, 3432.2B, 3707, 3708, 3708.2F, 3708.3 3708.5, 3710.1(I), 3710.3C(2), 3710.4, 3711.6F
  not provided within United States, 3154
  not reasonable and necessary, 3114B, 3151, 3430, 3431A 3431.1A, 3781.4
  not received by beneficiary, 3708.2D
  outpatient surgery, 3626.4
  respiratory therapy, 3101.10
  resulting from war, 3155
  supplies incident to physicians' services, 3110ff., 3112ff., 3212, 3322,
  urgently needed, 3360.1
Shock therapy, 3102.1A
Short-wave treatments, 3101.8C, 3118.1C
SIGNATURE (See also Certification and Recertification):
  claims, 3302.3
  hospital representative, request for payment, 3302.5A,
  legal representative of deceased patient, 3302.5B
  other than patient, 3302.5
  patient's:
    hospital record, 3302.4
    request for payment, 3302.1,
    start of care records, 3302.2C
    ward accommodations, 3101.1A, F, 3410.2,
  physician's, home health plan of treatment, 3120.3, 3148.3
  provider representative, 3302.5A
Similar fault, 3707.1, 3709.2B, 3799.13
Skilled nursing care (See Nursing services)
SKILLED NURSING FACILITIES:
  accommodations, 3101
  accommodations lacking, 3101.1C, 3317C, 3421.1A,
  agreement to participate (See Agreement to participate)
  assurance of payment procedure (See Assurance of payment procedure)
  availability of accommodations, 3421.1A
  billing, 3722.2

SKILLED NURSING FACILITIES (CONT'D):
- blood transfusion, 3235.6
- cancellation, 3008.4B
- certification statements, 3333, 3339
- Christian Science Sanatorium, 3023
- coinsurance, 3210
- conditions of participation, 3421.1B
- custodial care, 3159ff.,
- data record, 3871
- days remaining, 3518.2
- death first day of participation, 3135.4
- defined, 3020
- delayed certifications and recertifications, 3338
- denial paragraphs, 3722.2
- denial rate, 3433, 3434.1
- discharge first day of participation, 3135.4
- distinct part, 3020.1, 3101, 3501.1,
- durable medical equipment, 3137
- excessive denial rates, 3433.4
- expiration of term agreements, 3008.3, 3008.4B
- failure to timely review cases, 3421.1
- first day of participation, 3135.4
- fourteen-day transfer requirement, 3131ff., 3518.2, 3520.3,
- improper coverage decisions, 3439.2
- Indian Health Service, 3153.1B
- inpatient care, 3132.10
- inpatient hospital services, 3101, 3132
- late discharge, 3135.2
- level of care (See Level of care in skilled nursing facility)
- medical appropriatness, 3131.3B
- model letters to beneficiary re Medicare noncoverage, 3730
- noncoverage notice date, 3440.1A
- nonparticipating portion, 3520.5
- not considered residence, 3120.5
- outpatient physical therapy services, 3148.4,
- partial denial over $1,000, 3784.1B
- participating provider of services, 3005, 3131.2B, 3520.2
- partly certified, 3520.2
- patient's preference, 3421.1D
- posthospital extended care, 3132
- query procedures, Part B, 3525
- Railroad Retirement Act covered services, 3519.5
- readmission, 3131.3A, 3131.3B,
- readmissions in same spell of illness, 3542D
- recertification statements, 3333, 3336, 3339

SKILLED NURSING FACILITIES (CONT'D):
  services under Part B, Part A unavailable, 3137,
  sources of information on availability, 3421.1E
  spell of illness, 3123.1, 3131.3B(2e), 3409.1
    defined, 3005.3
    expiration, 3008.3, 3008.4B
    involuntary termination, 3008.2
    renewal-nonrenewal, 3008.1
    voluntary termination, 3008.1
  three day prior hospitalization requirement, 3121.1B, 3131ff., 3431B, 3518.2 (Item I), 3520.3,
  transfer agreement, 3020.2
  unavailability of SNF beds, 3101.1C, 3131.3B
  utilization review, 3420, 3421B
  VA authorized care, 3153.2
  VA benefits exhausted, 3153.2
Skilled nursing services (See Nursing services)
Skin care, 3117.4J, 3132.5F
Sleep Disorder Clinics, 3112.5
SOCIAL SECURITY ADMINISTRATION:
  assistance in query/query reply problems, 3537
  disclosure of information, 3760
  Health Insurance Master Record, 3512.7
  query reply (See Reply to Notice of Admission, HCFA-1568)
  Regulation No. 1, 3761, 3763, 3763.2
  Regulations Nos. 1 and 22, 3760
  Request for Carrier or Intermediary Assistance, HCFA-1938, 3706B
  Requests for Adjustment Bills, SSA-L389, 3817
Social security benefits, 3001.3
SOCIAL SECURITY OFFICE:
  administrative error referrals, 3307.3
  admission notice transmission, 3501ff.
  alien nonpayment cases, 3716
  appeal of full allowance, 3781.8B
  assistance to beneficiary:
    indemnification requests, 3446.3
    patient's appeals, 3782.1A, 3792.2A
  assistance to intermediary, 3537
  beneficiary cannot be located, 3728.1B, 3728.2B
  Congressional inquiries, 3735
  critical cases, 3538.2
  disposition of undeliverable EOMB forms, 3728.1B
  health insurance card, 3502
  incorrect claim number in query, 3512.7, 3535
  indemnification claims, 3446.1
  information and help obtainable, 3709.6

SOCIAL SECURITY OFFICE (CONT'D):
- location of participating skilled nursing facilities, 3421.1E
- notices returned directly to, 3728.2
- partially paid bills, 3715.2D
- query on timely filing, 3781.8B
- questions involving:
  - entitlement, 3780.1A
  - small estate laws, 3715.4A
- reconsideration requests, 3782.1A, 3782.6B, 3782.6C
- request for hearing, 3785.3
- requesting SSO assistance, 3706A, 3715.1C, 3728.2B
- review of payment determination, 3792
- underpayment claims development, 3715.1B
- waiver of recovery, 3709.5

SOCIAL SECURITY PROGRAM SERVICE CENTER:
- overpayment referral, 3712.6
- recovery waived, 3712.5

SPEECH THERAPY:
- conditions for coverage, 3118, 3148ff.
- covered home health service, 3116
- furnished by home health agencies, 3127D
- furnished under home health plan, 3120.3
- home health aide services, 3119.2
- home health services, 3025A, 3118
- inpatient services, 3110
- part-time or intermittent services, 3119.6
- physicians certification content, 3326B
- presumed coverage, 3129.5
- providers, 3147
- rehabilitation service, 3132.9
- related illness or impairment, 3121.3
- request for payment, 3301
- services furnished after termination, 3008.4D
- special option, 3127.1A
- speech pathologist, 3147, 3148.3
- under arrangements, 3118
- under Part B, 3110F, 3127.1A, 3132.8, 3147, 3212

SPELL OF ILLNESS:
- beginning, 3622A
- Christian Science Sanatorium extended care services, 3023, 3035A, 3121.1B
- continuing, 3035C
- defined, 3035
- determination, 3828D
- effect on Part A home health coverage, 3121.1
- eligibility, 3518.2
- extended care benefit days, 3135
- inpatient coinsurance, 3203, 3210
- inpatient deductible, 3201

SPELL OF ILLNESS (CONT'D):
  inpatient hospital benefit days, 3103
  inpatient psychiatric benefit days reduction, 3104, 3510.3
  maximum extended care service days, 3136
  maximum inpatient hospital service days, 3107
  multiple admissions, 3302.1A
  starting, 3035A,
  termination, 3035B, 3103.2, 3135.2
  workers' compensation, effect on, 3409.1
Splints, 3101.5, 3110C, 3110.3, 3112.4C, 3127A, 3212
Spouses of beneficiaries, 3001.3
Spouses of veterans, 3153.3D(1)
SSA Request for Carrier or Intermediary Assistance, SSA-1938, 3706B
START OF CARE, HOME HEALTH (See also Admissions):
  claim number discrepancies, 3504
  delay in transmitting reply, 3307.2
  HMO beneficiaries,
  HMO enrollee, 3540
  intermediary's reply, 3546
  noncoverage notice, 3439.1
  notice, 3121.1C, 3501ff., 3540, 3541, 3542, 3828B
  open item development, 3548
  report of eligibility, 3550
  request for payment, 3301, 3302.5
  SSA reply, 3545
  transmission of notices, 3544
STATE AGENCIES:
  complementary coverage indication,
  disclosure of information, 3302.1B, 3302.2, 3760, 3764A, 3770
  requests for cost report information, 3773C
  resurvey and recertification, 3008.3
STATE BUY-IN:
  files, 3770B
  Part A premium, 3001.4B
  Part B:
    eligibility for enrollment, 3003.1
    enrollment, 3003.4C
    indicator, 3505.3F
    query reject, possible State buy-in, 3535
    reenrollment, 3532
State financed hospitals, 3719.1B, 3719.2
State licensing boards, 3030, 3480A
State veterans homes, 3153.3C

STATE BUY IN (CONT'D):
State workers' compensation, 3431B
State Workers' Compensation Laws, 3408
Statement of Claimant or Other Person, HCFA-795, 3446.3, 3446.9, 3782.1
Statement of Person Regarding Medicare Payment for Medical Services to Deceased Patient, HCFA-1660, 3715.5A
Statement to Permit Payment of Medicare Benefits to Provider, Physicians, and Patient, 3302.2
STATUTE OF LIMITATIONS:
  defined, 3707.1
  fraud or similar fault, 3707.1, 3708.4, 3709.2B
  overpayments recovery, 3707.1
  payment decision not questioned within four years, 3708.4, 3709.2B
  recovery barred expiration of 48 months, 3708
Statutory exclusions, 3431A
STOCK DENIAL PARAGRAPHS:
  home health agency bills, 3722.3
  hospital bills, 3722.1
  miscellaneous, 3722.4
  skilled nursing facility bills, 3722.2
  special letters, inpatient services, 3724
Stump stockings, 3110.5
Subdivisions as home health agencies, 3025.1, 3025.2B
Subluxations of the foot, 3158B
Subpoenaed records, 3763.1B
Summary Totals Report, 3890
Supplement (1972 Amendment Supplement to Intermediary Workload Report), HCFA-1566, 3775A(11)
SUPPLEMENTARY MEDICAL INSURANCE:
  ambulance service, 3114, 3127F, 3212, 3322
  beginning of coverage, 3003.4
  blood deductible, 3235.2
  braces, 3110.5
  coinsurance (See Coinsurance)
  coverage ends, 3003.5
  deductible (See Deductible)
  dentist's service, 3101.7
  diagnostic services, 3112.3A
  disability beneficiaries, 3001.2, 3003.2
  disclosure of information, 3772B
  durable medical equipment, 3113
  enrollment, 3001.2, 3001.3, 3001.4A, 3768C
    automatic, 3003.2
    declined, 3003.2

SUPPLEMENTARY MEDICAL INSURANCE (CONT'D):

- eligibility, 3003.1, 3780.1A
- erroneous, 3004
- general enrollment period, 3003.3, 3003.4A, 3003.6
- grace period, 3003.7C
- initial enrollment period, 3003.3, 3003.4A
- late enrollment, 3003.7A
- periods, 3003.3
- premiums, 3003.7
- reenrollment, 3003.6
- State welfare recipients, 3003.4C
- termination and reenrollment, 3003.6
- waiver of requirements, 3004
- welfare recipients, 3003.4C

- entitlement, 3518.2, 3538
- exclusions from coverage, 3150
- hemodialysis equipment, 3110.4
- home health services, 3116, 3120ff., 3122.1, 3123ff., 3127ff., 3212, 3512.7
- hospital-based physician's services, 3145
- hospital services covered, 3110ff.
- incident to physicians' services, 3110.4, 3110.5, 3112.2, 3212
- incurred expenses, 3212
- inpatient hospital services, 3110
- inpatient services to HMO members, 3555.2
- intern resident services, 3101.6, 3115, 3145
- laboratory tests, 3110A
- mental disease, agency for treatment of, 3025
- offset against Part A overpayment, 3709.1A
- only, CHAMPUS/CHAMPVA entitlement, 3153.3D
- outpatient hospital services, 3012, 3112, 3112.3A
- pathological services, 3146
- payment explanation form to beneficiary, 3717-3719
- physical therapy, 3118.1A, 3301,
- physicians' services, 3145, 3159.1B, 3212
- premiums, 3003.7, 3212
- prosthetic devices, 3110.4
- query procedures, 3525ff.
- radiological services, 3146
- recovery of overpayment, 3711.1
- request for payment, 3302.1A
- skilled nursing facility services, 3137
- speech pathology services, 3301
- stump stockings, 3110.5
- termination of coverage, 3001.4D

SUPPLEMENTARY MEDICAL INSURANCE (CONT'D):
  time limits—charge claims, 3312ff.
  underpayment claims, 3715.1A, 3728.1B
  use of medical equipment, 3113
  voluntary termination, 3003.2
SUPPLIES:
  as covered home health services, 3116, 3119.3A
  as covered inpatient hospital services, 3101.4
  as extended care services, 3133.6, 3133.9A
  home dialysis delivery systems, 3212
  incident to physician's services (See Services and supplies incident to physicians' services)
  necessary for:
    durable medical equipment, 3113.4
    occupational therapy, 3101.9C
    prosthetic devices, 3110.4C
Supplies—Drugs, 3101.3
Supportive devices for feet, 3158.2
SURGICAL:
  definition, 3626.4A
  dressings, 3110C, 3110.3, 3112.4C, 3119.3A, 3127A, 3212
Surgical procedure codes, 3871, 3872, 3875, 3880.3, 3880.6
Survivors, 3715.5, 3715.6
Suspension of payment, 3466
Swing-bed services, 3634
System capability, automated, 3153.2, 3602, 3708.2F

-T-

TEACHING PROGRAM:
  dentistry interns and resident-in-training, 3101.6, 3133.7
  medical services of interns and residents, 3115, 3119.4, 3133.7
  podiatry internship and residency, 3101.6
Technicians, hospital, 3112.3B, 3112.4C
Teeth, removal, filling and replacement not covered, 3101.7, 3162
Telecommunication system (See Advanced record system)
Telegram mailing list, 3557
Telephone contact, 3439D, 3439.1, 3440.1A
Temporary Notice of Medicare Eligibility, 3502.1,
TENS (See Transcutaneous Electrical Nerve Stimulation)
Terminal illness (See Hospice)

TERMINATION:
- coverage, 3001
- due to death, 3512.8
- fraud, 3482
- hearing request, 3008.2
- home health services,
- hospital participation, 3008.4A
- payment for services, 3008.4
- Premium Hospital Insurance coverage, 3001.4D
- program abuse, 3482
- provider participation, 3005.1, 3008ff., 3401.3,
- skilled nursing facility, 3008.4B
- Supplementary Medical Insurance coverage, 3001.4D, 3003.5
- wife's benefits, 3001

TESTING:
- annually, 3563
- consistency edit, 3561
- coordinator, 3560, 3562
- eligibility, 3560, 3562
- entitlement, 3560, 3562
- intermediary's billing process, 3866
- retesting, 3563
- utilization, 3560, 3562

Theft of Medicare checks, 3478

THERAPEUTIC SERVICES:
- range of motion exercises, 3101.8C(5), 3118.1C
- therapeutic excercises, 3101.8C(5), 3117.4D, 3118.1C

THIRD CALENDAR YEAR:
- determination, 3708.6
- overpayment discovered subsequent to, 3708.4, 3708.5, 3709.3A, 3712.4
- special rules, 3708.1, 3708.4

THIRD PARTY:
- disclosure of information, 3770
- liability, 3152D
- overpayment, 3714.3
- payors, 3446
- services, 3157, 3764B

Three-day prior stay requirement (See Prior inpatient stay)

TIME LIMITATION:
- adjustment bills involved, 3816E
- appeals, 3311, 3781.7
- bill submitted after time limitation, 3308,

TIME LIMITATION (CONT'D):
  disposition of sums incorrectly collected, 3401.2
  expires, 3525
  filing for reconsideration, 3781.8A
  filing provider claims, 3307ff.,
  good cause, 3446.2
  late filing 3525, 3610B(11),
  Part B reasonable charge claims, 3312
  provider responsible for not filing timely, 3308A
  recovery of overpayments, 3707.1, 3708.4
  reopening determination, 3799.2, 3799.6
  sixty days of receipt of letter, 3784
  sixty days of receipt of reconsideration notice, 3735, 3781.1, 3781.7, 3790.3A, 3799.15
Title to durable medical equipment, 3113.5
Tolerance rule, 3709.2A, 3715.1D, 3828E
Topical ointments, 3117.4H
Torus palatinus, 3162
Tracheotomy aspiration, 3132.5C
TRAILER CODES:
  Part A, 3512.8
  Part B, 3535.1
Trailer Record Layout, 3882
TRANSFER:
  agreement, skilled nursing facility, 3020, 3020.2, 3131ff., 3133.8,
  delayed, 3431.1B
  of patient, 3121.4, 3121.4,
  requirement skilled nursing facility, 3131ff., 3431.1B, 3520.3
Transitional entitlement to Part A, 3001.1, 3001.4D
Transmittal and Report Form, 3890
Transportation (See Ambulance service)
Treatment, alcoholic , 3610.13
Trusses, 3110.5, 3112.4C, 3212
  active treatment, 3321,
  benefit limitation, 3107A
  certification and recertification by physician, 3315, 3321, 3324
Twenty-four hour grace period, 3431.1B

-U-

Ultrasound diagnostic procedures, 3146C,
Ultrasound treatments, 3101.8C, 3118.1C
Unassigned claims, 3302.3B, 3302.4B
Undeliverable notices, 3728
Under arrangements (See Arrangements for services)

UNDERPAYMENTS:
  adverse claims, 3715.7
  beneficiary deceased, 3715ff., 3728.1B, 3728.1B
  development of claims, 3715.1, 3728.1B
  entitlement dispute, 3715.1G
  evidence, 3715.2B
  general, 3715ff.
  less than $5., 3715.1D
  more than one person entitled, 3715.2C
  partially paid bills, 3715.2D
  payment to:
    legal representative, 3715.4
    person who paid for services, 3715.3
    survivors, 3715.5
  tolerance rule, 3715.1D
  unnegotiated checks, 3715.1C
Unethical conduct, 3480
Unibill record layout, 3674.5
Uniform Bill Code, 3871, 3872, 3875, 3876, 3880.2, 3880.3, 3880.7
Uniform Bill Form (See Inpatient & Outpatient Bills)
Uniformed Services, 3153.3D, 3153.3E
UNITED STATES:
  Attorney, 3468.1B
  beneficiary outside United States, 3113.7B, 3154
  citizen, 3001.4A
  crime against security, 3001.1
  Criminal Code, 3460A
  debt owed to United States Government, 3707
  District Court, 3773C, 3781.1
  emergency services outside United States, 3310
  Homeopathic Pharmacopoeia, 3101.3
  Pharmacopoeia, 3101.3
  Public Health Service, Commissioned Corps, 3153.3
  resident alien, 3003.1
  Secret Service investigation, 3476
  services outside United States, 3154, 3520.2
  territory, defined, 3154
Unlicensed graduates, foreign medical schools, 3115A
Unnecessary services, 3114B, 3151
Unprofessional conduct, 3480
Urinary aids, 3110.4
Use of durable medical equipment (See Durable medical equipment)

UTILIZATION:
  benefits, effect of workers' compensation, 3409.2, 3410.2C
  bills, 3828.2
  chargeable, 3718
  edits, 3827ff., 3828.1, 3828.3, 3845.2B
  error codes, 3828.1
  low utilization providers, 3434.6
  notices (See Medicare Hospital Extended Care and Home Health Benefits Record)
  Part A Bill Retrieval Listing (Bill History), 3512.7
  testing, 3560, 3562, 3563
UTILIZATION REVIEW:
  admission before entitlement, 3420.2
  adverse decision, 3421A
  adverse finding, 3421C
  appeal of committee decision, 3781.6
  availability of other facilities and services, 3421.1
  committee, 3420
  determination:
    level of care, 3421.1A, 3781.6
    presumed coverage cases, 3139.3
  documentation of files, 3783
  failure to timely review cases, 3421.2
  finding precludes payment, 3803
  location of alternative facilities, 3421.1C
  misutilization, 3480B(2)
  noncoverage notice, 3440A, 3440.1B, 3730.1B
  notices, 3421B, 3781.8A
  only home health services required, 3421.1B
  overutilization, 3480B, 3708.2B
  patient's financial status and personal preferences, 3421.1D
  payment limitation, 3421C
  physician compensation for, 3420.1
  plan, 3420
  podiatrist, excluded as physician, 3030.3
  provider informed of noncoverage, 3439B
  recertification requirement and utilization review:
    hospitals, 3315, 3317D
    skilled nursing facilities, 3336

-V-

Verifying prior stay, home health services requirement, 3520, 3547
VETERANS ADMINISTRATION:
  authorization to non-Federal providers, 3153.2, 3708.2F
  hospitals, 3030.4
  sharing agreements with non-VA hospitals, 3153.1A
  State veterans homes, 3153.C

Visits (See under Home health services)
Vitamin B-12 injections, 3117.4H
Vocational assessment, 3101.9B

-W-

WAIVER OF LIABILITY:
- amount in controversy, 3785.1A
- ancillary services, 3444
- appeal rights, 3721
- automatic consideration, 3799.16
- batching bills, 3803
- beneficiary without fault, 3708.4
- beneficary's liability determination, 3432.1, 3444.1
- change in provider waiver status, 3434.5
- charges waived, 3152
- criteria, 3433ff., 3439A
- decisions, 3442, 3721
- denial paragraphs, 3722.5
- denial under section 1862, 3794.8B
- determination, 3432, 3781.3L
- documentation, 3783.3
- favorable waiver presumption:
  - denial rate criterion, 3444.2, 3444.3
  - low utilization providers, 3434.6
  - notice of noncoverage, 3441.1
  - provider's qualification, 3433
  - reevaluating and notifying providers, 3433.3
  - reevaluating prior period, 3433.5
  - withdrawal, 3444.7
- home health services, 3431.3
- indemnification procedures, 3446
- no distinction of services, 3784.8
- "No Fault," 3640.7
- noncovered services, 3709.3
- nonentitlement case, 3712.4
- no-payment HCFA-1483,
- outpatient services, 3444
- overpayment, 3707, 3799.16
- overpayment referred to Medicare Bureau, 3709.3, 3709.5
- Part A claim, 3430, 3431, 3431.3,
- Part B claim, 3430, 3444
- Part B hearing, 3794.6
- Part B query, 3525
- Part B services, 3630
- payment, 3441
- payment limitation, 3421C

WAIVER OF LIABILITY (CONT'D):
  provider:
    and beneficiary without liability, 3432.2C
    liability determination, 3432ff., 3444.2
    right to appeal, 3784.7B
  reconsideration letter, 3784
  recording overpayment cases, provider not liable, 3711.10
  reevaluation element, 3799.14
  reversal decisions, 3786E
  SNF bills, 3630
  status, 3773C(5)
  stock paragraphs, 3722.5
  three-day prior hospitalization, 3431.1A, 3518.2
  transfer requirement, 3431.1B
  waiver of recovery, 3708, 3711.3B, 3711.6G, 3711.11B
War, servces resulting from, excluded, 3155
Wards (See Accommodations: ward)
Water mattresses, 3113.1B
Welfare agency, source of payment on behalf of patient, 3711.1
Welfare recipients, 3003.4C, 3711.3C, 3712.2
WHEELCHAIRS:
Whirlpool baths, 3101.8C, 3113.2B, 3118.1C
Widows age 50 or over, 3001.2
Widows of veterans, 3153.3D
Withholding payments (See Suspension of Payments)
WITHOUT FAULT:
  beneficiary, 3658B, 3708.4, 3709.2C, 3709.3A, 3712.4
  causing overpayment, 3711.6G
  deceased beneficiary, 3711.8
  determining liability, 3432.3
  provider, 3708, 3708.4, 3709.2C, 3709.3A
  waiver issue, 3799.16
Work-related conditions (See Workers' Compensation)
Work requirements, 3001.1
WORKERS' COMPENSATION:
  accommodations, 3410ff.
  ancillary services, 3410.4
  benefits, effect on, 3409.2
  benefits exhausted, 3415C, 3416
  billing, workers' compensation involved, 3679
  characteristics of program, 3408
  claim disputed, 3416.2
  contested cases, 3415D
  deductible and coinsurance, 3409.3
  determination, 3415E
  exclusion, 3163, 3407
  expiration of time limit, 3307.3
  Federal, 3431B
  Federal civil service employees, 3407

WORKERS' COMPENSATION (CONT'D):
  filing date expired, 3416.3
  fully paid, 3816F
  individual responsible to file, 3407
  intermediary action, 3415
  lifetime psychiatric limitation, 3409.2
  limitation, 3410.3
  lump-sum settlement, 3412, 3413, 3415D, 3416.4
  Medicare benefits erroneously paid, 3708.2A
  Medicare payments made, 3416.1
  no-payment cases, 3803
  overpayments, 3416, 3711.7B
  partial payments, 3410ff.
  payment expected, 3409, 3541H, 3542E
  provider handling, 3414
  referral of completed cases, 3417
  spell of illness, effect of, 3409.1
  State, 3431B
  State Workers' Compensation Laws, 3408
  work related injury, 3708.2A
WORKLOAD REPORTING FORMS:
  Medicare/Medicaid Abuse Report, HCFA-51, 3454.1G, 3455
  Postpayment Medical Review (Abuse Cases) Summary Report--Medicare, HCFA-60, 3455
  preparation and distribution, 3455
  workload reports (See Intermediary Workload Report, HCFA-1566)

-X-

X-ray, 3101.7, 3110B, 3112.3A, 3137.1, 3146C, 3152, 3157, 3162, 3212, 3912

-Y-

Your Record of Part B Medicare Benefits Used, 3719.2, 3726.1
"Your Right to Question the Decision on Your Hospital Insurance Claim," SSA-75-10085, 3721

U.S. GOVERNMENT PRINTING OFFICE 1989/241-194/05112